



WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD

130TH SESSION

GENEVA, 16–23 JANUARY 2012

SUMMARY RECORDS

GENEVA
2012

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

ACHR	– Advisory Committee on Health Research	OIE	– <i>Office International des Epizooties</i>
ASEAN	– Association of Southeast Asian Nations	PAHO	– Pan American Health Organization
CEB	– United Nations System Chief Executives Board for Coordination	UNAIDS	– Joint United Nations Programme on HIV/AIDS
CIOMS	– Council for International Organizations of Medical Sciences	UNCTAD	– United Nations Conference on Trade and Development
FAO	– Food and Agriculture Organization of the United Nations	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 employed and the presentation of the material in this volume do not imply the expression of any opinion whatsoever on the part of the Secretariat of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Where the designation “country or area” appears in the headings of tables, it covers countries, territories, cities or areas.

PREFACE

The 130th session of the Executive Board was held at WHO headquarters, Geneva, from 16 to 23 January 2012. 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. The resolutions and decisions, and relevant annexes are published in document EB130/2012/REC/1.

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¹ As adopted by the Board at its first meeting (16 January 2012).

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- C. Global strategy and plan of action on public health, innovation and intellectual property (resolution WHA61.21)

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- D. Smallpox eradication: destruction of variola virus stocks (resolution WHA60.1)
- E. Eradication of dracunculiasis (resolution WHA64.16)
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- J. Control of human African trypanosomiasis (resolution WHA57.2)
- K. Global health sector strategy on HIV/AIDS, 2011–2015 (resolution WHA64.14)
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Other

- M. Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets (resolution WHA57.12)
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EB130/1 Rev.1	Agenda ¹
EB130/1 Add.1	Proposal for a supplementary agenda item
EB130/1(annotated)	Provisional agenda (annotated)
EB130/2	Report by the Director-General to the Executive Board at its 130th session
EB130/3	Nomination of the Director-General: draft contract ²
EB130/4	Report of the Programme, Budget and Administration Committee of the Executive Board
EB130/5	WHO reform
EB130/5 Add.1	WHO reform: programmes and priority setting
EB130/5 Add.2	WHO reform: programmes and priority setting: summary information on the distribution of financial and human resources to each level and cluster
EB130/5 Add.3	WHO reform: governance
EB130/5 Add.4	WHO reform: governance: promoting engagement with other stakeholders and involvement with and oversight of partnerships
EB130/5 Add.5	WHO reform: managerial reform: making WHO's financing more predictable
EB130/5 Add.6	WHO reform: managerial reform: contingency fund for outbreaks
EB130/5 Add.7	WHO reform: managerial reforms: clarification on proposals for enhancing organizational effectiveness
EB130/5 Add.8	WHO reform: WHO evaluation policy
EB130/5 Add.9	WHO reform: managerial reform: evaluation

¹ See page xi.

² See document EB130/2012/REC/1, Annex 1.

EB130/6	Outcomes of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control ¹
EB130/7	Implementation of the global strategy for the prevention and control of noncommunicable diseases and the action plan
EB130/8	Implementation of the action plan for the prevention of avoidable blindness and visual impairment
EB130/9	Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level
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EB130/12	Early marriages, adolescent and young pregnancies
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EB130/16	Implementation of the International Health Regulations (2005)
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EB130/18	Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits: report of the Advisory Group
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¹ See document EB130/2012/REC/1, Annex 2.

² See document EB130/2012/REC/1, Annex 3.

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EB130/19 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly ¹
EB130/20	Elimination of schistosomiasis
EB130/20 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly ¹
EB130/21	Draft global vaccine action plan: update
EB130/22	Substandard/spurious/falsely-labelled/falsified/counterfeit medical products: report of the Working Group of Member States
EB130/22 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly ¹
EB130/23	Consultative expert working group on research and development: financing and coordination
EB130/24	WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies
EB130/25	Appointment of the Regional Director for the Eastern Mediterranean
EB130/26 and EB130/26 Add.1	Human resources: annual report
EB130/27	Report of the International Civil Service Commission
EB130/28	Amendments to the Staff Regulations and Staff Rules ²
EB130/28 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly
EB130/29 Corr.1	Election of the Director-General of the World Health Organization: report of the working group
EB130/30	Membership of the Independent Expert Oversight Advisory Committee

¹ See document EB130/2012/REC/1, Annex 6.

² See document EB130/2012/REC/1, Annex 4.

EB130/31	Reports of committees of the Executive Board: Standing Committee on Nongovernmental Organizations ¹
EB130/32	Awards
EB130/33	Provisional agenda for the Sixty-fifth World Health Assembly
EB130/34	Report on meetings of expert committees and study groups
EB130/34 Add.1	Reports of advisory bodies: expert committees and study groups – expert advisory panels and committees and their membership
EB130/35, EB130/35 Add.1, EB130/35 Add.2 and EB130/35 Add.3	Progress reports
EB130/36	United Nations Conference on Sustainable Development Rio+20
Information documents	
EB130/INF.DOC./1	Nomination of the Director-General: nomination for the post
EB130/INF.DOC./2	Statement by the representative of the WHO staff associations
Diverse documents	
EB130/DIV/1 Rev.1	List of members and other participants
EB130/DIV/2	Preliminary daily timetable
EB130/DIV/3	Decisions and list of resolutions
EB130/DIV/4	List of documents

¹ See document EB130/2012/REC/1, Annex 5.

COMMITTEES¹

1. Programme, Budget and Administration Committee

Dr Mouzinho Osvaldo de Assunção Saíde (Mozambique, Chairman), Mr Donville Inniss (Barbados), Dr Norbert Birintanya (Burundi, Vice-Chairman), Dr Paul Gully (Canada), Dr Ren Minghui (China, Vice-Chairman), Dr Ewold Seeba (Germany), Mr P.K. Pradhan (India), Dr Shigeru Omi (Japan), Dr Abdulla Al-Qahtani (Qatar), Dr Gaudenz Silberschmidt (Switzerland), Mrs Madalena Hanjam Soares (Timor-Leste), and Dr Abdul Karim Yahia Rasae (Yemen); and, as members ex officio, Mr Rahhal El Makkaoui (Morocco) and Dr Boubacar Samba Dankoko (Senegal).

Fifteenth meeting, 12 and 13 January 2012: Dr Mouzinho Osvaldo de Assunção Saíde (Mozambique, Chairman), Dr Joy St. John (alternate to Mr Donville Inniss, Barbados), Dr Norbert Birintanya (Burundi, Vice-Chairman), Ms G. Wiseman (adviser to Dr Paul Gully, Canada), Dr Ren Minghui (China, Vice-Chairman), Mr Björn Kümmel (adviser to Dr Ewold Seeba, Germany), Mr S. Prasad (adviser to Mr P.K. Pradhan, India), Dr Masato Mugitani (adviser to Dr Shigeru Omi, Japan), Dr Gaudenz Silberschmidt (Switzerland), Mr J.A.M. da Fonseca (alternate to Mrs Madalena Hanjam Soares, Timor-Leste), and Mr I. Al-Adoofi (alternate to Dr Abdul Karim Yahia Rasae, Yemen); and, as member ex officio, Dr Boubacar Samba Dankoko (Senegal).

2. Standing Committee on Nongovernmental Organizations

Dr Bernard Valentin (Seychelles, Chairman), Professor Ara Saenovič Babloyan (Armenia), Dr Maria Teresa Valenzuela (Chile), Dr Pe Thet Khin (Myanmar), and Dr Awad Ibrahim Abdi (Somalia).

Meeting of 17 January 2012: Dr Bernard Valentin (Seychelles, Chairman), Professor Ara Saenovič Babloyan (Armenia), Dr Jorge Díaz Anaiz (alternate to Dr Maria Teresa Valenzuela, Chile), Dr Pe Thet Khin (Myanmar), and Dr Awad Ibrahim Abdi (Somalia).

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 2012: Mr Rahhal El Makkaoui (Morocco, Chairman), Professor Phyllis Erdogan, appointee of Professor A. Doğramacı (President of Bilkent University) and Professor Tomris Türmen, representing the International Children's Center, Ankara.

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

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 18 January 2012: Mr Rahhal El Makkaoui (Morocco, Chairman), Professor K. Kiikuni (representative of the Founder), and Mr Luvsantseren Orgil, alternate to the member of the Executive Board for Mongolia.

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 17 January 2012: Mr Rahhal El Makkaoui (Morocco, Chairman), Mr Obaid Salem Saeed Al Zaabi (representative of the Founder), and Dr Wael Al-Halki, member of the Executive Board for the Syrian Arab Republic.

6. State of Kuwait Health Promotion 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 17 January 2012: Mr Rahhal El Makkaoui (Morocco, Chairman), Mr Zeyad Almashan (representative of the Founder), and Dr Abdulla Al-Qahtani, member of the Executive Board for Qatar.

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 17 January 2012: Mr Rahhal El Makkaoui (Morocco, Chairman), Mr Jeong In-ahn (representative of the Founder), and Mr P. Kase, alternate to the member of the Executive Board for Papua New Guinea.

SUMMARY RECORDS

FIRST MEETING

Monday, 16 January 2012, at 09:40

Chairman: Mr R. EL MAKKAOUI (Morocco)

- 1. OPENING OF THE SESSION AND ADOPTION OF THE AGENDA:** Item 1 of the Provisional agenda (Documents EB130/1, EB130/1(annotated) and EB130/1 Add.1)

The CHAIRMAN declared open the 130th session of the Executive Board and welcomed participants, especially new Board members Mr Pradhan (India) and Mr Espinosa Salas (Ecuador).

Election of Rapporteur

The CHAIRMAN said that Dr Chiriboga, the Board member designated by Ecuador who had been replaced by Mr Espinosa Salas, had been elected as Rapporteur at the Board's 129th session. The Member States of the Region of the Americas had proposed that Mr Espinosa Salas should be elected Rapporteur.

It was so decided.

Adoption of the agenda

The CHAIRMAN drew attention to item 7.1, Amendments to the Financial Regulations and Financial Rules, and proposed that, as no such amendment had been submitted, the item should be deleted.

It was so agreed.

The CHAIRMAN further drew attention to document EB130/1 Add.1, containing a proposal submitted by Brazil for a supplementary agenda item entitled "United Nations Conference on Sustainable Development (Rio+20)".

Mr HE Yafei (China), suggesting that the representative of Brazil be invited to elaborate on the proposal, said that the United Nations Conference on Sustainable Development (Rio+20) would have a significant impact on sustainable development worldwide. Public health was an important component of sustainable development and should be fully reflected in the future development agenda.

Having been given the floor by the CHAIRMAN, Mrs ESCOREL DE MORAES (Brazil)¹ said that the Rio+20 Conference would represent a once-in-a-generation chance to mobilize the political resources required to design a lasting solution to the international crisis, taking into account the interdependence and mutual supportiveness of the economic, social and environmental aspects of development. Health had been a core element of the concept of sustainable development since its

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

inception, and that principle was enshrined in the Rio Declaration on Environment and Development (1992). Chapter 6 of Agenda 21, the Plan of Implementation of the World Summit on Sustainable Development (Johannesburg 2002), and the Rio Declaration adopted at the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, 19–21 October 2011), all underlined the links between health and sustainable development. Strengthening health systems, achieving universal coverage, addressing social determinants and reducing health inequities were common aspirations and must be part of the roadmap towards sustainable development.

It would therefore be desirable to undertake an open and structured dialogue within WHO on the place of health in sustainable development. Consultations could take place between February and May 2012, allowing Member States to discuss WHO's contribution to the Rio+20 Conference, particularly with regard to its two main themes: the green economy in the context of sustainable development and poverty eradication, and governance for sustainable development. It would also help to ensure that health issues received appropriate attention in the Rio+20 proceedings.

Dr SILBERSCHMIDT (Switzerland) expressed support for the proposal, but recalled that the Board had agreed during its special session in November 2011 that it should limit the number of draft resolutions examined during its sessions. Criteria should be developed for that purpose, based on factors such as the priority, urgency and political importance of the issue. He was satisfied that the proposal of Brazil met such criteria, but urged the Board to exercise caution, discipline and courage in considering whether to adopt draft resolutions during the session.

Dr DAULAIRE (United States of America), echoing the comments made by the member for Switzerland, said that the Board and other governing bodies of the Organization must abide by agreements reached and rules established. He would not oppose Brazil's proposal, but it should – under Rule 8 of the Rules of Procedure of the Executive Board – have been submitted to the Director-General not later than 10 weeks before commencement of the session. Failure to abide by that Rule was troubling, particularly given that the Rio+20 Conference had been years in the planning. In view of the Board's heavy agenda, any supplementary item should be discussed at the end of the session.

Mr ESPINOSA SALAS (Ecuador) said that discussions in various United Nations forums had thus far failed to define the scope of the two main themes of the Rio+20 Conference, and further consultations on those themes and WHO's contribution to the Conference would be beneficial. He therefore supported the inclusion of the supplementary item.

Dr AL-ADOOFI (Yemen) expressed support for the proposal. The Rio+20 Conference would provide an important opportunity to advance efforts towards sustainable development, in which health should figure prominently. Including the proposed supplementary item on the Board's agenda would reflect the importance that WHO attached to the matter.

Dr GULLY (Canada) agreed with the views expressed by the members for Switzerland and the United States of America. He would not oppose the inclusion of a supplementary agenda item on the important issue of sustainable development, but he sought clarification about the nature and outcome of the discussion envisaged, given that governments were already engaged in such discussions. If the item were added to the agenda, it should be discussed at the end of the Board's session.

Mrs ESCOREL DE MORAES (Brazil),¹ responding to the member for Canada, suggested that the documents drafted by the Secretariat in preparation for the Rio+20 Conference could serve as a basis for discussion. She had no specific proposal to make about the outcome of the discussion, but

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

envisaged an exchange of views, not negotiations, on the contribution that WHO and individual Member States could make to the Rio+20 Conference and on how they might influence the outcome of the Conference itself.

The DIRECTOR-GENERAL said that the Secretariat had held discussions with other United Nations bodies in preparation for the Rio+20 Conference and had submitted a document on the subject to the United Nations System Chief Executives Board for Coordination, which she could provide to the Executive Board if it so wished.

The CHAIRMAN took it that the Board wished to include in its agenda the supplementary item as proposed in document EB130/1 Add.1 and to adopt the agenda as amended.

The agenda, as amended, was adopted.¹

2. ORGANIZATION OF WORK

Dr JESSE (Estonia) 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 130th session of the Board, as at previous sessions, representatives of the European Union 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.

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

It was so agreed.

Mr ESPINOSA SALAS (Ecuador), speaking on behalf of the Union of South American Nations, announced that the member countries of that group intended to submit a draft resolution on measles under agenda item 6.12, Draft global vaccine plan: update.

Dr SILBERSCHMIDT (Switzerland) enquired about arrangements for installing the "traffic light" system for limiting the duration of speakers' interventions, as agreed during the Board's special session in November 2011.

Mrs ROSE-ODUYEMI (Office of the Governing Bodies) replied that the system would be introduced during the current meeting.

The CHAIRMAN noted that items 3, Nomination of the Director-General, and 8.1, Appointment of the Regional Director for the Eastern Mediterranean, would be discussed in open meetings, attended only by members of the Board, their alternates and advisers, Member States not represented on the Board, Associate Members and the Secretariat, in accordance with Rule 7 of the Rules of Procedure. No official records of those open meetings would be prepared.

¹ Document EB130/1 Rev.1.

3. REPORT BY THE DIRECTOR-GENERAL: Item 2 of the Agenda (Document EB130/2)

The DIRECTOR-GENERAL, presenting her report, said that the public health community could be proud of its achievements since the start of the 21st century. Member States could be especially proud of their consistent ability to reach agreement on global governance instruments that provided collective protection against shared health threats or that met shared needs. Notable examples included the Pandemic Influenza Preparedness Framework and the Commission for Information and Accountability for Women's and Children's Health.

In 2011, a turbulent year, politicians, economists and the mass media had begun to pay more attention to inequality as a threat to social stability and world security. Research had shown that societies with the least inequality of income had the best health outcomes, regardless of levels of spending on health. Money alone could not buy better health; policies that promoted equity had a better chance. Universal health coverage was a powerful equalizer.

The long-standing public health quest for equity and social justice was yielding measurable results. Commitment to a limited number of time-bound goals had improved health outcomes and left a powerful legacy of disease control innovations. Public health authorities had broken new ground by tackling the need to build national capacity to generate and analyse basic health data. Without such information, there could be no accountability and, at a time of financial stringency, both donors and recipients must be held accountable. The public health community, facing pressing new challenges, in particular that of noncommunicable diseases, must tackle their root causes through an approach based on social determinants and engaging the whole of government and society. WHO would give its obligations in the area of noncommunicable diseases the highest priority.

The challenges facing public health and the broader global context surrounding them required WHO to make changes in its governance and management, its programmes and its approach to priority-setting. At the Board's special session in November 2011, members had worked hard to ensure that work on WHO reform was headed in the right direction. She looked forward to receiving further guidance from the Board and the Health Assembly on how to equip WHO to respond to the challenges it faced and encouraged the Board to keep the issue of reform in mind as it considered the other items on its agenda.

Mr GÓMEZ CAMACHO (Mexico), praising the leadership displayed by the Director-General, said that noncommunicable diseases and, in particular, obesity presented a major challenge. In cooperation with the Secretariat, Mexico had taken dramatic and innovative steps to tackle the problem, and had shared its experience with other Member States. It had also striven to ensure universal health care – an objective it had recently achieved – in the dual conviction that health was a central element of social justice and that a healthy population was a productive population.

Mrs BAMIDELE (Nigeria), speaking on behalf of the Member States of the African Region, thanked the Director-General for her effective management and her prioritization of African health issues. WHO had been innovative and pro-active in responding to public health challenges worldwide at a time of unprecedented social and economic upheaval. She commended the Organization's efforts to mobilize financial and other resources for important public health issues and encouraged the promotion of more predictable and sustainable financing of WHO. She supported the funding of special projects through voluntary contributions, but encouraged careful consideration in the use of assessed contributions for the payment of salaries for staff on such projects. She also welcomed the Director-General's efforts to reform WHO and reposition it to face the challenges ahead, urging greater transparency and accountability, improved internal oversight within WHO and continued maintenance of its intergovernmental nature.

Greater equity was needed in order to ensure improved health outcomes and greater social cohesion. WHO should continue to work in that area and to expand all activities aimed at increasing access to health-care services. Country health systems should be strengthened so that countries might achieve the Millennium Development Goals and progress beyond them. The availability of affordable medicines, a major challenge in Africa, was also crucial to good health outcomes. She requested the

Director-General to work towards empowering Member States to manufacture their own essential medicines. She noted the need to strengthen disease control and eradication programmes and combat noncommunicable diseases through enhanced surveillance and the setting of realistic targets. The ongoing transmission of wild poliovirus was a matter of concern, and she encouraged WHO to continue working with affected countries to eradicate poliomyelitis. Immunization coverage had improved in Africa, and she called on the Director-General to sustain the supply of vaccines to African countries.

Dr JESSE (Estonia), speaking on behalf of the European Union and its Member States, said that the acceding State Croatia, the candidate countries Turkey, the former Yugoslav Republic of Macedonia, Montenegro and Iceland, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina and Serbia, together with Ukraine, Armenia and Georgia aligned themselves with her statement. She welcomed the progress reported in numerous areas, but acknowledged that great challenges remained in others. One of those was WHO reform, on which considerable progress had been made during the Board's special session in November 2011; the current session should add substantially to that progress. The overall goal of reform should be to make WHO fit for purpose at all levels, strengthening its role as the lead agency for health while ensuring its full independence, transparency, accountability, efficiency and effectiveness. Prioritization would be a key element in shaping the future of the Organization.

The decisions taken by the Board during the special session should begin to be applied immediately. In particular, as the member for Switzerland had said earlier in the meeting, the Board should strive to limit the number of draft resolutions based on an assessment of their strategic value, financial and administrative implications, and reporting requirements and timelines. She strongly encouraged the Board to consider those criteria when examining the many draft resolutions before it. Through joint effort, Member States could make WHO stronger and better adapted to meet the challenges of global health governance, enabling it to advance towards its objective: the attainment by all peoples of the highest possible level of health.

Mr YUSOF (Brunei Darussalam) endorsed the Director-General's observations on the need to extend universal health care coverage so as to ensure accessibility and equality of health care, which was a means of achieving sustainable socioeconomic development. As a member of the Western Pacific Region, his country fully supported WHO's efforts to strengthen the implementation of current strategies and to seek innovative approaches to improving global health. He commended the Secretariat's efforts in focusing global attention on the prevention and control of noncommunicable diseases and securing political commitment during the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases. Progress had been made in respect of tobacco-control initiatives, and his country had a few days before it hosted a WHO technical meeting on plain packaging of tobacco products. Continued attention would be essential in order to ensure that those efforts were not undermined.

The Board's discussions the previous year on WHO reform had clarified strategic directions and identified key areas for improvement. The Organization must be more resourceful and innovative in order to make management and governance more efficient and achieve financial stability. The items on the Board's agenda reflected WHO's commitment to protecting public health globally and its recognition that health could be harmed by threats such as radiation and chemical events as well as by disease. Brunei Darussalam would continue to support WHO efforts to implement evidence-based policies and strategies in line with agreed priorities.

Mr MAXTONE-GRAHAM (Papua New Guinea), speaking on behalf of the Pacific island countries, commended the Director-General's leadership and achievements during her first term of office and expressed the hope that she would continue for a further term. He supported her frank view that health was in crisis but considered that, nevertheless, the Secretariat and Member States had made significant progress. Noncommunicable diseases and nutrition were a particular concern for Pacific island countries, and he welcomed their inclusion on the Board's agenda.

Dr GRALL (France) said that the discussion of WHO reform and of the roles, priorities and financing of the Organization was essential in order to equip WHO to adapt to changes in the international environment and respond to new health challenges, including natural disasters. The Board's deliberations ought to result in clear guidance on the main directions of reform: coherence of governance, priority-setting, the rightful role of the private sector, financing and evaluation. WHO should retain its role as an international health organization, and its normative functions should remain paramount. At a time of economic constraint, the Organization must remain at the service of its Member States and the health of their peoples. It must also preserve independence and transparency in its relations with the private sector in order to maintain its credibility and authority.

The Board's agenda revealed the range of health challenges to be faced. Much remained to be done in order to achieve the Millennium Development Goals. Intensified effort was needed in response to HIV/AIDS and other pandemics. Strengthening health information systems was vital to the attainment of Goals 4 and 5, and he saluted the work of the Commission on Information and Accountability for Women's and Children's Health. The increased attention to neglected tropical diseases was also welcome.

Noncommunicable diseases were placing a heavy burden on populations, health systems and economies. He commended WHO's leadership in mobilizing an international response to them and welcomed the adoption of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, which committed WHO to establishing reliable, evidence-based indicators that could be tailored to country situations.

The Secretariat should continue to support Member States in implementing the International Health Regulations (2005) and in strengthening international health security and epidemiological surveillance. Preparedness was an important aspect of health security, and he therefore welcomed the adoption of the Pandemic Influenza Preparedness Framework and looked forward to its implementation. Health crises and threats, such as antimicrobial resistance, were frequently of global importance, and efforts to respond to them must take into account environmental and social determinants of health. Health system strengthening and promotion of universal health coverage were also of critical importance and WHO should play a leading role in activities in those areas.

Dr REN Minghui (China) said that WHO had overcome various difficulties in 2011 and had continued to lead the international community in the promotion of public health. The First Global Ministerial Conference on Healthy Lifestyles and the Control of Noncommunicable Diseases and the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases had raised international awareness of noncommunicable diseases, whereas the World Conference on Social Determinants of Health had highlighted the need for intersectoral involvement in health policy-making aimed at reducing health inequalities. He commended the Secretariat's contributions to those conferences.

The occurrence of imported cases of poliomyelitis along China's borders during 2011 had clearly shown that eradication of the disease and the maintenance of poliomyelitis-free status would be a long-term task. Communicable disease prevention and control remained important for global public health. The Secretariat should continue to support Member States in their efforts to strengthen health systems and to promote universal access to essential medicines and vaccines.

WHO had demonstrated its leadership during the recent negotiations concerning the sharing of influenza virus strains. Brazil, Russian Federation, India, China and South Africa had established a mechanism for regular health ministerial meetings, which should help to strengthen cooperation in respect of access to medicines.

At the Board's special session in November 2011, unanimous agreement had been expressed on the necessity and urgency of WHO reform. China stood ready to work with other Member States in order to develop a more efficient, responsive, transparent and accountable Organization.

Dr AL-HALKI (Syrian Arab Republic) welcomed the progress made on WHO reform, with its aim of system-wide harmonization, transparency and accountability. Greater cooperation among all partners was essential in order to tackle the challenges facing the global health sector and to provide

countries with necessary support. His Government had allocated substantial funding to the health sector in order to enhance political and social stability. Notwithstanding the damage done to the country's health system and personnel by armed insurgents, it continued to deliver all health services, with an emphasis on chronic diseases and health development programmes. Those services were provided free of charge to all citizens, irrespective of their political affinities, which helped to foster social justice.

Dr AL-ADOOFI (Yemen) said that, in the interests of improving health service delivery in developing countries, WHO must continue to play its role in strengthening health systems, strategies and policies; ensuring the supply of medicines; and supporting countries' efforts to achieve the Millennium Development Goals. Socioeconomic stability, equity and social justice were important for a strong health sector. Sustainable development was intrinsically linked to public health; indeed, good public health was crucial to efforts to eradicate poverty. In that connection, the reported decline in child and maternal mortality rates was particularly welcome. The challenge for the future lay in sustaining such public health successes and pursuing attainment of the health-related Millennium Development Goals by 2015. The WHO reform process would be vital in enhancing the Organization's efficiency and effectiveness and enabling the Secretariat to better support Member States in meeting that challenge. The reform should be transparent and inclusive of all Member States.

Dr DANKOKO (Senegal) thanked the Director-General for her sustained interest in the health needs of the African countries and for inviting Senegal to participate in the useful work of the Commission on Information and Accountability for Women's and Children's Health. He commended her leadership of WHO reform and urged greater attention to the regional and national levels as a means of rendering the Organization more effective.

Dr LARSEN (Norway) commended the Director-General's frankness about the severe global challenges that lay ahead. The achievement she described instilled confidence that WHO continued to tackle those challenges and develop tools to improve health, such as the WHO Global Code of Practice on the International Recruitment of Health Personnel, which sent a clear signal of global solidarity in that area. The High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases had mandated WHO to develop indicators and targets for the prevention and control of noncommunicable diseases. Norway looked forward to participating in that activity.

Reform was essential to ensure that WHO maintained its leadership in international health. The Organization must improve its efficiency and transparency and uphold its democratic principles. That needed a more predictable and equitable process of financing and better priority-setting, with increased participation of Member States in governance procedures.

Dr OMI (Japan) welcomed the Director-General's emphasis on the need to redress social and health inequities, and congratulated her team for inculcating a sense of unity and solidarity in the Organization and beyond in the international community, as well as for the many technical achievements, for example the sharing of influenza vaccine and virus strains – a politically sensitive and technically complex area.

Progress on the eradication of poliomyelitis had recently stuttered. Resurgence of the disease in Nigeria and Pakistan had clearly shown that, despite enormous investment by United Nations organizations, governments, Rotary International and many other bodies, the final push to global eradication would not be easy and depended on matters beyond the control of the health sector, such as security. WHO should exercise its leadership in spearheading extraordinary additional efforts to ensure a successful outcome as soon as possible.

Ms AL-THANI (Qatar) said that her country attached particular importance to the prevention and control of noncommunicable diseases and had strongly supported the convening of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases. It would continue its focus on that area of work.

Mr PRADHAN (India) said that, as highlighted by the Director-General, economic constraints, social instability and environmental changes had a considerable impact on health, and innovative approaches were therefore needed to improve health outcomes. His Government was taking steps to achieve universal health care coverage by strengthening the public health system, extending coverage to unreached areas, ensuring access to generic medicines, and increasing health promotion and disease prevention activities.

He was pleased to report that India had recorded no case of poliomyelitis in the past 12 months, and it was to be hoped that the country was moving towards eradication of the disease, as envisaged.

The increasing burden of noncommunicable diseases, together with that of emerging and re-emerging communicable diseases, demanded a strong and determined public health effort, with firm political will and the participation of many stakeholders, including civil society, the voluntary and private sectors and research organizations. He was confident that WHO would provide the necessary leadership.

Mr DA FONSECA (Timor-Leste), welcoming the Director-General's frank analysis of the current situation, said that Timor-Leste was taking steps to strengthen its public health system and move towards universal health care coverage as the best means of improving health outcomes, in particular in relation to the prevention and control of noncommunicable diseases. He urged WHO to maintain its leadership role in health and its provision of support for action to strengthen health systems.

Dr WILLIAMS (Barbados) agreed that 2011 had been a challenging year and commended WHO's responses to the various health threats that had arisen, which had been rapid, effective and based on strong partnerships. She welcomed the increased awareness of the growing burden of noncommunicable diseases, but urged continued support for the prevention and control of communicable diseases, including HIV/AIDS. Given the increasing mobility of populations, pandemic preparedness should be prioritized. Member States would need to give increasing attention to the social determinants of health as they sought to deliver national health services. In the current period of budgetary constraints, WHO should continue to play a leadership role in health and to provide advice and support in order to enhance harmonization of the work of the Secretariat and Member States.

Professor BABLOYAN (Armenia) supported the Director-General's approach to WHO reform but requested further details about the proposed responsibilities of headquarters, regional offices and country offices and about the measures envisaged to strengthen coordination between those levels. The reform process should enable the Organization to overcome its current difficulties and rise to the challenges ahead, while maintaining its leadership role in health.

Dr GULLY (Canada) said that, in its discussions on WHO reform and priority-setting, the Board should take into account the three approaches to issues referred to by the Director-General: commitment to time-bound goals, development and implementation of novel instruments, and identification of solutions to pressing new challenges. Diverse approaches would be needed in designing new programmes and forging new partnerships and in adjusting existing programmes where there had been changes, for example in disease epidemiology.

Dr MBOYA OKEYO (Kenya)¹ supported the statement by the member for Estonia, and welcomed the Director-General's analysis. The diverse financing mechanisms applied by WHO and other health-related organizations and partnerships had helped to reduce health inequalities, but the involvement of stakeholders from other sectors had to be increased. He therefore welcomed the strengthening of cooperation between WHO and, among others, WTO in implementing the Doha Declaration on the Agreement on Trade-Related Aspects of Intellectual Property Rights and Public

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

Health (2001); the Office of the High Commissioner for Human Rights and other entities in implementing the right to health through promotion of universal health care coverage; and WIPO in the launch and implementation of the WIPO Re:Search initiative. Priority should be given to funding of activities to implement the International Health Regulations (2005) as a strategy for strengthening health systems and improving surveillance and health information.

He urged the Board to use the momentum of its special session in November 2011 and to facilitate a Member State-driven WHO reform process that was objective, evidence-based and inclusive. The Board should recommend a resolution for consideration by the Sixty-fifth World Health Assembly requesting the Director-General to commission an independent review of the Organization's financial and fiduciary problems, the essential reforms needed in WHO country offices to improve coordination and to strengthen health systems, and other WHO staffing and governance challenges.

Dr GWINJI (Zimbabwe),¹ expressing appreciation for the continued priority being given to the African Region, urged particular attention to the health of the Region's women and children. Zimbabwe was committed to implementing the recommendations of the Commission on Information and Accountability for Women's and Children's Health and was increasing investment in that area. Like other African countries, Zimbabwe faced a multitude of health challenges, including that of HIV/AIDS, and was therefore concerned at the uncertainty arising from the cancellation of Round 11 of grant proposals by the Global Fund to Fight AIDS, Tuberculosis and Malaria. Zimbabwe and the other countries that had been excluded from the Global Fund's Transitional Funding Mechanism, despite documented evidence of their disease burden, called on the international community to fulfil its financial commitments to the Global Fund.

He was encouraged by the political commitment to a global response to noncommunicable diseases, but emphasized an integrated approach in order to maximize synergies and existing capacities and to formulate a clear strategy with realistic and achievable targets. The commitment to addressing social determinants of health was also encouraging, but must be accompanied by the allocation of adequate funds to ensure appropriate support at national level.

The reform process should ensure that WHO was better financed so as to be able to implement priority programmes, maintain its leadership in global health, and promote equity and transparency across the Secretariat and its Member States. Current budgetary constraints necessitated continued financial prudence and greater efficiency in order to derive maximum value from assessed contributions and other resources. Attention should also be given to activities that were the keys to progress, such as ensuring adequate human resources for health and strengthening monitoring and surveillance systems. Health-related goals beyond 2015 should be broadened to include noncommunicable diseases, nutrition and the impact of environmental change on health. Ongoing managerial reforms within WHO threatened gains in research and development, in particular on diseases that disproportionately affected developing countries. Steps should be taken to reverse that trend and to facilitate capacity-building, technical support and technology transfer so as to ensure sustainable access to medical products through local manufacture.

Mr LEE Kyong-yul (Republic of Korea)¹ also commended WHO's many achievements and endorsed the Director-General's analysis and her approach to the Organization's strategic direction. His Government continued to contribute unilaterally and multilaterally to the improvement of health and, in particular, the prevention and control of noncommunicable diseases. It had hosted a regional high-level meeting on scaling up multisectoral actions for noncommunicable disease prevention and control in March 2011, and would host the Fifth Session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control in November 2012.

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

Professor SKVORTSOVA (Russian Federation)¹ observed that the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control, the High-level Meeting of the United Nations General Assembly on Non-communicable Diseases and the World Conference on the Social Determinants of Health had increased awareness and brought noncommunicable diseases to the forefront of the policy agenda, with particular attention being given to the standardization of treatment and the promotion of healthy lifestyles. The Moscow Declaration adopted at the First Global Ministerial Conference, resolution WHA64.11 and the Political Declaration adopted at the High-level Meeting had laid down the strategic basis for tackling noncommunicable diseases. A further resolution laying out specific steps to be taken would be useful, and her Government was willing to work with others in preparing an appropriate text by September 2012, as called for in the Political Declaration. The consultation process should include United Nations organizations and their Member States, the WHO regional offices, relevant nongovernmental organizations and the private sector.

She welcomed the progress made on WHO reform, which should lead to a more flexible, transparent and accountable Organization, and endorsed the priority areas set out by the Secretariat. WHO should not serve merely as a centre for collecting and collating information, but should remain at the forefront of health development, supporting technical advancement at the international, regional and national levels.

The DIRECTOR-GENERAL expressed appreciation for the supportive comments and guidance from Board members and other speakers, which had clearly shown Member States' commitment to WHO and recognition of the tireless efforts of the staff at all levels of the Organization to meet the expectations of Member States and to deliver on agreed priorities.

The Board noted the report.

4. REPORT OF THE PROGRAMME, BUDGET AND ADMINISTRATION COMMITTEE OF THE EXECUTIVE BOARD: Item 4 of the Agenda (Document EB130/4)

Dr DE ASSUNÇÃO SAÍDE (Mozambique), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, highlighted the items covered in the Committee's report that were not on the Board's agenda, namely: general management: update (including programme budgets 2010–2011 and 2012–2013; financial control framework: personal advances to staff; and risk management); report of the Office of Internal Oversight Services; report of the Independent Expert Oversight Advisory Committee; and reports of the Joint Inspection Unit. He would report on the Committee's deliberations on the items on the Board's agenda when they were taken up.

The meeting rose at 12:45.

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

SECOND MEETING

Monday, 16 January 2012, at 14:35

Chairman: Mr R. EL MAKKAOUI (Morocco)

1. REPORT OF THE PROGRAMME, BUDGET AND ADMINISTRATION COMMITTEE OF THE EXECUTIVE BOARD: Item 4 of the Agenda (Document EB130/4) (continued)

Dr BIRINTANYA (Burundi), speaking on behalf of the Member States of the African Region, expressed concern at the budgetary imbalances in the Programme budget 2010–2011 and the funding shortfalls already identified for the period 2012–2013. Further efforts were needed to identify flexible financing options and ensure better mobilization of resources to cover those gaps.

The Organization's efforts to reduce currency risks and resolve the systemic problem of outstanding salary advances were laudable but, for the former, more effective and sustainable long-term solutions were a priority, and in the case of the latter the Secretariat should strengthen the Global Management System so as to avoid recurrence of similar situations.

Internal control framework reports should concentrate on work done in the year covered by the report before outlining actions to be taken in the subsequent year. An independent external evaluation of WHO should be conducted to find radical and sustainable solutions to the Organization's problems. In the light of current circumstances, particularly with respect to human resources, the Office of Internal Oversight Services could not be expected to conduct the first phase of the evaluation, as the Independent Expert Oversight Advisory Committee had recommended.

In the context of the reform process, maintaining an open dialogue with representatives of the staff was particularly important. The steps already made towards decentralization were welcome and should be pursued by transferring posts currently held at headquarters to regional and country offices. Priority programmes should be protected from excessive cuts in staff. Currently-empty key posts should be filled as soon as the financial outlook improved.

Balanced geographical and gender representation should be ensured within the Independent Expert Oversight Advisory Committee.

Dr DANKOKO (Senegal) deplored the fact that, in finalizing its report to the Board, the Programme, Budget and Administration Committee had seen only a version in English, creating difficulties for participants speaking other languages, who had taken the risk of adopting a text that had been modified during a debate in which they could not participate. Multilingualism should be the byword at all the Organization's meetings, in order to guarantee transparency, equity and democracy.

2. TECHNICAL AND HEALTH MATTERS: Item 6 of the Agenda

Global burden of mental disorders and the need for a comprehensive, coordinated response from the health and social sectors at the country level: Item 6.2 of the Agenda (Document EB130/9)

The CHAIRMAN drew attention to the following draft resolution, which had been proposed by India, Switzerland and the United States of America and which read as follows:

The Executive Board,

Having considered the report on global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level,¹

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

The Sixty-fifth World Health Assembly,

PP1 Having considered the report on global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level;

PP2 Recalling resolution WHA55.10, which urged Member States to increase investments in mental health both within countries and in bilateral and multilateral cooperation, as an integral component of the well-being of populations;

PP3 Recalling further United Nations General Assembly resolution A/RES/65/95, which recognized that “mental health problems are of major importance to all societies and are significant contributors to the burden of disease and the loss of quality of life, and have huge economic and social costs” and which also welcomed the WHO Report on *Mental Health and Development*,² which highlighted the lack of attention to mental health in development, and made the case for governments and development actors to reach out to people with mental disorders in poverty reduction and development strategies as well as education, employment, health, social protection and other policies;

PP4 Noting the High Level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases, held 19–20 September, 2011, which recognized that mental and neurological disorders, including Alzheimer’s disease, are an important cause of morbidity and contribute to the global noncommunicable disease burden, for which there is a need to provide equitable access to effective programmes and health-care interventions;

PP5 Recognizing that mental disorders can be disabilities, as reflected in the United Nations Convention on the Rights of Persons with Disabilities, which also notes that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others and that the *World Report on Disability*³ charts the steps that are required to improve the participation and inclusion of people with disabilities, including persons with mental disabilities;

PP6 Concerned that millions of people worldwide are affected by mental disorders, that in 2004, mental disorders accounted for 13% of the global burden of disease, defined as premature death combined with years lived with disability, and that, when taking into consideration only the disability component of the burden of disease calculation, mental disorders account for 25.3% and 33.5% of all years lived with a disability in low- and middle-income countries, respectively;

PP7 Concerned also that exposure to humanitarian emergencies is a potent risk factor for mental health problems and psychological trauma and that social structures and ongoing formal and informal care of persons with severe, pre-existing, mental disorders are disrupted;

PP8 Recognizing that the treatment gap for mental disorders is high all over the world, and that between 76% and 85% of people with severe mental disorders receive no treatment for

¹ Document EB130/9.

² Funk M et al (Eds). *Mental health and development: targeting people with mental health conditions as a vulnerable group*. Geneva, World Health Organization, 2010.

³ World Health Organization, The World Bank, *World Report on Disability*. Geneva, World Health Organization, 2011.

their mental health conditions in low- and middle-income countries, and that the corresponding figures for high-income countries are also high – between 35% and 50%;¹

PP9 Noting that mental disorders are often co-morbid with noncommunicable diseases and a range of other priority health conditions, including HIV/AIDS, maternal-child health, and violence and injuries, and that in women and children, mental disorders often coexist with other medical and social factors, such as poverty, harmful use of alcohol and exposure to domestic violence and abuse, which have a negative impact on the quality of life;

PP10 Recognizing that the social and economic impact of mental disorders, including mental disabilities, is diverse and far-reaching;

1. URGES Member States:

- (1) to develop comprehensive policies and strategies that address care, support and treatment of persons with mental disorders by promoting human rights, tackling stigma, addressing poverty and, as appropriate, creating opportunities for generating income, providing housing and education as well as providing health-care services in the community;
- (2) to give appropriate priority to mental health in health and development programmes and to allocate appropriate resources in this regard;
- (3) to collaborate with WHO in the development of an Action Plan to enable persons with mental disorders to live a full and productive life in the community;

2. REQUESTS the Director General:

- (1) to develop a comprehensive Action Plan for consideration by Member States, covering services, policies, plans, strategies, programmes and legislation, to enable persons with mental disorders to live a full and productive life in the community;
- (2) to include in the Action Plan provisions to address:
 - (a) protection, promotion and respect for the rights of persons with mental disorders;
 - (b) access to quality comprehensive health services that include mental health at all levels of the health care system;
 - (bbis) development of adequate human resources to provide mental health services equitably;
 - (c) access to educational and social services, including health care, schooling, housing, secure employment and participation in income generation programmes;
 - (d) involvement of civil society organizations of persons with mental disorders in voicing their opinions and contributing to decision-making processes;
 - (e) participation of people with mental disorders in family and community life and civic affairs; and
 - (f) mechanisms to involve all relevant sectors in Member States in the implementation of the Action Plan
- (3) to collaborate with Member States, international, regional and national nongovernmental organizations, donors and technical agency partners in the development of the Action Plan.

¹ Demyttenaere K et al (2004). *JAMA*, **291**:2581–90.

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

- 2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)**

Organization-wide expected result(s): 3.1, 3.2, 3.5 and 3.6

The implementation of the resolution would increase political, financial and technical commitment in Member States to tackle mental disorders. It would also provide support for the development of services, policies, plans, strategies, programmes and legislation to enable people with mental disorders to live full and productive lives in the community through the adoption of a coordinated and integrated approach across all sectors including health, social services and housing, education and employment.

No

(a) Total cost

(ii) Total US\$ 970 000 (staff US\$ 270 000; activities: US\$ 700 000)

Total US\$ 970 000 (staff US\$ 270 000; activities: US\$ 700 000)

The costs would be incurred at all levels of the Organization.

No

US\$ 900 000

No

One P.4 staff member (50% full-time equivalent) would be required for 12 months at headquarters in order to coordinate both the development of the action plan and the relevant consultations.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

No

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ 900 000; source(s) of funds not yet known.

The CHAIRMAN suggested that members comment first on the report before proposing amendments to the draft resolution.

Mr DESIRAJU (India) noted that, although the burden of mental disorders in low- and middle-income countries in particular was high, the subject had not received the attention merited in national health and development plans. Countries needed to confront the realities of mental disorders, which resulted in, and were in some cases caused by, poverty, lack of opportunity, and stigmatization, and, as the report mentioned, the social and economic impacts, such as homelessness, violation of rights, drug abuse and domestic violence. Recognition of the importance of dealing with mental disorders was increasing, both in WHO with its recent reports and with the recognition by the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (New York, 19 and 20 September 2011) that mental disorders deserved attention. Countries needed to recognize that national responses could be put in place. The WHO Mental Health Gap Action Programme, which had not been developed in consultation with Member States, did not adequately cover prevention of mental disorders, raising public awareness and health promotion. The Secretariat could contribute significantly to better coordination by developing a comprehensive action plan, helping to strengthen health services for the mentally ill and tackling the social determinants of mental disorders. He appealed to all Member States to support the draft resolution.

Dr LARSEN (Norway) observed that mental health was influenced mainly by factors outside the health-care sphere, including family, school, work and community. Greater awareness of the impact of such social determinants was needed, and that should be reflected in the draft resolution. The number of new cases of mental disorders should be reduced through universal measures for health promotion and disease prevention. He endorsed the Secretariat's proposed strategy of providing packages of care on the basis of their cost-effectiveness, affordability and feasibility. Pharmacological treatment was not sufficient; sustainable psychosocial strategies to help people to cope with their condition and the challenges of daily life should also be promoted. Efforts to prevent the stigmatization and violation of human rights often faced by the mentally ill should continue. Besides improving health care, public health work had to be broadened to deal with factors outside the health system.

A distinction should be made between neurological disorders, such as epilepsy and dementia, and other mental disorders, such as depression, as the latter often represented an even greater challenge than the former, in both low- and high-income countries. The two types of disorders also had different causes, risk factors, prevention measures and treatments.

Ms REINAP (Estonia), speaking on behalf of the European Union and its Member States, welcomed the connection between mental health and other noncommunicable diseases that had been recognized at the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (New York, September 2011). Health inequalities were particularly apparent between people with mental disorders and the rest of the population, but the Member States of the European Union, many of which had instituted comprehensive mental health strategies, had significantly narrowed that gap in recent years. The European Pact for Mental Health and Well-being

reflected the European Union's commitment to good practice in priority areas of mental health. The Secretariat should accord high priority to work on the effective management of mental disorders, including the promotion of mental health and well-being. Such work must be based on four main principles: promotion of human dignity and social justice; combating stigmatization and discrimination; commitment to the recovery model; and use of holistic approaches combining practical and emotional support.

Mental health systems should focus on promoting early intervention, which was vital to balancing risk to both the patient and the public; providing care in the least restrictive environment possible; encouraging independence; improving the education and training of mental health professionals; and taking a holistic view of health.

The European Union supported the proposed draft resolution, but noted the need to avoid duplication of efforts, for instance through not repeating the work already done by the Secretariat.

Mr DÍAZ ANAIZ (Chile) said that mental disorders, a growing concern in most countries, could only be addressed effectively through the coordination of all social sectors, given the influence of social factors on mental health. In that connection, Chile had formulated a national health strategy for 2011–2020, one objective of which was to improve the functioning of people with mental disorders. The actions set out in the proposed draft resolution were in line with the measures his country had already been taking for several years, and were worthy of support.

Dr ABDI (Somalia) said that people with mental disorders were vulnerable and neglected; more than half of them were homeless and many were deprived of their basic human rights. There was a wide gap between the need for and provision of treatment for mental disorders, which were a public health concern worldwide, especially in countries in emergency situations. Somalia fully supported WHO's recommendations for improving mental patients' quality of life, which included the provision of better mental health care, greater human rights protection and increased access to welfare services and housing. In low- and middle-income countries, funding for the prevention and treatment of mental disorders remained inadequate. He supported the draft resolution.

Dr GULLY (Canada) said that his country was committed to promoting mental health and well-being as an important means of reducing illness, disability and injury. That and the prevention of mental disorders called for multipartner collaboration, and his Government was working closely with provincial and territorial governments and other stakeholders on various population-specific initiatives. In 2007 Canada had set up a mental health commission to develop a national strategy and raise awareness of mental illness.

He endorsed the proposed draft resolution. If it were adopted, countries would probably need to review their population demographics in order to tailor approaches to specific groups, such as aboriginal youth or the elderly. Already-existing strategies and tools would be useful in that regard.

Dr VALENTIN (Seychelles), speaking on behalf of the Member States of the African Region, said that the long-standing exclusion of mental disorders from the global health agenda had led to huge disparities in national approaches to mental health. Outpatient mental health facilities were 58 times more prevalent in high-income countries than low-income countries, and, in the former, mental health legislation covered 92% of the population as opposed to 36% in the latter. He welcomed the increasing attention that was being paid to mental health internationally, in particular by WHO, given the revelation of how little was spent on mental health worldwide and the inequitable distribution of resources for mental health.

He recommended the following: mental health services should be linked more effectively with other health sector services; greater attention should be paid to mental disorders as a subset of noncommunicable disease; the human rights of persons with mental disorders should be fully respected and the public should be made aware of mental health issues; and WHO should increase its efforts to reverse negative mental health trends through stronger advocacy and financial and technical

support, especially in the least developed parts of the world. It should also provide support to countries for developing or updating, monitoring and evaluating national policies, improving access to mental health facilities in communities, dealing with risk factors associated with mental disorder, conducting research, and setting up systems to collect data on mental and behavioural disorders.

Mr LEI Zhenglong (China) welcomed WHO's recent efforts and initiatives to improve global mental health, which had guided Member States in developing national policies, including those on service-assessment, and establishing psychosocial support systems in disaster areas. Knowledge sharing, coordination and legal frameworks needed to be improved both globally and nationally. He urged the Secretariat to continue providing support to governments for advocacy work and improving access to treatment. Such measures would help to ensure more effective implementation of WHO's recommendations.

Dr DAULAIRE (United States of America) said that his Government was committed to raising awareness of mental, neurological and substance use disorders, particularly given the predicted disease burden due to depression, and recommended that the three disorders be thus grouped together consistently in order to reflect the scope of the problem more accurately. He commended the Secretariat's efforts to support the training of health-care workers in non-specialized settings and urged further provision of training for mental health professionals. His Government had been focusing its efforts on taking people out of mental hospitals and integrating them into their communities, while providing a range of support services.

In its next report on mental disorders, the Secretariat should draw attention to the close correlation between mental, neurological and substance use disorders and physical health problems, including hypertension and heart disease. The Secretariat should provide guidance to countries on adapting the strategies outlined in the report to national circumstances.

As a cosponsor of the draft resolution, the United States urged Member States to allocate adequate resources to mental, neurological and substance use disorders within health and development programmes and to work with the Secretariat on the development of an action plan to aid people with mental disorders.

Ms VIEITEZ MARTÍNEZ (Mexico) said that the growing public health problem of mental disorders had a high social cost and affected people regardless of age, sex or socioeconomic status. Close cooperation between the health sector and the social, education and labour sectors was needed in order to implement community-based strategies to increase health service coverage and to integrate mental health programmes into broader categories such as noncommunicable diseases.

Greater financial and human resources would help to improve access to medicines and treatment, especially in low- and middle- income countries, and to reduce the stigmatization attached to mental disorders. She commended the Secretariat's efforts to assist Member States in drawing up evidence-based programmes based on systematic data collection, which would ensure a more efficient and equitable distribution of resources. WHO's support for countries that had conducted assessments of their mental health services from a human rights perspective was also laudable and had led to public policy protecting the interests of persons with mental disorders. She supported the draft resolution.

Mr ESPINOSA SALAS (Ecuador) said that greater attention needed to be paid to conditions such as depression, epilepsy, bipolar disorder, dementia and drug abuse in view of their social and economic impacts on subjects and their families. Special attention must be paid to human resources for mental health, which were particularly scarce in developing countries. Many countries earmarked only a paltry portion of their budget for mental health; in some cases, the figure was less than 1%. He supported the strategies recommended in the report and underlined the application of global policies aimed at improving inpatient psychiatric care and developing community services; helping countries to draw up legislation to protect the human rights of mental health patients; developing medicines for the principal existing mental disorders; promoting training for specialized mental health workers; and

encouraging the development of affordable programmes for the promotion of mental health and the prevention of mental illness.

Dr ST. JOHN (Barbados) welcomed the attention paid in the report to the impact of mental health on general health and well-being. In recent years, her country had taken various measures to promote mental health, including the adoption of a national mental health policy and the establishment of a mental health commission. The Government also planned to draw up minimum standards of care in substance abuse cases and to develop a programme aimed at reducing discrimination against people with mental disorders.

The time had come to include mental health in a broader health policy context, as recommended in the draft resolution. Mental disorders were present in all societies, even if the resources available to combat the problem varied widely.

Mr ALMEIDA CARDOSO (Brazil)¹ urged bold steps to improve the lives of people with mental disorders, including better treatment, greater access to social welfare services and to education and employment opportunities, and protection of human rights.

Brazil was endeavouring, at national, regional and international levels, to improve mental health. Recent measures included shifting the focus from psychiatric hospital care to community service networks and redirecting resources accordingly; increasing the number of psychosocial care centres; establishing a national programme for the social reintegration of long-term psychiatric hospital patients; and addressing substance abuse issues.

Much remained to be done in order to provide adequate health treatment of mental disorders in the developing countries, which lacked financial and human resources and affordable treatment and care. Mental illness must be brought to the fore in order to combat stigmatization and discrimination and guarantee the social integration and human rights of affected persons. He welcomed the proposed development of a comprehensive action plan and supported the draft resolution.

Dr NICKNAM (Islamic Republic of Iran)¹ said that the report would have been stronger if it had included benchmarks for adequate levels of spending on mental health; calculations or estimates of the economic cost of various disorders, including out-of-pocket expenses for patients; further information on the paucity of human resources for mental health and an explanation of how the Mental Health Gap Action Programme planned to scale up its services; guidance on how to protect the mental health of those who were currently free of mental disorders but who sometimes experienced mental distress; and strategies to deal with children's mental health and development issues. In view of the link between mental disorders and chronic disease, programmes to prevent noncommunicable diseases and promote a healthy lifestyle should be expanded to include mental health issues, with particular emphasis on the world's increasingly large elderly population and the rising incidence of age-related diseases.

Ms ADAMS (International Council of Nurses), speaking at the invitation of the CHAIRMAN, observed that there had been little progress in improving access to prevention and treatment of mental illness. Failure to integrate mental health care into primary health care systems and shortages of human resources, including psychiatric nurses, were among the main barriers to access, as shown in a global survey of mental health nursing conducted by WHO and her Council. The nursing workforce could play a leading role in mental health services if adequate training was available. The opportunity for nurses to take on other responsibilities, for example, prescriptive authority, was currently restricted by outdated nursing practice legislation and overly protective medical legislation that was unresponsive to population and community needs. The Council had launched an initiative on

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

noncommunicable diseases that aimed to develop nursing capacity and which included a project on the concurrent management of diabetes and depression. It was being piloted in five African countries and would be expanded to other regions and countries.

She urged the Secretariat and Member States to provide more mental health training for nurses and to increase the number of mental health nurse specialists. She also recommended that nurses should be authorized to identify, assess and treat common mental health disorders in primary health care settings.

Professor OMIGBODUN (International Association for Child and Adolescent Psychiatry and Allied Professions), speaking at the invitation of the CHAIRMAN, said that early investment in the mental and physical health of children offered the best results in future years for families, communities and countries, with improved levels of health, reductions in inappropriate use of health care, a decline in delinquency and violence, and economic gains, including a more productive workforce. Research indicated that interventions should start at conception and continue through gestation, delivery and thereafter. One in five children had a treatable mental disorder and half all cases of adult psychiatric illness began before the age of 14 years. There were almost no resources for the promotion of child and adolescent mental health in developing countries.

His Organization served as a resource, with an easily accessible web site, for countries considering policy development and programme implementation in the field of child and adolescent mental health. He endorsed the 2010 *WHO mhGAP Intervention guide for mental, neurological and substance use disorders in non-specialized health settings*, and joined calls for the inclusion of a child mental health plan in every national health agenda. Child mental health was relevant to every aspect of noncommunicable disease and it improved treatment compliance for communicable diseases.

Mrs LACHENAL (World Federation for Mental Health), speaking at the invitation of the CHAIRMAN, endorsed the draft resolution. The proposed comprehensive action plan should include an assessment of progress by independent civil society, in parallel to assessments by Member States; guidelines for the development of outcome protocols reflecting recovery and community orientation of mental health treatment and services, for use in monitoring progress; a focus on making psychiatric hospitals more humane and community-oriented; and an emphasis on children, adolescents, older adults and rural populations. Special attention should be paid to the physical health needs of people with severe mental disorders and the detection and treatment of mental illness in people with diabetes, cancer, and cardiovascular and respiratory diseases.

Dr THAKSAPHON THAMARANGSI (Thailand)¹ said that, although mental health problems were largely preventable, their global incidence remained high. Lack of access to care, insufficient prevention measures and violations of human rights were examples of the social injustice facing people with mental disorders. Financial, technical and political commitment to mental health was insufficient. Tackling mental health issues required a dual approach: focusing on mental health risk factors and attitudes towards mental disorders, and integrating mental health care into primary health-care systems – a step which would, among other things, lessen the stigmatization attached to mental health screening. Greater efforts and cooperation were needed in order to develop and strengthen both policy and practice and ensure that mental health was made a priority. That was the only way to reduce the burden of mental disorders on society.

He endorsed the draft resolution but proposed that the action plan include promotion of mental health and prevention of mental disorders.

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

Ms KUN NARYATIE (Indonesia)¹ strongly endorsed the draft resolution. Mental health problems were of great concern in many societies and the international community needed to come to grips with the social and economic burdens of mental disorders. Indonesia had developed national policies to incorporate mental health into the primary health-care system. It had also increased mental health funding and placed the medicines needed to treat mental disorders on a national list of essential medicines.

Dr WARNING (Assistant Director-General, ad interim), drawing attention to the estimated financial and administrative implications of the draft resolution, said that the calculations were based on past experience in developing similar action plans, but that the cost could be reduced if fewer consultative meetings were held, consultations were web-based, and no extra staff members were recruited to help implement the plan. If Member States agreed to such changes, the estimated costs could be decreased from about US\$ 1 million to US\$ 200 000 and could be incorporated into the regular budget. As a result, however, some lesser elements of the plan might need to be deferred or abandoned.

Dr SILBERSCHMIDT (Switzerland) said that his country had chosen to cosponsor the draft resolution for two reasons: first, the decision at the United Nations High-level Meeting on the Prevention and Control of Non-communicable Diseases that mental disorders should not be included explicitly in discussions on noncommunicable diseases as the risk factors were too varied and, secondly, the recognition that the global burden of mental disorders had not been sufficiently addressed to date. He encouraged the proposal of amendments that would further strengthen the draft resolution.

Dr LARSEN (Norway) suggested that the preamble to the draft resolution should be amended to include two additional paragraphs; the first should read “Recognizing that mental disorders can be prevented and that mental health can also be promoted in sectors outside health” and the second “Concerned that persons with mental disorders are stigmatized, and underlining the need for health authorities, working together with relevant groups, to change attitudes to mental disorders”.

In paragraph 1, the words “mental health promotion and disease promotion as well as” should be inserted after “strategies that address”. In subparagraph 1(3), the words “to promote mental health and” should be inserted after “Action Plan”.

The words “including the need to avoid stigmatization of persons with mental disorders” should be added to the end of subparagraph 2(2)(a), and a new paragraph inserted after subparagraph 2(2)(b), to read “The need for prevention to be included in policies in mental health”.

Ms REINAP (Estonia), speaking on behalf of the European Union, suggested that in the ninth preambular paragraph the words “in women and children” should be deleted and a new paragraph be inserted after the tenth preambular paragraph, to read “Noting that there is increasing evidence on effectiveness and cost-effectiveness of interventions to promote mental health and prevent mental disorders, particularly in children and adolescents;”.

In paragraph 1, a footnote should be inserted after the words “URGES Member States”, to read “And, where applicable, regional economic integration organizations” and in subparagraph 1(1), the words “mental health promotion, prevention of disorders, in particular among children and adolescents, as well as” should be inserted after “strategies that address”. In the same subparagraph, “empowering service users” should be inserted after “tackling stigma”.

In subparagraph 2(1), the word “comprehensive” should be deleted and the words “to promote mental health, prevent mental disorders and provide care and services and” should be inserted.

At the end of subparagraph 2(2)(b), the words “with particular focus on deinstitutionalized care and empowerment of service users” should be inserted after “programmes and legislation”. Following subparagraph 2(2)(bbis), a new subparagraph should be inserted, to read “enhance initiatives to

promote mental health and prevent mental disorders, including, where appropriate, support for parental skills”.

In subparagraph 2(3), the words “and as appropriate, with” should be inserted after “Member States”.

Dr PE THET KHIN (Myanmar) said that in subparagraph 1(1) the words “promotion and prevention of mental health problems and screening” should be inserted after “strategies that address”, and in the same subparagraph the words “tackling major modifiable risks of mental health problems” should be inserted after “addressing poverty”.

In subparagraph 1(2), the words “give appropriate priority” should be replaced with “prioritize and streamline” and the word “appropriate” should be replaced with “adequate”. Subparagraph 1(3) should be amended with the insertion of “to promote mental health and prevent mental health problems and” after the words “Action Plan”.

In subparagraph 2(1), the words “in consultation with” should be inserted after “Action Plan” and the words “to promote mental health and prevent mental health problems and” should be inserted after “programmes and legislation”. In subparagraph 2(2)(b) the word “equitable” should be inserted before “access” and the word “affordable” before “quality”. In subparagraph 2(2)(bbis), the word “competent” should be inserted after “development of”; the words “and equitable distributions” should be inserted after “adequate” and the words “promotion, prevention and” should be inserted after “mental health”. The word “equitably” should be deleted from the end of subparagraph 2(2)(bbis).

In subparagraph 2(3), the word “donors” should be replaced with “international development partners”. A new subparagraph 2(4) should be inserted to read “to submit the Action Plan for consideration by the Sixty-seventh World Health Assembly through the 134th Executive Board.”

Dr GULLY (Canada) endorsed the amendments proposed by the member for Norway, and the suggestion by the member for Estonia to delete the words “in women and children” from the ninth preambular paragraph. He suggested that the words “according to national priorities and within their specific contexts” should be inserted at the beginning of subparagraph 1(1). In the same subparagraph, the words “mental health promotion, mental illness prevention, as well as” should be inserted after “strategies that address”, the word “including” after “mental disorders”, the words “and homelessness” after “addressing poverty” and the words “promoting public awareness” after “as appropriate”.

In subparagraph 1(2), the words “including mental health promotion, mental illness prevention, care, support and treatment” should be inserted after “mental health”. In subparagraph 1(3), the words “promote mental health, prevent mental illness and” should be inserted after “Action Plan to”.

In subparagraph 2(1), the words “mental health promotion and mental illness prevention, as well as public awareness” should be inserted after “covering”, and following subparagraph 2(2)(a), a new paragraph should be added, to read “mental health promotion and mental illness prevention”.

Ms VIEITEZ MARTÍNEZ (Mexico) suggested that two new subparagraphs should be added under subparagraph 1(1), the first of which should read “to develop comprehensive programmes that include an integral approach to prevent and attend mental disorders with community-based interventions” and the second “to develop appropriate surveillance frameworks that include risk factors as well as social determinants of health to evaluate and analyse trends regarding mental disorders”.

A new subparagraph should be added under subparagraph 2(2)(d), to read “to design and provide special mental health support systems that will enable community resilience and will help people cope during humanitarian emergencies”. A new subparagraph should be added under subparagraph 2(2)(e), to read “to create special programmes for health-care providers that include mental health in community and primary care settings”.

Three new subparagraphs should be added under paragraph 2. The first should read “to ensure equitable access to quality health-care attention and medications”, the second “to ensure mental health support in schools and labour settings” and the third “to build up social frameworks in order to support

people with mental disorders as well as their families”. In addition, subparagraph 1(2) should be shifted to paragraph 2 and in that subparagraph, the words “to prevent mental disorders, as well as to provide appropriate treatment” should be inserted after the word “resources”.

Dr EL OAKLEY (Libya),¹ expressing support for the proposal made by the member for the United States of America to replace the term “mental disorders” in the Secretariat’s report with the words “mental, neurological and substance use disorders”, proposed that the draft resolution be amended along the same lines, ensuring in particular that it contained adequate reference to under-diagnosed conditions such as cognitive dysfunction, dementia and Alzheimer’s disease.

Dr SAXENA (Mental Health and Substance Abuse) said that the amendment proposed by the representative of Libya would require a major reworking of most of the resolution’s text and would dramatically change its scope. Furthermore, from a technical perspective, the issues related to neurological and substance abuse disorders varied greatly and would affect specific strategies that had already been suggested for inclusion in the draft resolution. Could Board members clarify their position with respect to the proposal?

The DIRECTOR-GENERAL also sought clarification from members on the proposal to replace the term “mental disorders” with “mental, neurological and substance abuse disorders”, which would dramatically change the scope of the draft resolution and require it to be rewritten.

Dr DAULAIRE (United States of America) said that the measures endorsed by the Board needed to be practical, targeted and amenable to implementation. The term “mental disorders” in the draft resolution should therefore remain as it stood to ensure a more targeted scope. In his earlier statement, he had suggested that, in general, the words “mental, neurological and substance use disorders” should be used to refer to that particular cluster. He had not intended to modify the wording of the draft resolution in that respect.

Dr GULLY (Canada), endorsing the statement made by the member for the United States of America, asked whether the proposed expansion of the draft resolution to include mental health promotion was necessarily linked to the proposed use of the wording “mental, neurological and substance use disorders” or whether the two issues were separate. If the Board chose to include mental health promotion in the draft resolution, it should be treated as a substantive issue. The alternative was to draft two separate resolutions, one on mental health promotion and the other on treatment of mental health disorders.

Dr SILBERSCHMIDT (Switzerland) said that the scope of the draft resolution should not be broadened. A new preambular paragraph, drafted by the Secretariat and making reference to neurological and substance use disorders, might however usefully be added to the draft resolution.

Mrs REITENBACH (Germany) endorsed the views of the previous speakers.

The DIRECTOR-GENERAL said that keeping the title of the draft resolution as it stood did not rule out making reference to prevention of mental disorders and promotion of mental health in the body of the resolution.

The CHAIRMAN requested the Secretariat to prepare a new draft resolution, taking into account Member States’ comments and proposed amendments.

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

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

Nutrition: maternal, infant and young child nutrition; nutrition of women in the preconception period, during pregnancy and the breastfeeding period: Item 6.3 of the Agenda (Documents EB130/10 and EB130/11)

Mr MAXTONE-GRAHAM (Papua New Guinea) welcomed the multisectoral nature of, and the inclusion of global targets in, the draft comprehensive implementation plan on maternal, infant and young child nutrition. In order for them to be effective and win the endorsement of Member States, the targets must be ambitious, meaningful and linked to tried and tested activities. The implementation plan should also include safeguards to prevent potential conflicts of interest and should avoid promoting public-private partnerships. With regard to specific targets, he proposed that global target 5 should read “To increase each national exclusive breastfeeding rate by 50%, and work towards setting up targets of exclusive breastfeeding at six months” and expressed concern that the global target 4 on obesity was not sufficiently ambitious and did not seek to reverse the growing trend of childhood obesity. Was the assumption that the challenge of nutrition deficiencies would be met by untested market solutions involving lipid-based prepared food rather than by community-based approaches encouraging the use of local ingredients? Would the promotion of foods and beverages high in sugar and fat continue unabated?

Mr DÍAZ ANAIZ (Chile) said that the promotion of maternal and infant health, in relation to which his country had achieved excellent results, called for ongoing review of strategies to meet the needs of populations at all levels. His country had implemented, solely and in cooperation with other countries in the Region, multisectoral policies to combat malnutrition among the most vulnerable sectors of the population, which had resulted in one of the lowest regional rates. He expressed his full support for the draft resolution.

Ms REINAP (Estonia), speaking on behalf of the European Union and its Member States, said that the acceding State Croatia, the candidate countries the former Yugoslav Republic of Macedonia, Montenegro and Iceland, the countries of the Stabilisation and Association Process and potential candidates Albania and Bosnia and Herzegovina, and Georgia aligned themselves with her statement. Proper nutrition was particularly important during the first two years of life, as it could determine a child’s future disease and mortality profile. Governments, civil society, the international community and the private sector must therefore take joint action to combat undernutrition, malnutrition and obesity, which were key risk factors for noncommunicable diseases and posed a significant threat to the development of cognitive functions in infants and young children. Owing to the multisectoral nature of the issue, she welcomed the dialogue between WHO, FAO, UNICEF and WFP, partners in the Scaling Up Nutrition framework launched by the United Nations General Assembly in September 2010.

Despite vigorous campaigning, less than 40% of babies worldwide were breastfed exclusively for the first six months. That figure could only be augmented through a more comprehensive approach which should strive to improve access to nutritious foods for the first two years of life and to promote exclusive breastfeeding. Most Member States had nutrition policies, but they often failed to meet the complex challenges of maternal, infant and young child nutrition. The global targets and time frames set out in the draft implementation plan might well be the key to solving that problem. Member States should be provided with the opportunity to consult further on the draft plan, preferably through web-based systems, before it was submitted to the Sixty-fifth World Health Assembly.

Dr BAYE LUKONG (Cameroon), speaking on behalf of the Member States of the African Region, said that malnutrition was particularly prevalent among African children under the age of five years as a result of poor breastfeeding practices, improper weaning and a lack of information on the use of locally available foods. Ongoing efforts to reduce the malnutrition rate included promotion of exclusive breastfeeding, community-based approaches and the organization of child health days.

However, the main challenge was to expand such interventions, and countries in the Region had been urged to draw up comprehensive plans for doing so.

Welcoming the incorporation of suggestions made by the Region into the draft implementation plan, she also proposed some amendments. A new subparagraph (3) should be inserted under paragraph 46, to read “Promote transformation of locally-produced, high-quality weaning foods and ensure their financial accessibility.” In the section on food manufacturing in Table 2, an additional intervention should be inserted, to read “Transformation and subsidizing of rich locally-produced weaning foods”. Implementation of the draft plan would give rise to various challenges, which included identifying ways to strengthen socioeconomic development, ensuring financial investment and technical capacity in food safety and nutrition, and formulating comprehensive communication strategies on food security and nutrition. The plan should be implemented using a multisectoral approach, with particular emphasis on community participation.

Mr YUSOF (Brunei Darussalam) said that his country had taken various measures to meet the multifaceted challenges of nutrition. Children under the age of five years were screened to detect, treat and monitor cases of undernutrition as early as possible; pregnant women were tested for anaemia in maternal health clinics and standard guidelines on such procedures had been issued. In an effort to increase the rate of exclusive breastfeeding during the first six months of life, breastfeeding education was dispensed and mandatory maternity leave had almost doubled to 105 days. He endorsed the five global targets of the draft plan and urged Member States to commit themselves wholeheartedly to achieving them.

Ms XU Xiachao (China) endorsed the targets and time frames set out in the draft plan. In China, there had been a sharpened focus on maternal, infant and young child nutrition in recent years, with the implementation of projects such as the distribution of free folic acid supplements in rural areas. There were also plans to develop projects for preschool children in poor areas and she encouraged the Secretariat to increase its assistance in that area and to monitor the effectiveness of such projects. It should also provide a platform to strengthen communication and allow Member States to share their experience.

Mr PRADHAN (India) said that improvement of maternal and child nutrition required an intersectoral approach based on the life cycle. In India, the Prime Minister chaired a National Council on Food Challenges to set priorities and facilitate multisectoral interventions, including food security. The global targets proposed in the draft implementation plan seemed reasonable, but the percentages aimed for should be country-specific rather than universal. Under the section on Actions, actions 1 and 3 should be merged.

The draft plan referred to two new initiatives - Scaling-Up Nutrition and Renewed Efforts Against Child Hunger and Undernutrition - but failed to provide an institutional mechanism for identifying, preventing and managing conflicts of interest or to emphasize the obligation of the private sector to comply with the International Code of Marketing of Breast-milk Substitutes or the global strategy for infant and young-child feeding. The areas of food security, infant and young child feeding practices, and water and sanitation required fuller treatment in the draft plan.

Mr ÁLVAREZ LUCAS (Mexico) supported the draft implementation plan. His country had reduced undernutrition among children under the age of five years, but had witnessed an alarming increase in obesity rates in recent years owing to poor eating habits, combined with a lack of nutritious food, during the early years of development. Mexico had been tackling the problem of undernutrition, overweight and obesity by offering nutrition programmes in primary health care units and providing training to parents and child-care workers. He proposed three additional measures: training of multi-country working teams under the leadership of WHO to develop progress indicators on breastfeeding, on the basis of which effective methods to promote breastfeeding could be developed; vigorous campaigns to promote breastfeeding at the local level; and establishment of closer ties with WHO for

the planning of capacity-building workshops. Table 3 of the draft plan should be revised, as it appeared to contain some inconsistencies.

Dr SHEIKH YUSUF (Somalia) said that, although effective nutrition interventions existed, they had not been implemented on a large scale. Indeed, countries with the greatest burden of undernutrition were often not able to carry out measures on the scale necessary to prevent undernutrition and foster child development. He fully endorsed the draft plan, into which the views expressed at the regional consultations had been incorporated.

Dr LARSEN (Norway) said that the draft plan, which he fully endorsed, should be accorded high priority and the necessary human and financial resources to implement it. The plan should focus on measures to promote breastfeeding, which had the single largest impact on child survival of all preventive measures, and should give more coverage to the Baby-Friendly Hospital Initiative, which should be expanded to cover neonatal wards and primary health-care services. The plan should also mention WHO's Child Growth Standards, and Table 1a should include vitamin D supplementation for women and children from northern countries at high latitudes.

Professor BABLOYAN (Armenia) said that inadequate nutrition represented a significant barrier to achieving the Millennium Development Goals. He therefore welcomed the draft plan, which proposed important measures for tackling that problem. Drawing attention to the progress made in his country with regard to nutrition, he explained that the Armenian Government had drafted a bill, which had the support of governmental and nongovernmental organizations, on appropriate breast-milk substitutes.

Dr AL-THANI (Qatar), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that they were committed to implementing health interventions that would improve nutrition in a wide range of settings, including health facilities, local communities and such sectors as agriculture, education and employment. Those interventions were to be followed by integrated action plans as part of the regional strategy on nutrition 2010–2019.

Malnutrition was a serious health problem in most countries in the Region, where millions of children were insufficiently active owing to lack of food and poor early feeding practices. Recent statistics showed that more than half of the deaths among the under-five-year-olds in the Region were linked to malnutrition and that almost one third of under-fives were stunted for their age. The roots of malnutrition lay in political instability, high food prices and natural disasters.

WHO's ongoing technical support for the implementation of its Child Growth Standards in the Region was much appreciated, as were its efforts to strengthen nutritional monitoring, including through capacity building. Several countries had introduced a strategy for infant and young child feeding, based on WHO's global strategy, which formed an integral part of child health programmes. The continuing lack of information available on the effectiveness and scope of such feeding initiatives was a hindrance to their improvement, however. The regional strategy for nutrition had nonetheless promoted the elaboration of nutritional policies and plans aimed at reducing the double burden of malnutrition, which would in turn promote the global efforts to promote nutritional activities and the United Nations Millennium Campaign. The Road Map for Scaling-Up Nutrition also envisaged multi-stakeholder processes at local and national levels that aimed to help programme staff, organizations and society effectively to expand activities on nutrition.

Dr GULLY (Canada) said that his country was playing a leading role in the Scaling-Up Nutrition movement and was a major donor in support of nutrition efforts at the country level. The International Code of Marketing of Breast-milk Substitutes should be adapted by countries to suit their specific conditions. The global targets set out in the draft implementation plan were a useful tool for measuring success and ensuring accountability, but also had to be meaningful, measurable and adaptable to country-specific situations. Achieving the targets would require strong and functional

health services and fully trained health personnel, particularly in the least developed countries. It was not clear how the global targets had been developed and he asked the Secretariat to prepare for the Sixty-fifth World Health Assembly a background document explaining the process. The actions recommended in the draft plan tended to be prescriptive; it would be preferable to view them as options that could be implemented on the basis of each country's needs. He wondered whether the Board would be able to note the report as requested, given that the member for Cameroon had called for it to be modified.

Dr DAULAIRE (United States of America) recognized that a significant amount of work had gone into drafting the implementation plan, but substantial further collaboration with multilateral and bilateral partners was needed, as the targets set out in the plan depended on concerted action. For example, it was not clear whether the other partners in the Scaling-Up Nutrition movement even supported all the targets, a matter that needed to be clarified. The International Code of Marketing of Breast-milk Substitutes should be vigorously and universally supported, applied and enforced. The draft plan should provide standardized guidance on legislation, labelling of food and Codex standards to assist Member States in implementing their own laws. Despite his comments at the 128th session of the Executive Board, the plan still contained no reference to the WHO recommendations on the marketing of foods and non-alcoholic beverages to children, which weakened the plan's ability to reduce obesity. He urged the Secretariat to identify and harmonize common targets in the areas of nutrition and noncommunicable diseases to avoid duplication of effort.

Mr ESPINOSA SALAS (Ecuador), endorsing the draft resolution, said that the nutritional strategy being implemented in his country focused on all stages of the life cycle, with particular emphasis on the target of "zero undernutrition", and recommended specific activities to combat micronutrient deficiencies and obesity, and to promote healthy lifestyles. He encouraged the Secretariat to continue expanding its scientific database, to publish guidelines on health and nutrition during pregnancy, and to make them available in the WHO electronic library.

Dr SAKAMOTO (Japan) welcomed the comprehensive plan's focus on mother and child nutrition, as good nutrition throughout a woman's life-cycle was closely related to the health of her children. Moreover, improving the nutritional status of mothers would contribute to the attainment of Millennium Development Goal 5 (Improve maternal health). Implementation of the draft plan should take into account local conditions, as nutrition problems varied greatly by region. Greater collaboration was needed among departments in the Secretariat dealing with nutrition, as was closer cooperation between the Organization and the relevant bodies in the United Nations system, such as FAO and UNICEF.

Dr AL-HALKI (Syrian Arab Republic) said that in the low-income countries of the Eastern Mediterranean Region poor maternal health and malnutrition were responsible for the incidence of low birth-weight children, who were vulnerable to infection and, in extreme cases, neonatal death.

Regardless of economic status or income level, women and children throughout the Region commonly suffered from iron-deficiency anaemia, primarily because of the low bioavailability of iron in the diet, the presence of intestinal parasites and close birth spacing. A substantial proportion of women had osteoporosis and were underweight and short in stature. Programmes aimed at ensuring iron-rich nourishment and iron supplementation were therefore ongoing in several countries of the Region with a view to addressing the problem.

The Secretariat continued to provide all countries of the Region with technical assistance for implementing its Child Growth Standards, thus far adopted by 17 of those countries, with the remainder due to complete the necessary changes to their own national standards by the end of 2012. The regional strategy on nutrition had also stimulated the development of nutritional policies, notably in order to tackle the double burden of undernutrition and overweight through a variety of means, including guidelines, technological resources and various forms of cooperation. Field studies would

undoubtedly be needed for the purpose of designing further programmes and effective interventions for the Region.

Mr DA FONSECA (Timor-Leste), stressing the importance of proper nutrition for pregnant women and for children, proposed that paragraph 43 of the draft plan should include a reference to the creation of an environment in the workplace for breastfeeding mothers that would enable them to breastfeed long enough to have a positive impact on their child's health. Moreover, the recommendation in paragraph 46(b) on dialogue between the health sector and other government sectors should also contain a reference to dialogue with those responsible for developing labour policies.

Dr ST. JOHN (Barbados) expressed appreciation of the strategic and operational support her country had been receiving from the PAHO/WHO Caribbean Food and Nutrition Institute, notably its assistance in improving the national child health record, which played a key role in monitoring the effects of nutrition on development. Barbados was pursuing its efforts to promote infant and young child nutrition, with a special focus on exclusive breastfeeding. Other activities included training in complementary feeding for health-care workers and the development of practical guidelines for nutritious school lunches. The implementation plan was particularly welcome as it should be one of the foundations for efforts to study the effects of noncommunicable diseases on health and development. More information was needed, however, on the plan's global targets and time frames.

Dr NICKNAM (Islamic Republic of Iran)¹ said that the complex subject of nutrition demanded resolute and concerted efforts. The draft plan contained effective nutritional strategies, and mentioned new global and regional joint initiatives that would presumably carry them out. Improved mechanisms for delivery of those strategies were nonetheless needed. Gaps in current programmes and ways to improve coordination across sectors should be identified. In addition, greater understanding was needed of the relationship between nutrition and other factors, such as micronutrient deficiencies and blood disorders, which were widespread in the Eastern Mediterranean Region. The plan should include ways to strengthen operational research on the obstacles to achieving good nutrition. The Secretariat should strengthen its advocacy and consider organizing a global campaign on maternal and child health.

Ms CABALLERO (Peru)¹ thanked the members for Chile and Ecuador for cosponsoring the draft resolution on the implementation plan. Adequate nutrition was an investment in the future. Her Government was making sustained efforts to promote social inclusion in all areas, including by ensuring optimal nutrition to newborn infants and promoting exclusive breastfeeding during the first six months of life and complementary feeding until the age of two years. Implementation of the plan would contribute to the achievement of the Millennium Development Goals.

Dr NAPAPHAN VIRIYAUTSAHAKUL (Thailand),¹ drawing attention to the draft plan, said that global target 5 was not sufficiently ambitious, given that an annual increase of only 1.5% was required to reach the target and some countries had already gone beyond that threshold. Moreover, the language of the target was not clear enough and might be misinterpreted. She suggested that the word "in" should be replaced by "for" in the target title, to read: "Increase exclusive breastfeeding rates for the first six months up to at least 50% by 2022". A more ambitious target, which would include countries that had already reached the 50% threshold, might be worded: "to halve the rate of non-exclusive breastfeeding for the first six months by 2022". Another concern was that the plan did not adequately address the issue of maternity protection and unsupportive environments. The maternity leave period defined in the ILO Maternity Protection Convention merited review.

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

Ms SMITH (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN, said that breastfeeding was the underlying principle of optimal nutrition and, as such, was the key to the successful execution of the draft implementation plan. She therefore called on WHO to ensure that breastfeeding did not get lost among other plans and to acknowledge that breastfeeding also affected mother-child bonding and the health of the community. She endorsed global target 5 in particular and considered that the target level might even be raised. She encouraged the Secretariat to reinvigorate and strengthen the promotion of the International Code of Marketing of Breast-milk Substitutes which was, unfortunately, flouted in many countries.

Dr COSTEA (International Special Dietary Foods Industries), speaking at the invitation of the CHAIRMAN, endorsed the implementation plan, and, in particular, its emphasis on dialogue and partnerships with relevant stakeholders, support for complementary feeding, improving sanitation and water supply and respect for the International Code of Marketing of Breast-milk Substitutes. In addition to breastfeeding, appropriate complementary feeding was crucial to good nutrition. Inadequacies in the composition of complementary foods and absence of appropriate preparation, use and storage of such foods put young children at risk. For that reason, the plan's focus on social determinants of health and nutrition counselling for women was welcome.

Dr LHOTSKA (Consumers International), speaking at the invitation of the CHAIRMAN, said that the draft plan placed excessive emphasis on nutrients and micronutrient deficiencies, failed to highlight adequately the impact of poor infant and young child feeding practices and made no reference to the inappropriate promotion of baby foods. More emphasis was required, furthermore, on the need for maternity protection to facilitate a full six months of breastfeeding. The Scaling-Up Nutrition "movement", not yet fully operational, did not have adequate safeguards in place to avoid conflicts of interest, defined links with the United Nations coordinating mechanism for nutrition or a proven record of effectiveness. The specific reference to that movement could be removed from the plan and replaced with paragraph 44 of the Global strategy on infant and young child feeding to ensure that the plan did not undermine the very policy document it was meant to implement. The report by the Secretariat failed to emphasize the right to adequate food and nutrition or the right to health; it also did not provide an analysis of the root causes of poor nutrition in women, which included structural violence and discrimination.

Ms HOLLY (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, said that progress on reducing malnutrition had been far too slow. The draft implementation plan was therefore welcome and, in that context, the Secretariat should work closely with the Scaling-Up Nutrition movement to ensure harmonization between the plan and other country-level nutrition programmes. The plan itself would benefit from a stronger focus on reducing inequalities in the nutritional status of women and children within countries, providing disaggregated data on gender, income level and other equity-related matters. The actions set out in the section on human resources should include methods to close the global health worker gap and improve the distribution of fully trained health workers. To make real progress on nutrition, other critical sectors, such as agriculture and education, should help to ensure that the plan was implemented in a cross-sectoral manner, with duly assigned accountability.

Dr BRANCA (Nutrition for Health and Development) said that the draft plan contained a set of actions that Member States could confidently implement according to their needs. The plan had been formulated following a lengthy consultation process that had included web-based and face-to-face consultations with Member States, organizations in the United Nations system, civil society and the Scaling-Up Nutrition community. As requested, further information would be provided on the global targets, in particular on the process by which they were developed, the actions required to achieve them, and the links to noncommunicable disease targets. Cooperation with organizations in the United Nations system had been vital to the development of the plan and would be needed to ensure

harmonization of activities at country level. The Renewed Efforts Against Child Hunger and Undernutrition Initiative had been implemented in 10 countries in 2011, and WHO was committed to its support. The plan was still in draft form and amendments from Member States were welcome.

The DIRECTOR-GENERAL, responding to the question by the member for Canada about changes to the draft plan, said that Secretariat reports might omit information or contain points needing clarification like any other document and could always be modified by the Member States. The plan would be adjusted to take into account the comments made during the session. The Secretariat would also comply with the request by the member for Canada for a background document on the rationale for the global targets. Further web-based consultations on the draft plan could be held as needed, in order to finalize it for consideration by the Sixty-fifth World Health Assembly in May 2012.

The Board noted the report.

(For continuation of the discussion and adoption of a decision, see the summary record of the ninth meeting.)

The meeting rose at 12:45.

THIRD MEETING

Tuesday, 17 January 2012, at 09:00

Chairman: Mr R. EL MAKKAOUI (Morocco)

1. NOMINATION OF THE DIRECTOR-GENERAL: Item 3 of the Agenda

Nomination for the post: Item 3.1 (Document EB130/INF.DOC./1)

The meeting was held in open session.

(For continuation of the discussion and adoption of a resolution, see the summary record of the fifth meeting.)

2. STAFFING MATTERS: Item 8 of the Agenda

Appointment of the Regional Director for the Eastern Mediterranean: Item 8.1 of the Agenda (Document EB130/25)

The meeting was held in open session until 10:30, when it resumed in public session.

At the request of the CHAIRMAN, Mr ESPINOSA SALAS (Ecuador), Rapporteur, read out the resolution on the appointment of the Regional Director for the Eastern Mediterranean adopted by the Board in open session:¹

The Executive Board,
Considering the provisions of Article 52 of the Constitution of WHO;
Considering the nomination made by the Regional Committee for the Eastern Mediterranean at its fifty-eighth session,

1. APPOINTS Dr Ala Din Alwan as Regional Director for the Eastern Mediterranean as from 1 February 2012; and
2. AUTHORIZES the Director-General to issue to Dr Ala Din Alwan a contract for a period of five years from 1 February 2012 subject to the provisions of the Staff Regulations and Staff Rules; and
3. AUTHORIZES the Director-General to amend the conditions of employment of Dr Ala Din Alwan as follows: “You will not participate in the United Nations Joint Staff Pension Fund but will instead receive as a monthly supplement the contribution that the Organization would have paid each month to the Pension Fund had you been a participant.”

The CHAIRMAN congratulated Dr Alwan on his appointment.

¹ Resolution EB130.R1.

At the invitation of the CHAIRMAN, Dr Alwan took the oath of office contained in Staff Regulation 1.10 and signed his contract.

Dr ALWAN (Regional Director-Elect for the Eastern Mediterranean) said that he was honoured and gratified to be appointed Regional Director and paid tribute to his predecessor. The Region faced numerous health, socioeconomic and political challenges and diverse needs that called for a strong and dynamic Regional Office with a clear strategy and concrete plans. During his term, the Office's strategic focus would be on strengthening health systems, intensifying action to prevent communicable diseases (including eradication of poliomyelitis), expanding actions to promote health and prevent noncommunicable diseases, and providing support to countries in crisis. With the commitment and backing of Member States and the support of WHO colleagues and the human resources available in the Region, he expressed confidence that the Regional Office would reach its full potential.

The success of the WHO reform process depended on the Organization's capacity to strengthen its technical support and its commitment to creating synergy and making joint planning and management effective across all three levels. WHO's credibility as an Organization that coordinated international health work depended on its ability to adapt readily and effectively to constantly evolving situations. The Regional Office would work with headquarters and other regional offices to build a strong one-WHO response to global health challenges and the increasing need for intersectoral approaches to major public health issues.

At the invitation of the CHAIRMAN, Mr ESPINOSA SALAS (Ecuador), Rapporteur, read out the following resolution expressing appreciation to the outgoing Regional Director for the Eastern Mediterranean adopted by the Board during the open meeting:¹

The Executive Board,

Desiring to express its appreciation to Dr Hussein A. Gezairy, on the occasion of 30 years of devoted service to the World Health Organization as Regional Director for the Eastern Mediterranean Region;

Mindful of his lifelong, professional devotion to the cause of international health,

1. EXPRESSES its profound gratitude and appreciation to Dr Hussein A. Gezairy for his invaluable and longstanding contribution to the work of WHO;
2. ADDRESSES to him on this occasion its sincere good wishes for many further years of service to humanity.

The DIRECTOR-GENERAL, congratulating Dr Alwan on his appointment, said that his experience in many areas and at all levels of the Organization would provide a solid foundation for his work as Regional Director. She paid tribute to Dr Gezairy for his many achievements. He had helped to build a strong sense of corporate spirit within WHO, thanks to his conviction that poliomyelitis would only be eradicated through the engagement of all regions, and would be remembered for his wisdom, his political insight and skill, and his dedication to primary health care. She looked forward to continuing to work with him in his new role as a special representative of WHO championing poliomyelitis eradication and primary health care.

Dr AL-ADOOFI (Yemen) praised Dr Gezairy for his effectiveness and kindness, which had been widely recognized and appreciated. He congratulated Dr Alwan on his appointment and wished him success in dealing with the many complex health challenges in the Eastern Mediterranean Region.

¹ Resolution EB130.R2.

Dr SILBERSCHMIDT (Switzerland) thanked the outgoing Regional Director for his commitment to WHO over many years. He welcomed the appointment of Dr Alwan, who possessed all the skills needed to lead the Region to a bright future. He looked forward to continued interregional collaboration between the Eastern Mediterranean Region and the European Region.

Dr OMI (Japan), speaking on behalf of the Member States of the Western Pacific Region, expressed appreciation to the outgoing Regional Director for his numerous achievements and his dedication to the Organization, and congratulated his successor on his appointment.

Dr BIRINTANYA (Burundi), speaking on behalf of the Member States of the African Region, commended Dr Gezairy's efforts to improve health in the Eastern Mediterranean Region and was gratified to know that he would continue to share his wealth of experience with the various regions. He joined previous speakers in welcoming the appointment of Dr Alwan.

Mr SAMRI (Morocco) said that his Government welcomed the appointment of Dr Alwan as Regional Director.

Mr DESIRAJU (India), speaking on behalf of the Member States of the South-East Asia Region, thanked the outgoing Regional Director for his long years of service to the Organization and wished him well in his new role. He congratulated Dr Alwan on his appointment and looked forward to working with him in the future.

Mr BADR (Egypt)¹ said that Dr Gezairy had spared no effort in supporting the countries of the Eastern Mediterranean Region, all of which had benefited from his valuable work. It was to be hoped that he would continue to provide support and guidance in the future.

His Government would offer Dr Alwan its full support and looked forward to benefiting from his efforts to improve and extend health services in the countries of the Region. His appointment came at a time of great upheaval in the Eastern Mediterranean, but he had the skills and experience needed to support the Region in building social justice.

Dr AL-HAKIM (Iraq)¹ thanked the outgoing Regional Director for his 30 years of dedicated service and welcomed the appointment of Dr Alwan.

Dr NICKNAM (Islamic Republic of Iran)¹ said that his Government congratulated Dr Alwan on his appointment and assured him of its full support in his efforts to enhance health conditions in the Region. It also thanked Dr Gezairy for his dedication and hard work.

Mrs HASSAN (Sudan) wished Dr Gezairy well in his new role as special representative and congratulated Dr Alwan on his appointment.

Dr GEZAIKY (Regional Director for the Eastern Mediterranean Region) said that his work as Regional Director had been guided by three convictions. The first was that Member States were the owners of the Organization. He had consequently put in place several mechanisms to strengthen dialogue between Member States and the Regional Office and to ensure transparency and accountability in the latter's activities. One outcome of the close partnership with Member States had been the establishment in every country of a solid surveillance system, which had helped national authorities to anticipate epidemics of communicable disease, significantly reducing morbidity and mortality. His second conviction concerned the spiritual dimension of health, an idea that had been

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

introduced into WHO's philosophy of health mainly at the initiative of Member States of the Region and had been acknowledged by the Health Assembly in resolution WHA37.13 on the spiritual dimension in the Global Strategy for Health for All by the Year 2000. The Regional Office had developed a programme that sought to identify ways in which religious leaders of different faiths could help in promoting health, notably by discouraging tobacco use. His third conviction was that the basic minimum needs of life must be met in order to achieve a satisfactory quality of life. Primary health care alone could not maintain health in its fullest sense. Community participation was crucial in identifying needs and determining how to meet them, and in establishing community ownership of health initiatives and ensuring the sustainability of their impacts.

A regional priority had been the development of national health systems, in particular training of health personnel. The Regional Office had collaborated with national institutions in developing new medical curricula, promoting health education and health publications in national languages, and fostering a gender perspective in the training of health professionals and in the delivery of health care. Cooperation with other WHO regions, another priority, had yielded significant achievements in disease prevention and control.

He highlighted some other important issues that the Regional Office had addressed. First was the rising tide of noncommunicable diseases. The Office had responded with initiatives that included promoting healthy lifestyles, discouraging tobacco use, and ensuring access to treatments for chronic diseases. Poliomyelitis had also been a particular concern, and he had placed the eradication programme under his direct supervision. The disease remained endemic in only two countries, Afghanistan and Pakistan, owing largely to political and security issues. He was optimistic that those challenges would not be allowed to jeopardize the gains made and that circulation of poliovirus in those countries would soon be halted. The third issue was essential medicines. A regional initiative had been set in motion to strengthen local pharmaceutical industries to produce high-quality and affordable essential medicines and vaccines. Fourthly, a major concern had been the continuous changes in WHO's managerial tools, with a shift in focus of programme management from technical aspects to financial and administrative matters. As a result, technical staff were spending increasing time on administrative issues and less on technical activities – a situation that, in his view, should be reversed. In order to maximize impact and use resources most efficiently, disease control programmes should be managed in the area in which the disease was most prevalent, as with the leprosy programme. The most important issue the Region faced, however, was emergency preparedness and response. Health authorities had a duty to ensure not only medical and psychosocial support but also respect for human rights and ethical norms.

He acknowledged the support that he had received from WHO headquarters staff, fellow regional directors and national health authorities during his 30 years as Regional Director.

3. TECHNICAL AND HEALTH MATTERS: Item 6 of the Agenda (continued)

Early marriages, adolescent and young pregnancies: Item 6.4 of the Agenda (Document EB130/12)

Dr GULLY (Canada), affirming that the improvement of maternal, newborn and child health was a priority for his Government, observed that, unless the difficulties facing adolescents in developing countries were effectively addressed, it would be hard to attain the health-related Millennium Development Goals.

Dr BAYE LUKONG (Cameroon), speaking on behalf of the Member States of the African Region, confirmed that early marriage and adolescent pregnancy constituted a major public health problem, which, coupled with sexually transmitted infections, contributed to poor reproductive health among young women in the Region. A lack of proper sexuality education, low contraceptive use and socioeconomic and cultural constraints were among the underlying factors. Obstetric fistula was a particularly serious problem.

She supported WHO's "4-S framework"¹ for strengthening the health sector response to adolescent health, which, if effectively implemented, could have a positive impact on adolescent reproductive health. In addition to the four strategies envisaged under the framework, Member States should seek to improve access to education for both girls and boys and formulate or reinforce laws and policies that prohibit marriage for girls under 18 years of age. Adolescent reproductive health strategies could not be fully implemented, however, without ensuring sufficient investment and overcoming sociocultural barriers.

Mr PRADHAN (India) said that measures taken by his Government that were leading to later marriage for girls included: legislation for universal elementary education, which was increasing the enrolment and retention of girls in school, initiatives to empower adolescent girls, training programmes in life skills for adolescents, and establishment of adolescent-friendly health clinics offering treatment and counselling on sexual and reproductive health. All the initiatives were in line with WHO guidelines. There was clear evidence that, on average, girls were marrying later and that fertility among young women aged 15–19 and 20–24 years was declining, providing an incentive to pursue existing strategies with greater vigour.

Ms ARTHUR (France), welcoming WHO's recommendations on early pregnancy and poor reproductive outcomes among adolescents in developing countries,² said that recognition of the harmful effect of early and forced marriage on women's health represented a major step forward for women's rights and physical integrity and a measure of the effectiveness of international health policies. Efforts to uphold women's right to manage their own fertility and sexuality must be accompanied by effective anti-discrimination policies, universal access to education, and provision of health services that were affordable, accessible and culturally appropriate. Raising the legal marriage age, ensuring that female births were registered and affording girls secondary education and occupational training were prerequisites for reducing the number of early marriages and pregnancies. Her Government had recently enacted legislation designed to combat forced marriage and was taking action to heighten awareness of and prevent violence against women. It was also collaborating with several intergovernmental bodies, including WHO, on projects to improve maternal and child health.

Dr LARSEN (Norway), speaking on behalf of Denmark, Finland, Iceland, Sweden and the Netherlands, attached high priority to the sexual and reproductive health of young people and to their right to information and relevant services. Sexual health and rights must extend to all, regardless of sexual orientation and gender identity. Increased resistance to recognizing the sexual and reproductive rights of young people was a cause for concern. Young people must be involved in the development, implementation and monitoring of programmes concerning their sexual and reproductive health and rights. Men and boys had a crucial role to play in promoting sexual health and rights and in preventing early marriage and pregnancy. Women's sexual and reproductive health and rights, including freedom of choice and self-determination, had to be realized if gender equality was to be achieved.

Lack of adequate health care during pregnancy and childbirth and poor abortion services remained the main cause of death among women of reproductive age in many developing countries. Harmful traditional practices such as female genital mutilation had unacceptable consequences for women's physical and psychological health and well-being. He commended the report's clear demonstration of the burden of disease and high mortality rate associated with poor sexual and reproductive health. The Secretariat had a key role to play in documenting health problems relating to early marriage and adolescent pregnancy and in establishing guidelines and recommendations on

¹ *Strengthening the health sector response to adolescent health and development*. Geneva, World Health Organization, 2009.

² *WHO guidelines on preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries*. Geneva, World Health Organization.

sexual and reproductive health services, such as the *WHO guidelines on preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries*, which were welcome. The Organization should continue to prioritize work on reproductive health and research and ensure the allocation of adequate funding for that work.

Mr DÍAZ ANAIZ (Chile) said that his country's health authorities, together with representatives of nongovernmental organizations and institutions, were developing a 10-year strategic plan of action to meet the health needs of adolescents and young people. Under the plan, which was consistent with recommendations of PAHO's Regional strategy for improving adolescent and youth health (resolution DC48.R5), several activities had been defined, including: the provision of integrated health services with quality assurance; development of a reliable information system; strengthening of intersectoral work; development of human resources; formulation of technical standards, clinical guidelines and other regulatory documents; family-, community- and school-based interventions; and sustained financial support. The plan was evidence-based, emphasized health promotion and disease prevention and highlighted the need for integrated health system responses, with a particular focus on the most vulnerable adolescents and young people. A law enacted in January 2010 gave everyone the right to receive clear, complete and confidential education, information and guidance on fertility regulation. As part of the Andean Plan to Prevent Teen Pregnancy, youth organizations throughout the country had been invited to share their opinions and make suggestions regarding access to health services and the provision of sexual and reproductive health care.

Dr NASHER (Yemen), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the reduction of early pregnancy rates would promote the attainment of Millennium Development Goals 3 (Promote gender equality and empower women), 4 (Reduce child mortality) and 5 (Improve maternal health). Early marriage and adolescent pregnancy were encouraged in some countries of the Region for cultural, social and economic reasons. The average age of marriage continued to rise, however, and adolescent pregnancies had fallen noticeably over the past two decades as a result of systematic multisectoral efforts. Early marriage was less harmful to the health and well-being of adolescent girls when they benefited from effective family planning services and delayed their first pregnancy until after the age of 18 years. Very early pregnancies could be prevented through girls' completion of secondary schooling, the empowerment of adolescent girls, the introduction of economic incentives, and the encouragement of a change in male attitudes towards women's participation in decision-making about the timing of marriage and pregnancy. Respect for the cultural specificities of different countries was important, however.

Organizations in the United Nations system, including WHO, should work together and intensify their efforts to ensure that the reduction of adolescent pregnancies was a top health priority for their Member States. Sufficient resources were needed for strengthening health infrastructure so as to ensure the ready availability of reproductive services for all adolescents, especially in countries with high rates of adolescent pregnancy and maternal and child mortality. Age-disaggregated data on early marriage and its effects on maternal and neonatal mortality rates should be produced.

Mr SCHOLTEN (Germany) said that his Government was strongly committed to achieving Millennium Development Goals 4 and 5. Its new family planning initiative was tackling an important aspect of maternal health: access to contraceptives. The low number of adolescent pregnancies in Germany could be attributed to the delivery of mandatory comprehensive sexuality education from primary-school age. The Federal Centre for Health Education – a WHO collaborating centre for sexual and reproductive health – had been working on standards for sexuality education for Europe, seeking to ensure that children and adolescents had the right to age-appropriate information to assist them in making healthy choices.

Mr KOLKER (United States of America) said that forced and early marriage raised significant concerns about human rights and public health. Early marriage curtailed educational and employment

opportunities for girls and women, and young brides were sometimes forced to endure violence. Early pregnancy could have serious health consequences, including higher risks of complications and death.

The report could be strengthened by noting the clear linkages between the reduction of early marriage and Millennium Development Goals 2 (Achieve universal primary education), 3 (Promote gender equality and empower women) and 5 (Improve maternal health). It should also give more attention to measures that could reduce the incidence of early marriage and pregnancy, and better describe the reproductive health needs of married adolescents, particularly in view of gaps in global knowledge of effective adolescent reproductive health programming. Few countries had adopted evidence-based tools and resources, such as standards for comprehensive sexuality education, and some needed to overcome barriers, such as limited funding, political sensitivities and a lack of understanding. The Secretariat had an important role to play in supporting Member States' efforts to introduce or adapt evidence-based standards and guidelines. His Government welcomed the opportunity to work with WHO, national governments, international partners and civil society organizations to discourage early marriage and pregnancy.

Mr ESPINOSA SALAS (Ecuador) said that his Government attached great importance to the topic and had drawn up a national plan for the prevention of adolescent pregnancy and a national intersectoral strategy for family planning. It was also involved in the Andean Plan to Prevent Teen Pregnancies. Training in the provision of comprehensive care for adolescents was being provided and an information system on adolescents was being developed in order to ensure the delivery of high-quality, integrated and differentiated primary care that emphasized the sexual and reproductive health of adolescents of both sexes. The health sector was also collaborating with other sectors in order to protect the human rights of pregnant adolescents and prevent discrimination against them, particularly in educational institutions. He welcomed the report, which contained useful guidance and recommendations that his country would take into consideration in its efforts to achieve the Millennium Development Goals and its national development goals.

Mr YUSOF (Brunei Darussalam) said that adolescent pregnancies had accounted for about 6% of all registered pregnancies in his country in 2010. As part of the Government's efforts to provide universal access to reproductive health care and promote the achievement of Millennium Development Goal 5, any pregnant adolescent registered in a maternal and child health clinic in his country would be seen throughout her pregnancy and the delivery would be attended by a skilled midwife and doctor.

Mr XIMENES (Timor-Leste) said that the physical and social consequences of adolescent pregnancy had implications for the achievement of Millennium Development Goals 4 and 5. National-level data existed on pregnancies among unmarried adolescents or abortion and its complications in the South-East Asia Region. Timor-Leste would adopt the *WHO guidelines on preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries*. His country had also developed a national strategy for adolescent health, and steps were being taken to establish adolescent-friendly health services for all adolescents, irrespective of their marital status.

Mr TOSCANO VELASCO (Mexico) said that all countries should continue to improve sexual and reproductive health. Mexico had developed strategies to promote cooperation between the Government and civil society, which included strengthening information, education and communication; facilitating the access of adolescents to sexual and reproductive health information and services; improving the skills of service providers; and evaluating services. Mexico had also launched mass media campaigns that promoted condom use as one of the most effective ways of preventing sexually transmitted infections and unplanned adolescent pregnancies.

Dr KESKINKILIC (Turkey)¹ said that early pregnancy was an important issue for developed and developing countries alike, and was linked to the achievement of Millennium Development Goals 4 and 5. The cultural conditions of countries should be taken into account and tailor-made solutions identified.

Mgr VITILLO (Holy See), speaking at the invitation of the CHAIRMAN, said that he understood the serious risks incurred by young women and men forced into marriage. He recognized the need, outlined in the report, to influence family and community norms relating to delayed marriage and the retention of girls in school and to encourage men and boys to question prevailing norms that could be harmful to women, girls, families and communities. Nevertheless, he registered serious concern about the reference to increased access to emergency contraceptives and safe abortion care. Abortion was not a dimension of reproductive health or reproductive health services and represented the antithesis of human rights. Human life began at the moment of conception, and that life must be defended and protected. The Holy See could never condone abortion, policies that favoured abortion or legislation that permitted it.

Ms ARMITAGE (United Nations Population Fund), speaking at the invitation of the CHAIRMAN, commended the Director-General's commitment to maternal, child, adolescent and reproductive health. The issue of child marriage, despite its widespread practice, had historically received limited attention. In his report on the girl child,² the United Nations Secretary-General had underlined that marriage of a girl or boy before the age of 18 years was recognized in international legal instruments as a violation of the child's human rights. At a time when the largest generation of adolescents ever was coming of age, the issues raised in the report were critical. Efforts should be made to encourage political and community leaders to enforce laws prohibiting child marriage, promote investment in girls' education, and provide comprehensive sexuality education and reproductive health services.

Dr BUSTREO (Assistant Director-General) said that the largest-ever cohort of babies was indeed about to enter adolescence, and there were therefore important public health reasons to tackle the issue of early pregnancy. Work on the issue was central to WHO's agenda and, as many speakers had noted, was linked to the health-related Millennium Development Goals, in particular Goal 5, but also Goals 2 and 3. Multisectoral action was therefore required. WHO was developing guidelines and policy papers and was also working closely with other United Nations bodies, such as UNFPA, UNICEF and UN Women, and the World Bank to address legal and other determinants that were crucial to progress.

The Board noted the report.

Monitoring of the achievement of the health-related Millennium Development Goals: Item 6.5 of the Agenda (Documents EB130/13 and EB130/14)

- **Progress in the achievement of the health-related Millennium Development Goals**
- **Global health goals after 2015**
- **Implementation of the recommendations of the Commission on Information and Accountability for Women's and Children's Health**

Dr DANKOKO (Senegal), speaking on behalf of the Member States of the African Region, said that the Region had made substantial progress towards the achievement of the Millennium

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

² United Nations document A/66/257.

Development Goals and targets, in particular those relating to malaria, HIV/AIDS and child health. Forty-four countries had introduced *Haemophilus influenzae* type b vaccine and 11 provided the pneumococcal conjugate vaccine as part of their immunization programmes. Application of the Integrated Management of Childhood Illness approach was becoming more widespread in the Region, and integrated community case management of pneumonia, diarrhoea and malaria was being introduced in 17 countries. He thanked WHO and other partners for their support with regard to interventions to combat pneumonia and diarrhoea in young children.

He commended the United Nations Secretary-General's Global Strategy for Women's and Children's Health and welcomed the 10 recommendations of the Commission on Information and Accountability for Women's and Children's Health. The Millennium Development Goals relating to HIV/AIDS and other communicable diseases should enjoy the same level of commitment as those relating to women's and children's health. The decision to suspend funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria and the lack of resources for programmes aimed at combating neglected diseases could jeopardize progress towards those Goals. Support from international partners remained vital to the Region's ability to achieve the Goals, and the financial crisis affecting donor countries should not be used as an excuse to reduce their commitment to the fight against communicable diseases that threatened global health. Steps should be taken to accelerate achievement of those Goals in the Region, including: promotion of more intensive vaccination campaigns; health systems strengthening through the training of appropriate numbers of qualified and motivated health workers; support for subregional initiatives to control disease vectors; greater commitment from WHO to facilitate access to effective medicines; more extensive health insurance coverage; and compliance with national and international financial commitments.

Dr LARSEN (Norway) observed that the world would be very different in 2015 from what it had been in 2000. New global challenges, such as climate change, migration, the financial crisis and noncommunicable diseases would affect all countries, irrespective of their level of development. The future development agenda would have to take into account changing realities and new challenges, such as security. The establishment of sustainable development goals at the United Nations Conference on Sustainable Development (Rio+20) due to be held later in the year would be an important step to that end. In the meantime, it was important to remain focused on achieving the health-related Millennium Development Goals. Significant progress had been made in reducing the number of women and children dying from preventable causes, but work remained to be done. Promises must continue to be translated into effective action to improve the health of women and children worldwide, and results and resources must be tracked. The recommendations of the Commission on Information and Accountability for Women's and Children's Health provided an effective tool for that purpose.

Dr AL-HALKI (Syrian Arab Republic), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the countries of the Region and the Secretariat were cooperating closely in preparing and implementing national plans for interventions in the areas of maternal, neonatal and child health and in linking them with national human development programmes. Concerning the Region's progress towards achievement of Millennium Development Goal 4, mortality of children under five years of age had fallen by an estimated 32% in the past decade and four countries were more than two thirds of the way towards attainment of the target, with a further six on track to follow suit. With sustained effort, the remaining countries with high child mortality were also likely to attain the Goal. Coverage with three doses of the tetravalent vaccine against diphtheria, tetanus and pertussis had recently climbed to 90% in several countries and the *Haemophilus influenzae* type b vaccine had been introduced in 18 countries, the pneumococcal vaccine in eight and the rotavirus vaccine in four. Despite that progress, 1.5 million infants had not received the triple vaccine in 2010 and an even higher number had not been fully immunized in line with national schedules. Coverage with the measles vaccine was 90% in 16 countries and a further three countries were close to that level. Efforts to eradicate measles must continue if the downward trend in mortality was to be

sustained. The introduction of new vaccines posed a major challenge for the Region's middle- and low-income countries.

As to Millennium Development Goal 5, an estimated 52 000 women and 510 000 children died each year as a result of pregnancy and birth complications. Some 50% of births took place outside health care facilities and 40% were not attended by health professionals. With regard to Goal 6, some 264 000 persons a year died of tuberculosis, malaria or AIDS. A particular concern was the number of new AIDS cases, which had increased by an estimated 36% in 2011. The countries with the highest malaria burden were grappling with the problem of low diagnostic testing coverage and poor monitoring systems. According to 2010 estimates, the Region's 650 000 tuberculosis cases accounted for 7% of the global burden; nine countries accounted for 95% of those cases.

The challenge for Member States lay in empowering communities to take decisions and play an effective part in tackling health inequalities, particularly in relation to achievement of the Millennium Development Goals. The compilation of data disaggregated by sex, age and geographical region would be important for planning and targeting interventions. Countries should be encouraged to implement policies aimed at ensuring gender equality, women's empowerment, poverty eradication and the full enjoyment of human rights.

Mr DE SANTIS (Switzerland) said that, even though important progress had been made towards the health-related Millennium Development Goals, substantial challenges remained. Health system strengthening was important, particularly for targeted reduction of maternal and child mortality, malaria control, and ensuring the sustainability of interventions. His country remained committed to working with partner countries to strengthen health systems.

With regard to global health goals after 2015, new challenges would need strategies and actions beyond the health sector and a comprehensive intersectoral approach based on global experience and local realities. A limited number of broadly accepted new health goals should be set, building on past experience and best practices and reflecting WHO reform. WHO should take a proactive role within the United Nations system in establishing relevant future social and development goals.

Mr ÁLVAREZ LUCAS (Mexico) agreed that, even though progress had been made, much remained to be done if the Goals were to be attained by 2015. The report in document EB130/13 should include a paragraph on the progress made in stopping the vertical transmission of HIV. Geographical barriers continued to hinder the access of pregnant women to antenatal care and to integrated HIV/AIDS services. Efforts should be made to expand health services in order to make HIV testing universally available and free of charge, train staff in offering HIV testing to pregnant women receiving antenatal care, and develop health promotion and communication strategies to empower women and raise their awareness of the importance of HIV testing. Steps should also be taken to enhance the cost-effectiveness of interventions in respect of HIV/AIDS and other diseases of epidemiological importance, such as malaria and tuberculosis.

His country had made significant progress in the area of reducing child mortality. In order to achieve Goal 4 by 2015, it was implementing strategies focused on the training of medical staff in integrated care for the period from before birth to adolescence.

Mr PRADHAN (India), outlining some of his Government's efforts to achieve Goals 4 and 5, said that several strategies were being implemented to offer access to institutional care for all pregnant women and newborn babies, as a result of which institutional deliveries were expected to rise from the current level of about 73%. In order to improve services for pregnant women and newborn infants, a mother-and-child tracking system had been established. The provision of essential newborn care followed by home visits would help to reduce neonatal mortality. Progress had also been recorded with respect to Goal 6: the prevalence of tuberculosis and HIV in adults had fallen steadily, and a multifaceted approach was being taken in order to combat malaria.

Global health goals after 2015 should focus on preventing and controlling noncommunicable diseases, removing barriers to health care and achieving universal access to quality services, closing gaps between and within countries, and strengthening health systems.

The meeting rose at 12:40.

FOURTH MEETING

Tuesday, 17 January 2012, at 14:40

Chairman: Mr R. EL MAKKAOUI (Morocco)

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

Monitoring of the achievement of the health-related Millennium Development Goals: Item 6.5 of the Agenda (Documents EB130/13 and EB130/14) (continued)

The CHAIRMAN, drawing attention to a draft resolution on monitoring the achievement of the health-related Millennium Development Goals: implementation of the recommendations of the Commission on Information and Accountability for Women's and Children's Health, invited the member for Norway to introduce it.

Dr LARSEN (Norway), said that the draft resolution, which had been proposed by Australia, Barbados, Burkina Faso, Canada, Chile, Colombia, Costa Rica, Côte d'Ivoire, Ghana, India, Indonesia, Japan, Kenya, Mexico, Morocco, Norway, Qatar, Senegal, Seychelles, South Africa, Thailand, Timor-Leste, Togo, Uganda, United Republic of Tanzania, United States of America, Uzbekistan, Zimbabwe, and the 27 Member States of the European Union, read:

The Executive Board,

Having considered the report on Monitoring the achievement of the health-related Millennium Development Goals: Implementation of the recommendations of the Commission on Information and Accountability for Women's and Children's Health,¹

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

The Sixty-fifth World Health Assembly,

PP1 Recalling resolutions WHA 63.15 on Monitoring the achievement of the health-related Millennium Development Goals and WHA 64.12 on WHO's role in the follow-up to the United Nations High-level Plenary Meeting of the General Assembly on the Millennium Development Goals (New York, September 2010);

PP2 Expressing deep concern at the inadequate progress in achieving Millennium Development Goals 4 and 5 on reducing child mortality and on improving maternal health;

PP3 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;

PP4 Acknowledging the pledges and commitments made by a large number of Member States and partners to the United Nations Secretary-General Global Strategy "Every Woman Every Child" since it was launched in September 2010;

¹ Document EB130/14.

PP5 Welcoming the final report of the Commission on Information and Accountability for Women's and Children's Health and its set of bold recommendations for strengthening accountability for resources and results in women and children's health;

PP6 Commending the work and contributions of the Commission, including in particular the development of an accountability framework built on three interconnected processes – monitor, review and act;

PP7 Noting that the key recommendations relate to strengthening national accountability processes both with regard to resources as well as monitoring of results;

PP8 Welcoming the steps taken to implement the recommendations of the Commission, including the development of a multistakeholder workplan for the implementation of the accountability framework;

PP9 Welcoming the establishment of a global review mechanism which will report annually to the United Nations Secretary-General;

PP10 Reaffirming WHO's key role in the implementation and follow-up of the recommendations of the Commission and acknowledging the crucial role of the Director-General in particular,

1. URGES Member States to honour their commitments to the Global Strategy and to further strengthen efforts to improve women's and children's health;
2. ALSO URGES Member States to implement the recommendations provided by the Commission on Information and Accountability for Women's and Children's Health to improve the accountability of results and resources by:
 - (1) strengthening the accountability mechanisms for health in their own countries;
 - (2) strengthening their capacity to monitor and evaluate progress and performance;
 - (3) contributing to the strengthening and harmonization of existing international mechanisms to track progress on all commitments made;
3. REQUESTS the Director General:
 - (1) to work with and support Member States in implementing the full scope of the recommendations;
 - (2) to ensure WHO's effective engagement in collaboration with all stakeholders in the workplan to implement the Commission's recommendations;
 - (3) to provide support to the independent Expert Review Group in its work of assessing progress in the Global Strategy and implementation of the accountability framework;
 - (4) to report annually until 2015 to the World Health Assembly on progress achieved on the follow-up of the recommendations of the Commission in connection with the agenda item concerning the Millennium Development Goals.

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

<p>1. Resolution: Monitoring of the achievement of the health-related Millennium Development Goals: implementation of the recommendations of the Commission on Information and Accountability for Women's and Children's Health</p>
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<p>2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)</p>

Strategic objective(s): 10

Organization-wide expected result(s): 10.4 and 10.10

<p>How would this resolution contribute to the achievement of the Organization-wide expected result(s)?</p> <p>It would support the strengthening of (i) country health information and accountability systems and (ii) global monitoring of results and resources.</p> <p>Does the programme budget already include the products or services requested in this resolution? (Yes/no)</p> <p>Yes, some are included.</p>
<p>3. Estimated cost and staffing implications in relation to the Programme budget</p> <p>(a) Total cost</p> <p>Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).</p> <p>(i) 4 years (covering the period 2012–2015)</p> <p>(ii) Total US\$ 22 million (staff US\$ 16 million; activities: US\$ 6 million)</p> <p>(b) Cost for the biennium 2012–2013</p> <p>Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000)</p> <p>Total US\$ 11 million (staff US\$ 8 million; activities: US\$ 3 million)</p> <p>Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant</p> <p>Headquarters and regional offices</p> <p>Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)</p> <p>No</p> <p>If “no”, indicate how much is not included.</p> <p>US\$ 5.5 million, about 50%.</p> <p>(c) Staffing implications</p> <p>Could the resolution be implemented by existing staff? (Yes/no)</p> <p>Yes</p> <p>If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.</p>
<p>4. Funding</p> <p>Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)</p> <p>No</p> <p>If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).</p> <p>US\$ 4 million; source(s) of funds: many other potential donors are being approached.</p>

The United Nations Secretary-General's Global Strategy for Women's and Children's Health had given new impetus to efforts to achieve Millennium Development Goals 4 and 5. More than US\$ 40 000 million had been pledged by partners to the Global Strategy, with the aim of saving 16 million lives by 2015. Broad support for the Strategy, combined with the need to monitor commitments and outcomes, had led to the establishment, in January 2011, of the Commission on Information and Accountability for Women's and Children's Health, responsible for determining the most effective institutional arrangements for global reporting, oversight and accountability on women's and children's health. In its final report, the Commission had issued a set of recommendations to ensure monitoring of progress up to 2015.

The draft resolution urged Member States to honour their commitments to the Global Strategy and to implement the recommendations of the Commission. It also sought to underline WHO's crucial role in the follow-up to the Commission's recommendations.

Dr JESSE (Estonia), speaking on behalf of the Member States of the European Union, said that the acceding State Croatia, the candidate countries the former Yugoslav Republic of Macedonia, Montenegro and Iceland, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, and Serbia, as well as Ukraine and Georgia aligned themselves with her statement. Progress towards the attainment of the health-related Millennium Development Goals had been made but was uneven among regions, and between and within countries. Governments needed to make greater efforts to prevent childhood diseases and make postnatal care more accessible. The international community should act in concert to help to strengthen health systems.

Progress in reducing maternal mortality was good but insufficient; in particular, there should be more comprehensive reporting on all indicators for Target 5.B (Achieve, by 2015, universal access to reproductive health). She encouraged the Secretariat to provide support to countries in designing integrated maternal, neonatal and child health programmes within broader health sector planning. Such programmes should take into account the determinants of health and the need to train more skilled personnel, improve access to basic obstetric care, and to remove obstacles to women's health, including financial barriers and discriminatory laws. She expressed particular concern that most young people still had only limited access to sexual and reproductive health programmes that could provide them with information, skills, and social support. The right to health should also be guaranteed for the most marginalized groups in society.

The subsequent report should provide an analysis of why progress was more rapid in some countries than others, including information on any factors that had led to accelerated progress.

Mortality rates due to malaria and tuberculosis had shown an encouraging decline, and the number of people receiving antiretroviral treatment had risen. The HIV/AIDS epidemic had stabilized globally, but rates in eastern Europe were still increasing, as was the proportion worldwide of HIV-infected women under 24 years old. Effective responses to such threats as multidrug-resistant tuberculosis and antimalarial drug resistance were needed. She endorsed the Political Declaration adopted at the United Nations High-level Meeting on HIV/AIDS in 2011, and welcomed the ensuing momentum.

The debate on post-2015 global health goals should focus on the right to health and include new and emerging issues. New goals and the priorities to be defined in the Organization's next general programme of work should be closely aligned. At the same time, current efforts towards attaining the Millennium Development Goals should be pursued.

Mr DÍAZ ANAIZ (Chile) said that his country had incorporated the health-related Millennium Development Goals into its national policy and programmes, with, as a result, significant reductions in infant mortality and improved maternal health. Chile had already identified its post-2015 global health goals under its national health strategy for 2011–2020, which used a results-based management model similar to that of WHO's Medium-term strategic plan, 2008–2013. The strategy had four key goals: improving the population's health; reducing health inequality; increasing user satisfaction with health services; and ensuring the quality of health care. The goals were to be attained through the implementation of nine strategic objectives, under which were subsumed 50 identified targets with measurable progress indicators and expected results.

The national strategy had been developed within the health sector, but in view of the multiple factors affecting health, it was preferable that all relevant stakeholders be involved in efforts to ensure a healthy population. The strategy had therefore been issued as government policy to all departments.

Dr GULLY (Canada) supported the efforts of partner countries to achieve the health-related Millennium Development Goals through programmes aimed at better nutrition, improving infant and child health, reducing maternal mortality, combating major infectious diseases, and strengthening

national health systems so as to provide integrated and comprehensive health services, thereby ensuring sustainable gains.

The opportunity to discuss post-2015 goals was welcome but, at the same time, it was important to focus on what was needed to achieve the existing Goals by 2015. Because the least progress had been made towards Goals 4 and 5, Canada had made maternal, newborn and child health a priority of its 2010 G8 Presidency, launching its Muskoka Initiative. Furthermore, with WHO it had hosted a meeting (Ottawa, 20–22 November 2011) to identify challenges arising from the work plan for implementation of the recommendations issued by the Commission on Information and Accountability for Women's and Children's Health, partners' roles and the next steps. That work plan merited general endorsement in order to sustain progress on improving maternal, newborn and child health. He encouraged the governing bodies and the Secretariat to use the conclusions of the Ottawa meeting, as well as those of other national and regional meetings, to identify measures needed for implementation of the Commission's recommendations.

He expressed the hope that Member States would support the draft resolution at the Health Assembly in order to strengthen the accountability of Member States and the Secretariat.

Mr SAMRI (Morocco) said that effective coordination within national health systems and with other sectors engaged in health-related work was vital to the reduction of maternal and under-five mortality. His Government had made the reduction of maternal deaths during childbirth a priority, introducing such measures as free birthing facilities, village health programmes and mobile medical teams, with the result that maternal mortality ratios had halved in only three years. Efforts were under way to halve that figure again to 50 deaths per 100 000 live births.

The impact of pneumococcal and rotavirus vaccines, introduced in 2010, on the mortality rate of children under the age of five years was currently under study. For middle-income developing countries such as Morocco, however, the exorbitant cost of those vaccines was problematic, particularly without support from the GAVI Alliance.

Dr PHILLIPS (Barbados), welcoming the significant progress made towards attaining several of the health-related Millennium Development Goals, said that the substantial efforts being made at all levels should continue in order to ensure that the Goals' targets were reached, and should be pursued after 2015 to achieve further gains. WHO and its partners in the H4 Initiative to improve maternal and newborn health were making commendable efforts to encourage national commitment to the measures needed to accelerate progress towards the health-related Millennium Development Goals. By working together with its partners to support efforts to achieve the Goals and facilitating the measurement of progress, the Organization would continue to play a leading role.

He expressed appreciation for the support his country had received from the PAHO subregional office in the Caribbean, which included contributions from the PAHO Revolving Fund for Vaccine Procurement to ensure affordable access to vaccines, and technical support for HIV-programme development and assessment.

He endorsed the proposed draft resolution, including its request that the Director-General support the independent Expert Review Group in its work of assessing progress towards the agreed objectives.

Ms XU Xiaochao (China) stated that China had already achieved the health-related Millennium Development Goal Target 4.A for under-five mortality, and was on track for the others. In its efforts to improve maternal and child health, it would continue to make use of United Nations experience in setting targets, including rates for delivery in hospital. Globally, attainment of the Millennium Development Goals still presented challenges and an even greater commitment from the international community was needed. The health-related goals should be integrated into the wider political and development agenda.

WHO should review the experience gained from global, regional and national efforts to achieve the health-related Goals, and should play a major part in establishing any goals for the years after 2015 at all levels, in particular introducing health into more goals so as to generate more resources. WHO

also had a role to play in monitoring, and should ensure that its indicators were measurable, achievable and flexible enough to allow for regional diversity. In setting new goals, due consideration should be given to the multisectoral nature of the economic and social determinants of health, which would require political commitment to the health-related goals from all sectors. The reform process should be accelerated in order to enable the Organization to lead the goal-setting process effectively.

Mr SCHOLTEN (Germany) explained that his country's main focus was on strengthening health systems, with special emphasis on the promotion of sexual and reproductive health and rights and the combating of HIV/AIDS. Reduction of maternal and neonatal mortality rates required continuity of care provided by functioning health systems, including contraceptive services, early pregnancy and antenatal care visits, identification of high risk pregnancies, professional delivery and postnatal care for mother and child. He endorsed the guiding principles of the Commission on Information and Accountability for Women's and Children's Health.

In its efforts to alleviate the social and economic impact of AIDS, his country had three main objectives: reducing the number of new HIV infections through prevention, facilitating access to treatment, and helping people with HIV and their families to live with dignity. It contributed more than €500 million annually to efforts aimed at halting and reversing the spread of HIV, tuberculosis and malaria by 2015.

With regard to child health globally, his country had increased its financial contribution to the GAVI Alliance from €4 million in 2010 to €20 million in 2011, and was planning to donate €30 million in 2012, subject to budgetary and parliamentary approval.

Past experience had shown that ambitious targets had a global impact and imparted great mobilizing power. He therefore welcomed work on setting post-2015 global health goals, but they should form part of a holistic development framework.

Dr OMI (Japan) recalled that his country had expressed on various occasions its commitment to accelerating progress towards attaining the Millennium Development Goals. It endorsed the Global Strategy for Women's and Children's Health and had adopted, in the United Nations General Assembly High Level Meeting in 2011, the Political Declaration on HIV/AIDS. It also planned to implement the recommendations of the Commission on Information and Accountability for Women's and Children's Health.

Endorsing the concept of "better information for better results", he underlined monitoring and assessment, including establishment of a birth registration system, as a priority. The burden of data collection should nonetheless not be too heavy for Member States.

As it was unlikely that the Millennium Development Goals would be attained by 2015, tracking of those goals should be part of any post-2015 global health initiative.

Mr YUSOF (Brunei Darussalam) noted that many Member States had made significant progress towards the Millennium Development Goals, demonstrating that concerted and sustained effort and political commitment did yield results. Member States that were struggling to meet targets could benefit from adopting best practices and adapting them to their circumstances, with support from WHO and other international partners.

In Brunei Darussalam, the mortality rate for children under five years of age had been reduced to 7.3 per 1000 live births in 2010, and there had been only one maternal death in the current year. Malaria and poliomyelitis had been eradicated in 1987 and 2000, respectively, and low levels of HIV infection had been maintained. Having achieved its targets, his country would pursue its efforts to improve quality of life by further strengthening health systems.

Global economic instability, environmental catastrophes, climate change and the burden of noncommunicable diseases seriously threatened basic health requirements and social and economic development, including food safety and security. Those factors must be given due consideration in the setting of post-2015 global health goals, one of which should be universal health coverage.

He endorsed WHO's recommendations to provide sufficient health funding, build robust health systems, and improve information and best-practice sharing among Member States.

Ms ARTHUR (France) said that her country was committed to accelerating progress towards the attainment of Millennium Development Goals 4 and 5. Access to reproductive health services could not be separated from the active promotion of gender equality and the empowerment of women. Bolstering national health information systems, in particular by using new communication technologies, was vital to making progress on the targets set and French experts were available to support countries in that regard. France would be implementing the recommendations of the Commission on Information and Accountability for Women's and Children's Health, with particular emphasis on health indicators, in the course of its implementation of and follow-up to the measures it had taken in response to the Muskoka Initiative. It was following with interest the work of the independent Expert Review Group responsible for assessing progress on the Global Strategy for Women's and Children's Health.

Ms BLACKWOOD (United States of America) said that her Government was committed to accelerating progress towards the Millennium Development Goals and helping to ensure that development gains were sustainable. Progress towards several Goals was encouraging, in particular the reduction of child mortality in developing countries, especially in Africa. Member States needed to redouble their efforts, nonetheless, if the health-related Goals were to be attained, despite the challenge of mobilizing sufficient resources in a time of economic crisis.

The lack of progress in reducing maternal mortality and morbidity globally was a matter of serious concern. Additional study was needed to understand why some countries had succeeded in that area but many others had failed. Greater attention should be paid to improving maternal mortality data, which would result in more effective monitoring of impact.

It was important that the health-related Goals, which had helped to guide her Government in determining its development assistance policies, remained a priority for the Organization.

Dr AZODOH (Nigeria) acknowledged the efforts of WHO and other partners to accelerate progress towards the Millennium Development Goals. The number of cases of malaria in Nigeria had gradually reduced, but in some countries, especially in rural Africa, malaria continued to cause neonatal and child deaths and recurrent spontaneous abortion. In Nigeria's hot climate people spent a large amount of time outside, where they were exposed to malaria vectors. She proposed, therefore, that, in addition to the use of long-lasting insecticide-treated bed nets, greater emphasis be placed on larviciding and she called on WHO to advocate that approach.

Mr KASE (Papua New Guinea), speaking on behalf of the Member States of the Western Pacific Region, said that despite some achievements, many countries in the Region had not yet made sufficient progress towards attaining the Millennium Development Goals. The epidemiology of malaria and other diseases had stabilized in some countries, but mothers and children continued to die from preventable causes, because many Member States had weak and ineffective health systems and received little government support or funding for them. WHO and its partners were nonetheless helping countries to make progress.

Mr ESPINOSA SALAS (Ecuador) said that, with a view to achieving the Millennium Development Goals, his Government had implemented a national intersectoral strategy for integrated child development, comprising three objectives: improving coverage and equality of institutional prenatal care, health care for newborn infants and children aged 29 days to five years; improving the quality of health-care services by developing human resources, infrastructure and equipment; and institutional strengthening and coordination, including dissemination of standards and regulations, use of a monitoring and audit system, and setting up of a perinatal information system. His country had worked in partnership with PAHO and UNFPA on activities involving sexual, reproductive and perinatal health.

Over the previous decade, Ecuador had taken steps to reduce maternal and neonatal mortality, including improving quality of care, training personnel, updating care standards, and monitoring to prevent the death of newborn infants.

The region of Latin America and the Caribbean had reduced its infant mortality rate by more than any other developing country region. That was a source of pride, and would certainly inspire further efforts towards universal coverage, vaccination, intercultural health, education of women and poverty reduction.

Dr IKRAMOV (Uzbekistan) endorsed the comments made by the member for Estonia on the attainment of Millennium Development Goals 4 and 5. Although maternal and child health systems differed across countries, the two Goals could generally be met by ensuring health for all. Immunization should be a priority in every country. Regional challenges included how to approach the issue of early marriage. That was a matter for not only the health system, but also society and the media, which could influence societal attitudes towards the value of the family. In many countries premarital medical examinations were not undertaken, even though such examinations could detect markers of disease. Reduction of maternal and infant mortality depended on ensuring access to qualified medical personnel and appropriate equipment, including adequate anaesthesia for women giving birth, and guaranteeing caesarean sections to at-risk patient groups. Another challenge was that currently the average spacing between pregnancies did not give women enough time to recover. He endorsed the comments made by the member for Germany regarding HIV/AIDS.

Political commitment and investment in health systems were essential and must be well coordinated in order to facilitate attainment of the Millennium Development Goals. The work of WHO and other relevant organizations, especially with regard to Goals 4 and 5, merited continuing support. He also endorsed the recommendations of the Commission on Information and Accountability for Women's and Children's Health.

Dr PE THET KHIN (Myanmar) stressed the monitoring of progress towards the health-related Millennium Development Goals, including human resource needs and areas where progress was slow. WHO country offices, in cooperation with local and regional partners, could contribute by conducting a rapid review of programmes where progress was flagging. Monitoring relied on properly functioning health information systems that provided accurate data, and WHO should provide technical support in that regard. It would, in addition, be useful to have more detailed information on specific examples of successful technical support.

Detection and treatment targets for tuberculosis had been attained in his country, but recent research had demonstrated that about 40% of sputum smear-negative patients had been found to be culture-positive, which meant that the real situation was being underestimated. Similar discrepancies had occurred for malaria indicators, and he emphasized the use of good-quality microscopes. He questioned the figure quoted in the report of 50% of women in developing countries receiving four or more antenatal visits.

Working together with partners on the ground, and with technical support from WHO, countries and regions should identify what remained to be done to achieve the health-related Millennium Development Goals by 2015. Post-2015 targets should focus on general practitioners and private sector medical care.

Ms QUACOE (Côte d'Ivoire)¹ said that a significant number of maternal deaths still occurred in Africa. To improve maternal health, she recommended putting in place effective, high-quality health systems, in particular in rural regions; extending coverage to all people, especially vulnerable and marginalized groups, thereby ensuring their empowerment; guaranteeing better quality of care, in particular safe births and high-quality vaccination programmes, by investing in motivated, qualified, health personnel serving throughout the country; raising awareness among girls and young women of the need to use professional health-care services; and integrating the protection of mothers into

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

national economic and social development policies. She supported the draft resolution and remained committed to the attainment of the Millennium Development Goals.

Mr LEE Kyong-yul (Republic of Korea)¹ welcomed the progress made towards attaining the Millennium Development Goals but warned that progress in meeting the health-related targets was low when compared with other targets. He therefore welcomed the priority that had been accorded to achieving the health-related Goals in the context of the WHO reform process. His Government had focused its efforts on maternal and child health, in the framework of official development assistance projects, and was proud that development assistance projects in South-East Asia were being used as a benchmark for other donors.

Dr NICKNAM (Islamic Republic of Iran),¹ welcoming the progress towards achievement of the Millennium Development Goals, observed that current challenges included achieving targets in the face of national emergency situations, lack of commitment to improving maternal and child health, and inequalities in health resources allocation. With reference to the latter, he suggested that countries that had achieved their targets at the national level should endeavour to ensure that targets were met at the provincial and district levels through more effective programmes.

Political commitment was essential if the Goals were to be achieved. Member States should develop comprehensive national plans, approved at the highest level. High-quality health-care systems were also vital. His country had a well-functioning health-care system, following expansion five years previously by the addition of a family physician programme. In addition, it had a comprehensive, modern surveillance system to monitor progress towards the Goals, and he recommended in that regard that a global collaborative monitoring system be set up. Other factors affecting progress towards the Goals were difficulties associated with urban and suburban areas (“hidden cities”) and noncommunicable diseases.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland),¹ recognizing the need to keep up the momentum of efforts to attain the Millennium Development Goals, said that any future health goals should be part of a simple, focused and legitimate framework that reflected the multidimensional nature of poverty and took into account the evolving nature of health challenges in developing countries. Any such framework should inspire strong ownership at the country level, have a good global/national balance, reflect the new global context of a world where it was becoming increasingly difficult to classify countries as “developing” or “developed”, and take into account that development assistance aid was shrinking. Securing global agreement on such a framework was a priority for her Government, and broader consultations were needed on how to best achieve results in combating world poverty.

Dr NIPUNPORN VORAMONGKOL (Thailand)¹ recalled that maternal and child deaths were largely preventable. WHO and its partners must work together to increase efforts and resources, focusing on strengthening services that saved lives and improved women and children’s health.

Many countries were still far from achieving Millennium Development Goals 4 and 5, and time was running out. An accountability framework, comprising monitoring, review and action, was essential if Member States were to improve women and children’s health. The monitoring system and the feedback mechanism that were being used in relation to the Goals should therefore be strengthened. The draft resolution failed to pay adequate attention to the feedback mechanism and also failed to mention the need to mobilize financial and technical support from partners other than Member States.

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

Ms KUN NARYATIE (Indonesia)¹ said that her Government was in the process of implementing the recommendations of the Commission on Information and Accountability for Women's and Children's Health. A national health and demographic survey had identified disparities in achieving Millennium Development Goal targets between and within regions, and between socioeconomic levels and education levels. Millennium Development Goals programmes had been adjusted accordingly as Indonesia was a diverse country and each region required specific attention and action. The Government had launched a new maternity health insurance programme designed to monitor resources for women's and children's health more effectively and aimed at encouraging pregnant women to use skilled birth attendants at official health facilities. It provided financial support for antenatal to postpartum care, including family planning, for 2.3 million pregnant women every year. It also provided universal health coverage, even to people living in the most remote regions.

Ms CHILDS (MSF International), speaking at the invitation of the CHAIRMAN, said that attainment of the health-related Millennium Development Goals was being threatened by the lack of resources. One major source, the Global Fund to Fight AIDS, Tuberculosis and Malaria, had cancelled a funding round, thereby cutting off new funding for three years. Insufficient funding could lead to the rationing of HIV care, the reversal of plans to implement effective treatment protocols, a delay in expanding treatment of multidrug-resistant tuberculosis, and postponement of the use of injectable artesunate to treat severe malaria. She urged WHO to take a leading role in monitoring and reporting on health programmes threatened by the economic crisis, and in estimating shortfalls. She asked the Board to respond to the calls for funding in 2012 and to appeal to Member States that had not yet fulfilled their financial pledges to the Global Fund to do so without delay. WHO should actively ensure that health needs, including treatment, were considered in discussions on financial transaction taxes.

Mr DA FONSECA (Timor-Leste) said that the draft resolution provided an important platform for better international cooperation in the health sector. At the same time, the Organization must ensure that it did not become yet another tool for ranking States in order of achievement. He said that he hoped that subparagraph 2(3) of the draft resolution was also intended to include cooperation on the social determinants of health.

Dr AZODOH (Nigeria) said that her country wished to be added to the list of cosponsors.

Dr KIENY (Assistant Director-General), thanking Member States for their comments, said that she had taken note of the request made by the member for Estonia that future reports should include an analysis of why progress was slower in some countries or regions than in others.

Replying to the enquiry by the member for Mexico about HIV/AIDS, she said that, according to the most recent statistics published by WHO and UNAIDS, the number of new cases and deaths was clearly decreasing, and treatment coverage was increasing, with more than one million more people receiving treatment each year. According to a recent study, when individuals living with HIV received antiretroviral treatment, the risk of transmission to their sexual partners could be reduced by as much as 96%. The new data were encouraging as they demonstrated that it was possible to reverse the epidemic by strengthening existing prevention efforts and extending treatment coverage. WHO and its partners were working towards eliminating new HIV infections among children by 2015 by preventing transmission of HIV from mother to child. That effort had to be based on strong and supportive health systems and close cooperation with maternal and child health programmes, as implied in the Global health sector strategy on HIV/AIDS, 2011–2015 (resolution WHA64.14).

She welcomed the comments that had been made about the link between the post-2015 development goals and the Rio+20 United Nations Conference on Sustainable Development, both of

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

which contained a substantial health component. Health contributed to, and benefited from, social, economic and environmental policy, and universal health coverage was a means of reducing poverty. Sustainable development should be linked with the social, economic and environmental determinants of health so that the health dimension would be integrated into all policies, including sustainable energy, transport and climate change mitigation. Moreover, health was a measure of progress towards sustainable development goals. New targets, such as premature mortality due to noncommunicable diseases, should be included.

The discussion on post-2015 development goals should be led by the Member States. The United Nations System Task Team on Health as a Tracer Sector, which included WHO, would back up that process and report to the high-level panel to be set up by the United Nations Secretary-General to advise him on the post-2015 development agenda.

The work plan of the Commission on Information and Accountability for Women's and Children's Health brought together three clusters in the Secretariat work on family, women's and children's health, and health system strengthening, and included work being done by Member States and their partners.

The CHAIRMAN took it that the Executive Board wished to take note of the report on the progress in the achievement of the health-related Millennium Development Goals 2015 and adopt the draft resolution.

The resolution was adopted.¹

Social determinants of health: outcome of the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, October 2011): Item 6.6 of the Agenda item (Document EB130/15)

The CHAIRMAN, inviting comments on the report, drew attention to the following draft resolution, proposed by Brazil, Chile and Ecuador:

The Executive Board,

Having considered the report on the World Conference on Social Determinants of Health, held in Rio de Janeiro, Brazil, 19–21 October 2011,²

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

The Sixty-fifth World Health Assembly,

PP1 Having considered the report on the World Conference on Social Determinants of Health, held in Rio de Janeiro, Brazil, 19–21 October 2011;

PP2 Recalling the three overarching recommendations of the final report of the Commission on Social Determinants of Health, namely, to improve daily living conditions; to tackle the inequitable distribution of power, money and resources; and to measure and understand the problem and assess the impact of action;

PP3 Further recalling resolution WHA62.14 on reducing health inequities through action on the social determinants of health;

PP4 Recognizing the need to do more to accelerate progress in addressing the unequal distribution of health resources as well as conditions damaging to health at all levels;

PP5 Acknowledging the negative impact of the global economic and financial

¹ Resolution EB130.R3.

² Document EB130/15.

crisis on the population's health in developed and developing countries;

PP6 Further acknowledging that health equity is a shared goal and responsibility and requires the engagement of all sectors of government, of all segments of society, and of all members of the international community, in an "all for equity" and "health for all" global actions;

PP7 Reaffirming the political will to make health equity a national, regional and global goal and to address current challenges, such as eradicating hunger and poverty, ensuring food and nutritional security, access to affordable, safe, efficacious and quality medicines as well as to safe drinking-water and sanitation, employment and decent work and social protection, protecting environments and delivering equitable economic growth through resolute action on social determinants of health across all sectors and at all levels;

PP8 Welcoming the discussions and results of the World Conference on Social Determinants of Health held in Rio de Janeiro, Brazil, from 19 to 21 October 2011;

1. ENDORSES the Rio Political Declaration on Social Determinants of Health adopted by the World Conference on Social Determinants of Health;
2. URGES Member States to implement the pledges made in the Rio Political Declaration with regard to (i) better governance for health and development, (ii) increased participation in policy-making and implementation, (iii) reorientation of the health sector towards reducing health inequities, (iv) strengthening global governance and collaboration, and (v) monitoring progress and increase accountability including through:
 - (a) the development of action plans on social determinants of health with clearly defined goals, activities and accountability mechanisms;
 - (b) building capacities among policy-makers, managers, and programme workers in health and other sectors to facilitate work on social determinants of health; and
 - (c) advocating for action on social determinants of health as part of the deliberations on sustainable development, in particular in the United Nations Conference on Sustainable Development (Rio+20), including targets following the Millennium Development Goals;
3. CALLS UPON the international community to support the implementation of pledges made in the Rio Political Declaration for action on social determinants of health, including through:
 - (a) joint assistance by United Nations agencies and development banks to Member States, particularly developing countries;
 - (b) exchange of best practices;
 - (c) provision of technical assistance; and
 - (d) in facilitating access to financial resources;
4. URGES those developed countries which have pledged to achieve the target of 0.7% of the gross national product for official development assistance by 2015, and those developed countries that have not yet done so, to make additional concrete efforts to fulfil their commitments in this regard;
5. ALSO URGES developing countries to build on progress achieved in ensuring that official development assistance is used effectively to help achieve development goals and targets;
6. REQUESTS the Director-General:
 - (a) to make social determinants of health a priority of the WHO reform process in particular through comprehensively incorporating a focus on social determinants

of health and the reduction of health inequities across all WHO programmes and workplans;

(b) to provide support to Member States in implementing the Rio Political Declaration in particular the “Health in All Policies” approach to address social determinants of health;

(c) to coordinate joint work with other United Nations agencies in advocacy, research, capacity-building and direct technical assistance to Member States for work on social determinants of health;

(d) to coordinate joint work with other United Nations agencies in order to identify the impact of social determinants of health such as international financial transactions and international trade on health conditions of Member States and to establish common strategies to enhance the positive and reduce the negative effects of these social determinants of health;

(e) to promote, in collaboration with Member States, the convening of a United Nations high-level event in 2013 focused on “social determinants of health”;

(f) to report to the Sixty-sixth and Sixty-eighth World Health Assemblies, through the Executive Board, on progress in implementing this resolution and the Rio Political Declaration.

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

<p>1. Resolution: Outcome of the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, 19–21 October 2011)</p>
<p>2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)</p> <p>Strategic objective(s): 7 and 10 Organization-wide expected result(s): 7.1, 7.2, 7.3 and 10.5</p> <p>How would this resolution contribute to the achievement of the Organization-wide expected result(s)?</p> <p>It would support implementation of the Rio Political Declaration on Social Determinants of Health (2011), and enhance the provision of technical support by the Secretariat to Member States.</p> <p>Implementation of this workplan and budget would represent the totality of the Secretariat’s work to achieve Organization-wide expected results 7.1, 7.2 and 7.3. Implementation would also include the work related to the social determinants of health within the health sector, which is currently budgeted for headquarters under Organization-wide expected result 10.5.</p> <p>Does the programme budget already include the products or services requested in this resolution? (Yes/no)</p> <p>Yes</p>
<p>3. Estimated cost and staffing implications in relation to the Programme budget</p> <p>(a) Total cost</p> <p>Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).</p> <p>(i) 6 years (covering the period 2012–2017)</p> <p>(ii) Total: US\$ 94 million (staff: US\$ 63 million; activities: US\$ 31 million)</p> <p>(b) Cost for the biennium 2012–2013</p> <p>Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000).</p> <p>Total: US\$ 34 million (staff: US\$ 24 million; activities: US\$ 10 million)</p> <p>Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.</p>

Headquarters: US\$ 10.7 million; Regional offices: US\$ 10.8 million; Country offices: US\$ 12.5 million
Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

Yes

If “no”, indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

One additional staff member at headquarters at grade P.4. Required skills: the ability to coordinate global action on social determinants of health, especially the work with the United Nations platform on social determinants of health. Six additional positions would be required at the regional level at grades P.3 and P.4.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

No

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ 21.4 million; source(s) of funds: voluntary contributions from countries, private donors and multilateral organizations.

Dr JESSE (Estonia), speaking on behalf of the European Union and its Member States, said that the acceding State, Croatia, the candidate countries the former Yugoslav Republic of Macedonia, Montenegro and Iceland, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, and Serbia, as well as Georgia aligned themselves with her statement. The World Conference on Social Determinants (Rio de Janeiro, Brazil, 19–21 October 2011) had enabled examination of ways of making policy and action on social determinants of health more effective in reducing health inequities within and between countries. Options for preventing or reducing health inequities varied with a country’s level of development. Yet, with the global economic crisis, equity in health must be given due consideration in policy, practice and law. A good environment, positive early experience, education and employment were essential to preventing health inequities, in addition to policies on social protection, family and gender. The European Union was committed to health in all policies, with a special focus on health equity.

Developing guidelines for countries on how to address social determinants of health and equity issues and how to integrate a social determinants approach into health strategies were examples of the support that the Secretariat should provide to Member States. WHO should also strengthen its cooperation, including the sharing of norms, standards and good practices, with other organizations in the United Nations system and development partners. She welcomed the report of WHO and UN-HABITAT on urban health equity, and called for a strong health sector contribution to the Rio+20 process.

The 8th Global Conference on Health Promotion, due to be held in Helsinki in June 2013, would provide an opportunity to review progress and identify what remained to be done.

Dr DE ASSUNÇÃO SAÍDE (Mozambique), speaking on behalf of the Member States of the African Region, said that among the challenges to reducing health inequities were: the limited capacity for coordinating and managing multisectoral actions concerning social determinants of health; the lack of coherence across sectors; and the paucity of data available for measuring trends in health inequity and the impact of social determinants of health across population groups.

In 2010, a regional strategy to identify key determinants of health had been adopted and the Regional Office had set up three programmes within the health promotion cluster to accelerate action on social determinants of health. It had also produced two reports, on health equities and on urbanization and health, and produced, through the African Health Observatory, regional and country data on health equity. Support had been provided to six countries to conduct workshops on strengthening multisectoral actions, and to eight countries to conduct case studies on multisectoral action in relation to key social determinants of health.

In formulating action on the key social determinants of health, the Region faced complex structural challenges which included weak health systems, inconsistent public health policies, limited financing options, lack of community participation in decision-making, lack of multisectoral actions, and inefficient mechanisms for collecting, analysing, disseminating and using data on health equity.

International cooperation to promote health equity should be strengthened through the sharing of expertise, technologies and scientific data. Policy approaches must be based on the right to the enjoyment of the highest attainable standard of health. Without significant gains in poverty reduction, food security, education, women's empowerment and living conditions, most countries would not be able to achieve the health-related Millennium Development Goals.

Mr PRASAD (India), applauding the Rio Political Declaration on Social Determinants of Health, drew attention to the need to improve governance and to promote the participation of socially and economically vulnerable groups in policy-making so that the needs of those most affected by health inequities were recognized. India placed great emphasis on action on social determinants as a means of achieving its national health goals. The national health programme was designed to reduce inequities, and the Government demanded that all new policy proposals specify how they would help to enhance equity. At the federal level, the National Rural Health Mission provided additional resources for primary health care and a framework to ensure equitable and affordable care. Strong involvement of civil society and communities in implementation was encouraged, with a large workforce of 800 000 accredited social health activists acting as a bridge between communities and the health-care system.

The Regional Office for South-East Asia should develop a regional strategy to tackle the key determinants of health and commission a regional review of the health divide and inequalities in health in order to provide information that would underpin new health policy in the Region.

Mr DÍAZ ANAIZ (Chile) described his country's epidemiological transition over the previous half-century and drew attention to its 10-year national health strategy (2011–2020), which provided guidelines for health sector policy-making and intersectoral activities aimed at building on achievements to date and meeting present-day needs: the prevalence of noncommunicable diseases (which contributed more than 80% of the national disease burden), an ageing population and widespread inequalities. The strategy placed emphasis on health promotion, disease prevention, the introduction of a social welfare net and improved primary health care, with a life-cycle, rights and social-determinants focus. It was underpinned by health protection legislation for, inter alia, smoke-free areas and food labelling. To encourage healthy living and tackle the problems of obesity and inactivity, the Office of the First Lady had launched a nationwide programme that set out to persuade people to eat healthily and to take outdoor exercise. The Government had also set up a ministry for social development and introduced social protection legislation covering maternity leave and pension contributions.

He endorsed the comprehensive vision set out in the Rio Political Declaration on Social Determinants of Health and hoped that its consensus would galvanize countries into action to raise their levels of health equality.

Dr REN Minghui (China) said that tackling the social determinants of health was crucial to sustainable development at the global level and to efforts to reduce health inequities. His country had endorsed the Rio Political Declaration on Social Determinants of Health and would actively participate in and promote research on the subject. Its national health system reforms, launched in

2009, already focused on the five priority action areas, under the leadership of a multisectoral steering group. A health-for-all system had been established, covering basic health services and health security, and specific policies were in place to guarantee access to health services for women, children, the elderly and the rural poor. Foreign experts had been invited to help in a mid-term assessment of the reforms.

The Secretariat should further define the meaning of the social determinants of health, and continue global action to raise additional funding and technological resources in order to play a leading role in improving health equity. Member States should place health at the heart of their national social development agendas, taking concerted action to avoid policy fragmentation and overlaps. The international community should step up support for least developed countries and regions, and widen the focus from tackling health inequities within countries to among countries.

Dr DAULAIRE (United States of America) said that the World Conference on Social Determinants of Health had helped to provide countries with pointers for identifying ways to tackle health risks that lay outside the health sector, and to use data on disparities in health to ensure that resources reached the most-at-risk people and communities. He fully supported that approach. WHO had a key role to play in helping countries to identify best practices, setting standards for the collection and analysis of data on health disparities, and showing national governments how to use those tools to develop their own strategies for promoting greater health equity. Action on social determinants must centre first and foremost on the national level, and WHO could assist governments in developing indicators and targets suited to tackling health disparities. His Government would work with the Secretariat and other stakeholders, and share its knowledge and experience for future national action. It was ready to adopt a revised version of the draft resolution.

Dr SAMRI (Morocco), speaking on behalf of the Member States of the Eastern Mediterranean Region, drew attention to the trends in health inequities, particularly for people in the Region who were living in areas of conflict and consequently were deprived of services. The Region had been represented at the World Conference on Social Determinants of Health and information on effective strategies for action on social determinants of health in the Region had been presented in the form of papers dealing with the work of nongovernmental organizations in Cairo slums, an Iranian student-police initiative relating to road traffic injuries, measures for tackling obesity in Jordan, and aspects of health equity in Morocco and Pakistan. At the close of the Conference, the Regional Office had worked with Member States to draft a regional plan for follow-up of the Rio Political Declaration on Social Determinants of Health through a range of actions, including circulation of the Declaration within the Region, strengthening of multisectoral measures, incorporation of social determinants of health into national health policies, capacity building and the pooling of regional expertise on social determinants of health. A report on the proceedings of the Conference would be submitted to the Regional Committee at its next meeting.

Dr GULLY (Canada) said that his Government was committed to implementing the Rio Political Declaration on Social Determinants of Health. It planned to invest in new research programmes to improve health equity, and to continue supporting the work of the Canadian Reference Group on Social Determinants of Health. He encouraged WHO to take the lead in advocating a social-determinants-of-health approach to reducing health inequalities.

Dr LARSEN (Norway) described the Rio Political Declaration on Social Determinants of Health, which was in line with the core principles of WHO's Constitution, as a stepping stone for progress in global action to reduce health inequities. Those inequities, which stemmed from an unfair distribution of societal benefits and resources both within and between countries and had caused much unrest around the world in the previous year, were of utmost concern. Fairness and equity were crucial to a socially and economically stable future and the Secretariat must lead the social-determinants-of-health agenda. It needed capacity and resources to provide Member States with technical support for strategies to operationalize the agenda based on the principle of "health in all policies", and to

capitalize on the current opportunity to create synergies with the United Nations Conference on Sustainable Development (Rio+20): health equity relied on sustainable development and a society with health inequities was unsustainable.

He generally supported the draft resolution.

Dr SILBERSCHMIDT (Switzerland), also applauding the Rio Political Declaration on Social Determinants of Health, agreed with most of the comments on the action needed to tackle those determinants and welcomed the work of the Regional Office for Europe to develop a European perspective on the matter. He expressed concern, however, about the health sector's capacity to engage in constructive dialogue with other sectors and to foster a sector-wide approach to tackling the social determinants of health with coherent policies. Such an approach had been lacking at the World Conference on Social Determinants of Health, and it might be premature to convene a United Nations high-level event on social determinants of health in 2013; the health sector needed time to work on itself in order to become a partner to others.

He supported the draft resolution.

Mr TOSCANO VELASCO (Mexico) said that his Government shared the views expressed at the World Conference in Rio de Janeiro on tackling the social determinants of health. It was crucial to consider the direct bearing that they had on health and to promote a holistic, inclusive approach with the participation of not only other government departments but also civil society and industry. One element yet to be considered was the proliferation of social networks throughout the world, which had become a key means of communication among young people at various levels of society. The use of cell phones, for example, was common in Mexico, even among the poor.

Mr ESPINOSA SALAS (Ecuador) said that the World Conference on Social Determinants of Health had helped his Government to focus on previously undervalued aspects of health care. Ecuador attached particular importance to the five key areas highlighted at the Conference: adopting better national governance for health and development; promoting participation in policy-making; further reorienting the health sector towards reducing health inequities; strengthening global governance and collaboration; and monitoring progress and increasing accountability. The negative impacts of the social determinants of health had prompted his Government to act at the national and regional levels with a view to ensuring that those determinants were taken into account in the formulation of public health policies. That would be a major challenge and, recognizing it as such, Ecuador had supported the adoption of the Rio Political Declaration on Social Determinants of Health. Urging the Board to adopt the draft resolution, he requested that the representative of Brazil be invited to take the floor in order to provide further clarification on its content.

Dr PE THET KHIN (Myanmar) drew attention to the fact that developing countries like his might lack the capacity to implement recommendations, and stressed the need to work closely with other sectors and civil society organizations to ensure that actions on social determinants of health were adapted to the respective social, cultural and economic contexts of individual countries and regions.

Having been given the floor by the CHAIRMAN, Mrs FARANI AZEVEDO (Brazil)¹ briefly reviewed the background to the adoption of the Rio Political Declaration on Social Determinants of Health, which constituted a clear commitment on the part of Member States to reduce inequities in access to health services and to promote better living conditions for the most vulnerable groups. It represented a new chapter in the promotion of social justice. The draft resolution set out, inter alia, to secure the endorsement of the Political Declaration by the Health Assembly, as recommended in the

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

Declaration itself, and to ensure the inclusion of social determinants as a priority in the WHO reform process. She was ready to continue working on the language with other interested parties so as to ensure that the resolution achieved its objectives and tackled all the concerns expressed.

The multisectoral nature of the social determinants of health called for more holistic dialogue with other sectors and, hence, efforts to pave the way for a high-level meeting on the subject.

Dr CHUTIMA AKALEEPHAN (Thailand)¹ expressed the hope that the Rio Political Declaration on Social Determinants of Health would be implemented fully and effectively. She supported the draft resolution in principle. In order to eradicate health inequities and improve public health, however, the text needed to take into account the concept and practice of universal health coverage, which was a major breakthrough in promoting access to health care, avoiding catastrophic expenditure and, hence, preventing poverty, one of the most influential social determinants of health. In view of the fact that the social determinants of health, in a globalized world, could no longer be confined within national borders, the text also needed to accommodate the concept of protecting public health through the promotion of global governance tools.

Ms EGGERMONT (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, said that the Rio Political Declaration on Social Determinants of Health neither broke new ground nor charted a fresh approach to problems widely acknowledged as being in need of urgent attention. Member States should take into consideration six key areas: building and strengthening equity-based social protection systems and publicly-provided and funded health systems; financing action on social determinants from progressive taxation and measures to eliminate tax evasion; using health-impact assessments to document how unregulated and unaccountable transnational corporations and financial institutions, and the global trading system, constituted barriers to health for all; presenting aid for health as an international obligation to – and a basic right of – developing countries; adopting a code of conduct for managing institutional conflicts of interest in global health policy decision-making; and developing monitoring systems that provided disaggregated data on social stratifiers related to health outcomes. Successful attempts to tackle social determinants of health called for a bold approach that targeted the upstream structural determinants.

Dr GULLY (Canada) said that the draft resolution, in order to build on the successful outcome of the World Conference on Social Determinants of Health, should be significantly shortened and based on the actual language of the Rio Political Declaration. He was willing to take part in any drafting group assigned to that task.

Dr JESSE (Estonia), speaking on behalf of the European Union, said that the Rio Political Declaration on Social Determinants of Health, which was important for public health at all levels, already contained many commitments to be met across several government sectors. She requested the Secretariat to provide, in its report to the Sixty-fifth World Health Assembly, information on the financial and staffing implications of implementing the Political Declaration under WHO's current mandate. She joined the member for Canada in suggesting that the text of the draft resolution should remain as close as possible to that of the Political Declaration. She asked the Secretariat to clarify the somewhat ambiguous figures provided on the financial and administrative implications for the Secretariat of the resolution.

Mrs FARANI AZEVÊDO (Brazil)¹ reiterated her willingness to join interested parties in streamlining the language of the draft resolution.

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

Dr PHILLIPS (Barbados) expressed satisfaction with the five priority action areas of the social-determinants approach set out in the Secretariat's report. He supported the draft resolution, and its call for actions at the national, regional and global levels to operationalize that approach as a key mechanism for achieving equity in the attainment of health goals. He also supported the request to the Director-General to continue work on assessing the impact of social determinants and assisting Member States in their efforts. He would be willing to join any drafting group set up to refine the text.

Dr KIENY (Assistant Director-General) said that the Secretariat, when calculating the financial implications of the draft resolution, had taken into account the cost of convening a United Nations high-level meeting in 2013. Using figures from the previous biennium, during which the World Conference on Social Determinants of Health had been held, it had arrived at the sum of US\$ 34 million. Given the availability at present of some US\$ 13 million, a shortfall remained of around US\$ 21 million. In view of the fact that only one such meeting would be held per biennium, the figure for the next biennium would be lower; and the final amount would depend on the outcome of the drafting group's work on the draft resolution.

The CHAIRMAN said that, in the absence of any objection, he took it that the Board agreed to suspend its consideration of the agenda item.

It was so agreed.

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

Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level: Item 6.2 of the Agenda (Document EB130/9) (continued from the second meeting, section 2)

The CHAIRMAN drew attention to a revised version of the draft resolution that incorporated amendments proposed by Member States, which read:

The Executive Board,

Having considered the report on the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level,¹

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

The Sixty-fifth World Health Assembly,

PP1 Having considered the report on the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level;

PP2 Recalling resolution WHA55.10, which urged Member States to increase investments in mental health both within countries and in bilateral and multilateral cooperation, as an integral component of the well-being of populations;

PP3 Recalling further United Nations General Assembly resolution A/RES/65/95, which recognized that "mental health problems are of major importance to all societies and are significant contributors to the burden of disease and the loss of quality of life, and have huge economic and social costs" and which also welcomed the

¹ Document EB130/9.

WHO Report on *Mental Health and Development*,¹ which highlighted the lack of **appropriate [MEXICO]** attention to mental health ~~in development, [MEXICO]~~ and made the case for governments and development actors to reach out to people with mental disorders **to design, strategies and programmes that include them in in-poverty reduction and development strategies as well as [MEXICO]** education, employment, health, social protection and **poverty reduction** ~~other [MEXICO]~~ policies;

PP4 Noting the High-Level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases, held 19–20 September, 2011, which recognized that mental and neurological disorders, including Alzheimer's disease, are an important cause of morbidity and contribute to the global noncommunicable disease burden, for which there is a need to provide equitable access to effective programmes and health-care interventions;

PP5 Recognizing that mental disorders can ~~be~~ **produce [MEXICO]** disabilities, as reflected in the United Nations Convention on the Rights of Persons with Disabilities, which also notes that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others and that the *World Report on Disability*² charts the steps that are required to improve the participation and inclusion of people with disabilities, including persons with mental disabilities;

PP6 Recognizing that mental disorders fall within a wider spectrum that also includes neurological and substance-use disorders which also cause substantial disability and require a coordinated response from health and social sectors; [SECRETARIAT]

~~PP7~~ **PP6** Concerned that millions of people worldwide are affected by mental disorders, that in 2004, mental disorders accounted for 13% of the global burden of disease, defined as premature death combined with years lived with disability, and that, when taking into consideration only the disability component of the burden of disease calculation, mental disorders account for 25.3% and 33.5% of all years lived with a disability in low- and middle-income countries, respectively;

~~PP8~~ **PP7** Concerned also that exposure to humanitarian emergencies is a potent risk factor for mental health problems and psychological trauma and that social structures and ongoing formal and informal care of persons with severe, pre-existing, mental disorders are disrupted;

~~PP9~~ **PP8** Recognizing that the treatment gap for mental disorders is high all over the world, and that between 76% and 85% of people **in low- and middle-income countries [MEXICO]** with severe mental disorders receive no treatment for their mental health conditions ~~in low- and middle-income countries, [MEXICO]~~ and that the corresponding figures for high-income countries are also high – between 35% and 50%;³

PP10 Recognizing that mental disorders can be prevented and that mental health can also be promoted in sectors outside health; [NORWAY]

PP11 Concerned that persons with mental disorders are stigmatized and underlining the need for health authorities, working together with relevant groups, to change attitudes to mental disorders; [NORWAY]

PP12 Noting that there is an increasing evidence on effectiveness and cost-effectiveness of interventions to promote mental health and prevent mental disorders, particularly in children and adolescents; [ESTONIA]

¹ Funk M et al (Eds). *Mental health and development: targeting people with mental health conditions as a vulnerable group*. Geneva, World Health Organization, 2010.

² World Health Organization, The World Bank, *World Report on Disability*. Geneva, World Health Organization, 2011.

³ Demyttenaere K et al (2004). *JAMA*, **291**:2581–90.

PP13 PP9 Noting that mental disorders are often co-morbid with noncommunicable diseases and a range of other priority health conditions, including HIV/AIDS, maternal-child health, and violence and injuries, and that ~~in women and children~~, [ESTONIA] [CANADA] [MEXICO], mental disorders often coexist with other medical and social factors, such as poverty, harmful use of alcohol **and other substances** [MEXICO] **and that women and children are more vulnerable because of the co-exposure exposure** [MEXICO] and exposure to domestic violence and abuse, which have a negative impact on the quality of life;

PP14 PP10 Recognizing that the social and economic impact of mental disorders, including mental disabilities, is diverse and far-reaching;

1. URGES Member States¹ [ESTONIA]:
 - (1) **according to national priorities and within their specific contexts** [CANADA] to develop comprehensive policies and strategies that address **mental health promotion and disease prevention as well as** [NORWAY] **mental health promotion, prevention of disorders, in particular among children and adolescents as well as** [ESTONIA] **promotion and prevention of mental health problems and screening,** [MYANMAR] **mental health promotion, mental illness prevention, as well as** [CANADA] care, support and treatment of persons with mental disorders **including** [CANADA] by promoting human rights, tackling stigma, **empowering service users,** [ESTONIA] **addressing poverty and homelessness** [CANADA], **tackling major modifiable risks of mental health problems,** [MYANMAR] and, as appropriate, **promoting public awareness,** [CANADA], creating opportunities for generating income, providing housing and education, as well as providing health-care services in the community;
 - (2) **to develop comprehensive programmes that include an integral approach to prevent and attend mental disorders with community based interventions;** [MEXICO]

Alternate text to paragraph (1) and paragraph (2) above proposed by sponsors

- (1) **according to national priorities and within their specific contexts, to develop comprehensive policies and strategies that address the promotion of mental health, prevention of mental disorders, early identification, care, support, and treatment of persons with mental disorders;**
- (2) **to include in policy and strategy development the need to promote human rights, tackle stigma, empower service users, address poverty and homelessness, tackle major modifiable risks, promote public awareness, create opportunities for generating income, provide housing and education, provide health-care service and community based interventions;**
- (3) **to develop appropriate surveillance frameworks that include risk factors as well as social determinants of health to evaluate and analyse trends regarding mental disorders;** [MEXICO]

Alternate text to paragraph (3) above proposed by sponsors

- (3) **to develop, as appropriate, surveillance frameworks that include risk factors**

¹ And, where applicable, regional economic integration organizations.

as well as social determinants of health to analyse and evaluate trends regarding mental disorders;

(4) ~~to give appropriate priority to~~ **prioritize and streamline [MYANMAR] to give priority to mental health, including mental health promotion, mental illness prevention, care, support and treatment** ~~mental health [CANADA]~~ in health and development programmes and to allocate ~~adequate appropriate~~ **[MYANMAR]** resources in this regard;

(5) to collaborate with WHO in the development of an Action Plan **to promote mental health and [NORWAY] to promote mental health and prevent mental health problems and [MYANMAR] promote mental health, prevent mental illness, and [CANADA] to enable persons with mental disorders to live a full and productive life in the community;**

Alternate text to paragraph (4) and paragraph (5) above proposed by sponsors

(4) **to give priority to mental health in health and development programmes and to allocate appropriate resources in this regard;**

(5) **to collaborate with WHO in the development of a Mental Health Action Plan;**

2. REQUESTS the Director General:

(1) to develop a comprehensive Action Plan **in consultation with [MYANMAR]** for consideration by Member States, covering **mental health promotion and mental illness prevention, as well as public awareness [CANADA]** services, policies, plans, strategies, programmes and legislation, **to promote legislation and mental health, prevent mental disorders and provide care and social services [ESTONIA] to promote mental health and prevent mental health problems and [MYANMAR]** to enable persons with mental disorders to live a full and productive life in the community;

Alternate text to paragraph (1) above proposed by sponsors

(1) **to develop a comprehensive Mental Health Action Plan in consultation with and for consideration by Member States covering services, policies, plans, strategies, programmes and legislation to treat and prevent mental disorders, promote mental health and enable persons with mental disorders to live a full and productive life in the community;**

(2) to include in the Action Plan provisions to address:

(a) protection, promotion and respect for the rights of persons with mental disorders **including the need to avoid stigmatization of persons with mental disorders; [NORWAY]**

(abis) **mental health promotion and mental illness prevention; [CANADA]**

(b) **equitable [MYANMAR] access to affordable [MYANMAR] quality comprehensive health services that include mental health at all levels of the health-care system with particular focus on deinstitutionalized care and empowerment of service users [ESTONIA];**

Alternate text to paragraph (abis) and (b) above proposed by sponsors

(b) **equitable access to affordable, quality and comprehensive health services that integrate mental health into all levels of the health-care system;**

(bbis) development of competent, [MYANMAR] adequate, and equitable distributions [MYANMAR] human resources to provide mental health promotion, prevention and [MYANMAR] services ~~equitably~~ [MYANMAR];

Alternate text to paragraph (bbis) above proposed by sponsors

(bbis) development of competent adequate human resources to provide mental health services equitably;
(bter) the need for prevention to be included in policies in mental health; [NORWAY]

Alternate text to paragraph (bter) above proposed by sponsors. This is based on an amendment suggested by Mexico as paragraph 4 below

(bter) the promotion of equitable access to quality health care including psychosocial interventions and medication;
(b?) enhance initiatives to promote mental health and prevent mental disorders, including, where appropriate, support for parental skills; [ESTONIA]
(c) access to educational and social services, including health care, schooling, housing, secure employment and participation in income generation programmes;
(d) involvement of civil society organizations of persons with mental disorders in voicing their opinions and contributing to decision-making processes;

Alternate text to paragraph (d) above by sponsors

(d) involvement of civil society organizations, persons with mental disorders, families and caregivers in voicing their opinions and contribution to decision-making processes;
(dbis) to design and provide special mental health support systems that will enable community resilience and will help people cope during humanitarian emergencies; [MEXICO]

Alternate text to paragraph (dbis) above proposed by sponsors

(e) the design and provision of mental health and psychosocial support systems that will enable community resilience and will help people cope during humanitarian emergencies;
(e) participation of people with mental disorders in family and community life and civic affairs; and
(f) mechanisms to involve all relevant sectors in Member States in the implementation of the Action Plan
(fbis) to create special programmes for health-care providers that include mental health in community and primary care settings; [MEXICO]

Alternate text to paragraph (f) and paragraph (fbis) above proposed by sponsors

(f) mechanisms to involve the education, employment and other relevant sectors in Member States in the implementation of the Action Plan;
(3) to collaborate with Member States, and as appropriate, with [ESTONIA] international, regional and national nongovernmental organizations, ~~donors~~ international development partners [MYANMAR] and technical agency partners in the development of the Action Plan;

- (4) to ensure equitable access to quality health-care attention and medications; [MEXICO]**

Alternate text to paragraph (4) above proposed by sponsors

May consider for deletion as suggestion has been incorporated as 2(bter) above.

- (5) to ensure mental health support in schools and labour settings; [MEXICO]**
(6) to give appropriate priority to mental health in health and development programmes and to allocate appropriate resources to prevent mental disorders, as well as to provide appropriate treatment in this regard; [MEXICO]
(7) to collaborate with WHO in the development of an action plan to enable persons with mental disorders to live a full and productive life in the community; [MEXICO]
(8) to build up social frameworks in order to support people with mental disorders as well as their families; [MEXICO]

Alternate text to paragraph (5–8) above proposed by sponsors

May consider for deletion as suggestions have been incorporated in text above.

- (9) to submit the Action Plan for consideration by the Sixty-seventh World Health Assembly through the 134th Executive Board; [MYANMAR]**

Alternate text to paragraph (9) above proposed by sponsors

- (9) to submit the Action Plan for consideration by the Sixty-sixth World Health Assembly through the 132nd Executive Board.**

Mr PRADHAN (India), speaking on behalf of the all the sponsors of the draft resolution, presented a summary of the additional amendments to the revised text that had been received. The third preambular paragraph towards the end should be amended to read: “to reach out to people with mental disorders in the design of strategies and programmes that ...”. In the first line of the fifth preambular paragraph, the word “produce” should be replaced by “lead to”. The tenth preambular paragraph should be amended to read: “Recognizing that a number of mental disorders can be prevented and that mental health can be promoted in the health sector and in other sectors;”. In the first line of the eleventh preambular paragraph, the word “often” should be inserted before “stigmatized”, and the subsequent text be amended to read: “and underlining the need for health authorities to work with relevant groups to ...”. The word “an” in the first line of the twelfth preambular paragraph should be deleted. In the thirteenth preambular paragraph, the term “co-morbid” should be replaced by “associated”; the word “conditions” on the next line should be replaced by “issues”; and the last three lines should be amended to read: “poverty, substance abuse and the harmful use of alcohol and, in the case of women and children, greater exposure to domestic violence and abuse”. The member for Estonia had suggested adding a new fifteenth preambular paragraph, reading: “Taking into account the work already carried out by the WHO on mental health, particularly the mental health Gap Action Programme;”.

With regard to the operative paragraphs, the words “and treatment” in subparagraph 1(1) should be replaced by “treatment and recovery”. The member for China had suggested inserting the words “strengthen advocacy and” before “develop” in the alternative text for subparagraph 2(1), and other sponsors had suggested inserting the words “with measureable outcomes” after “Action Plan”, and replacing “to treat and” by “to provide treatment, facilitate recovery and”. He pointed out that subparagraphs 2(2)(abis) and 2(2)(b) reflected the repeated reference in the Board’s discussions to integration into primary health care. In order to convey the fact that the human resources providing

mental health services had to be more than merely competent, a word such as “considerate” should be inserted before “adequate” in the alternative version of subparagraph 2(2)(bbis). To reflect the point made in the discussions that persons with mental disorders might also have physical disorders in need of attention, the word “medication” at the end of the alternative version of subparagraph 2(2)(bter) should be replaced by “addressing physical health-care needs”. In view of doubts as to whether paragraph 2 was the right place to mention parental skills, it was proposed to delete subparagraph 2(2)(b) and include a reference to such skills in the twelfth preambular paragraph. A new subparagraph 2(2)(g) should be added, reading: “to build upon the work already done and to avoid duplication of action;”. In place of subparagraphs 2(4) to 2(8), should the Board decide to accept the sponsors’ proposal to delete them, the member for China had suggested adding a new subparagraph 2(4), reading: “to work with Member States and technical agencies to promote academic exchange through which to contribute to policy-making in mental health”.

Dr JESSE (Estonia) said that she needed to consult the competent experts before responding to the suggestion that the proposed text on parental skills be transferred from subparagraph 2(2) into the twelfth preambular paragraph.

Dr GULLY (Canada) proposed four further amendments. First, the words “fall within a wider spectrum that also includes” in the sixth preambular paragraph should be deleted and replaced by “include and are associated with”. Secondly, the beginning of the alternative version of subparagraph 1(4) should be amended to read: “to give appropriate priority to mental health, including mental health promotion, mental illness prevention, care, support and treatment in health and development programme”. Thirdly, the words “and legislation to provide treatment, facilitate recovery and prevent mental disorders” in the amended alternative version to subparagraph 2(1) should be further amended to read: “and legislation to prevent mental disorders, provide treatment and facilitate recovery”. Lastly, the words “, in accordance with national priorities:” should be added to the end of the introductory phrase to subparagraph 2(2).

Dr LARSEN (Norway), referring to the sixth preambular paragraph, said that it was uncommon in his country for patients with neurological disorders, such as multiple sclerosis or amyotrophic lateral sclerosis, to be associated with those that had mental disorders. He therefore requested that the text be redrafted. He further requested that his delegation’s proposed subparagraph 2(2)(bter) remain where it was, as the content did not appear to be reflected elsewhere in the draft resolution.

Mr TOSCANO VELASCO (Mexico) said that he would consult further but that the proposed amendments seemed acceptable.

Dr DAULAIRE (United States of America) said that the word “sensitive” might be more appropriate than “considerate” in the alternative version of subparagraph 2(2)(bbis).

The DIRECTOR-GENERAL suggested that members wanting to make additional amendments to the text submit them to the member for India, and that a finalized version of the draft resolution be submitted to the Board the following morning.

Dr SILBERSCHMIDT (Switzerland), endorsing the suggestion by the Director-General, requested that the finalized version be a clean copy.

Dr EL OAKLEY (Libya)¹ questioned earlier comments that neurological and mental disorders were not interrelated. Unless neurological disorders were already covered by existing WHO

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

programmes, it would save time and money to include the management of those disorders in the draft resolution.

The CHAIRMAN, in the absence of any objection, took it that the Board wished to approve the Director-General's suggestion.

It was so agreed.

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

The meeting rose at 17:45.

FIFTH MEETING

Wednesday, 18 January 2012, at 09:05

Chairman: Mr R. EL MAKKAOUI (Morocco)

NOMINATION OF THE DIRECTOR-GENERAL: Item 3 of the Agenda (continued)

Nomination for the post: Item 3.1 of the Agenda (Document EB130/INF.DOC./1) (continued from the third meeting, section 1)

Draft contract: Item 3.2 of the Agenda (Document EB130/3)

The meeting was held in open session from 09:05 to 11:30, when it resumed in public session.

Nomination for the post: Item 3.1 of the Agenda (Document EB130/INF.DOC./1) (resumed)

At the request of the CHAIRMAN, Mr ESPINOSA SALAS (Ecuador), Rapporteur, read out the resolution on the nomination for the post of Director-General adopted by the Board in open session:¹

The Executive Board,

1. NOMINATES Dr Margaret Chan for the post of Director-General of the World Health Organization, in accordance with Article 31 of the Constitution;
2. SUBMITS this nomination to the Sixty-fifth World Health Assembly.

The CHAIRMAN expressed his congratulations to the Director-General on her nomination for a second term and wished her every success. Her nomination was a testimony to the confidence placed in her by Member States on account of her discerning leadership, far-sightedness, ongoing commitment and experience accumulated during her professional life and years in office as Director-General. She would play a major role in the WHO reform that she had instigated in order to enhance the Organization's effectiveness in promoting the health of current and future generations worldwide and ensuring their equal right to health. He said that he was sure that all Member States would support her in performing her functions. Having had the honour of working closely with her, he could affirm without hesitation that WHO was fortunate to have such a professional, competent, dynamic and creative individual at its head.

The DIRECTOR-GENERAL said that she was honoured by the Board's expression of confidence in her ability to continue to lead the Organization. When she had been nominated for her first term as Director-General, she had promised to work tirelessly, and she had done so. All those involved in public health would need to work even harder to maintain the increased momentum that had marked the start of the 21st century. It could be done: the public health sector was used to struggle and setbacks. The work of public health was never finished. The persistent challenges and ongoing struggles had been exacerbated by a world rocked by economic upheaval, and the globalization of unhealthy lifestyles, ageing and the rise of noncommunicable diseases added to the challenges.

¹ Resolution EB130.R4.

FIFTH MEETING

Wednesday, 18 January 2012, at 09:05

Chairman: Mr R. EL MAKKAOUI (Morocco)

NOMINATION OF THE DIRECTOR-GENERAL: Item 3 of the Agenda (continued)

Nomination for the post: Item 3.1 of the Agenda (Document EB130/INF.DOC./1) (continued from the third meeting, section 1)

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¹ Resolution EB130.R4.

The public health sector and WHO were both feeling under pressure; yet there were many promising signs of improvement and a thirst for efficiency. A “shift to thrift” and smart innovations could sustain the recent unprecedented drive for better health. Universal health coverage was a powerful equalizer. The public health sector and WHO were well positioned to create greater fairness, balance and social cohesion. If her nomination were confirmed by the Health Assembly, she would work even harder to ensure that more people attained the highest possible level of health. She expressed appreciation to Member States and the staff of WHO for their hard work and support during her first term. With continued support and cooperation, they would build on their achievements and accomplish even more together.

Mr ZHANG Mao (China) warmly welcomed the nomination of Dr Chan, and expressed his appreciation to the Board for the trust and support that it had shown. He congratulated the Director-General on her achievements over the previous five years.

Global health faced many challenges. Changes to the ecosystem and the way people lived and worked had given rise to a host of complex public health issues. New communicable diseases continued to emerge, and the treatment of chronic diseases had led to a rapid increase in health costs. Health inequities were steadily widening and had an adverse impact on traditional health systems. At the same time, there were new opportunities. Medical reforms in his country were yielding good initial results. The international community was increasingly becoming aware that human health was not just a product of economic development but, more importantly, also contributed to it. Human well-being and health development had attracted unprecedented attention.

In that context, the international community was calling for the reform of the global health governance structure, demanding a stronger, more efficient, more transparent and more accountable WHO Secretariat. The Board’s nomination of Dr Chan reflected its recognition of her expertise, managerial competence, capable and efficient working methods, and leadership, as well as the expectation that, under her continued leadership, the Secretariat would support Member States in meeting new and emerging challenges for global public health.

Dr Chan would continue to lead WHO in continuous reform and innovation, promoting the development and strengthening of health systems in developing countries, improving health security, increasing access to medical products and paying attention to vulnerable groups, particularly women and African populations, so as to make fresh contributions to attaining the objective of WHO. His Government would continue to support Dr Chan and the Secretariat in working for human health, and hoped that the Health Assembly would approve the Board’s nomination.

Dr JESSE (Estonia), speaking on behalf of the European Union and its Member States, said that the acceding State Croatia, the candidate countries Turkey, the former Yugoslav Republic of Macedonia, Montenegro and Iceland, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina and Serbia, together with Ukraine, Armenia and Georgia, aligned themselves with her statement. Over the previous five years, the ambitions that the Director-General had declared on taking office had been transformed into action. It had been a challenging time, and many of those challenges – the influenza pandemic, achieving the health-related Millennium Development Goals, facing up to the financial crisis and environmental disasters, and tackling communicable and noncommunicable diseases – were still present, underlining the need to maintain a strong focus on health systems. Throughout, the Director-General had demonstrated her firm resolve to attain results for health and to care for people, determined to steer the work of WHO into areas where it had a unique advantage and where it could have a distinct and measurable impact and create added value.

She agreed with the Director-General that the Organization should not follow a “full-menu” approach, and supported the ambitious reform process, including the commitment to strengthen accountability for results and impact, which the Director-General had initiated in order to make WHO “fit for purpose”. In the modern world, leadership was not mandated, but earned. The Director-General had earned deep respect and support, as evidenced by her nomination for a second term, and the

expectations for her future work matched the great challenges remaining. The European Union wished her resilience, strength and good health, and stood ready to support her in her work.

Mr DESIRAJU (India), speaking on behalf of the Member States of the South-East Asia Region, congratulated the Director-General on her nomination. For five years, she had guided the work of WHO with firmness and determination, but also with understanding and concern. In difficult times for the Organization, she had shown wisdom and courage in addressing challenges and had put the issues of governance, financing and reform firmly on its agenda. He trusted that, during her second term, substantial reforms would be accomplished, and he assured the Director-General of the Region's continued good wishes and support.

Mr HILALE (Morocco), warmly congratulating the Director-General, said that her nomination bore witness to Member States' confidence in her leadership and the high regard in which she was held, both professionally and personally. The determination and strong will she had shown during her first term had helped the Organization to confront major challenges and overcome difficulties, including numerous health emergencies. His Government would continue to offer her its full support, in the conviction that she would maintain her tenacity and determination in working with Member States and others to improve health worldwide.

WHO must fully assume its responsibilities as a United Nations specialized agency and the global coordinating body for health. In view of the number and complexity of challenges it faced, its objective would be difficult – but not impossible – to achieve. The international community should pull together in a spirit of equity and solidarity, and the Organization must obtain the resources needed to confront those challenges, meet the expectations of Member States and improve the lot of the most vulnerable members of society, building on the hard-won health achievements to date. The fragility of those achievements, particularly in developing countries, required swift and urgent action to strengthen health systems and promote equitable access to health services.

The Director-General's ambitious reform programme offered an opportunity to make WHO more efficient and transparent and to consolidate its position as a standard-setting body. He wished her well in her mission.

Dr BAYE LUKONG (Cameroon) congratulated the Director-General on her well-deserved nomination, knowing she could be counted upon to work to improve health, particularly the health of women and children. Her Government would give the Director-General its full support.

Dr SILBERSCHMIDT (Switzerland), adding his congratulations, said that he trusted the Director-General to lead WHO through the reform process and make it fit for the 21st century, helping more people to enjoy the highest possible level of health and protecting and promoting equity. As host country, Switzerland would continue to do its utmost to provide the Secretariat with optimal conditions and to support the Director-General.

Dr OMI (Japan), echoing the congratulations, said that, in view of her track record and strong leadership in global health, the Director-General's nomination for a second term was particularly well deserved. The energy she had invested during her first term in reaching out to stakeholders had laid excellent foundations for achievements over the coming five years, during which he and his Government would support her fully.

Dr AL-HALKI (Syrian Arab Republic), in congratulating the Director-General on her nomination, paid tribute to her leadership of WHO, her successful handling of public health emergencies, her selfless dedication to improving global health systems for attainment of the Millennium Development Goals, and her professionalism. She would undoubtedly achieve further successes and bring added value to work in the area of health, finding in addition the support needed from Member States in order to promote public health across the globe.

Dr DANKOKO (Senegal), welcoming the transparency with which the nomination process had been conducted, extended his congratulations to the Director-General for her well-earned nomination and pledged his country's further support.

Dr ST. JOHN (Barbados), speaking on behalf of the member countries of the Caribbean Community, added to the expressions of appreciation for the contribution made by the Director-General and of confidence in her leadership of WHO. As the international lead agency for technical health matters, WHO should continue to be led by somebody with the knowledge, credibility and skills to negotiate the worlds of international relations, resource mobilization, agenda-setting and prioritization. The Director-General understood the clear and distinct mandate of WHO in the context of concerns about its unique role and the finances available for health promotion. Her willingness to speak forthrightly, her clear articulation of the core role of WHO, and her role in helping Member States to assess the need and direction for reform were much appreciated. With Dr Chan at the helm, WHO would have a place in achieving improvements in health over the following five years.

Dr BIRINTANYA (Burundi) said that the nomination of the Director-General for a second term reflected the confidence of all Member States in her abilities, the progress made under her leadership, and her vision for the future. Continuity at the highest level was important as the reform process moved forward. Even with her experience in the post, the Director-General would need the support of all Member States to tackle new challenges in an ever-changing world. His Government would support her fully, and hoped that she would visit Burundi during her second term.

Dr GULLY (Canada), welcoming the nomination of the Director-General, said that his country had always been a strong supporter of WHO and would continue to be so, at a time when WHO would continue to change in order to confront the shifting and complex global health environment. The Director-General had set a stage where all Member States and their populations were engaged, where partnerships across all sectors were fundamental, and where results benefiting the most vulnerable and combating inequity were important. In the conviction that she would continue to follow that path, he offered the Director-General his congratulations.

Mr DA FONSECA (Timor-Leste) congratulated the Director-General, who faced a hard task in guiding WHO through the important process of reform and overcoming the complex challenges to achievement of the Organization's objective. Her first term had equipped her well for that task. He urged her to redouble her efforts to support developing countries and wished her success.

Dr AL-ADOOFI (Yemen) said that the nomination confirmed the Director-General's accomplishments of recent years and the confidence of Member States in her ability to overcome future challenges. He encouraged her to address the issue of easy access to medicines in least developed countries in the light of the world's current financial and economic crisis, as well as working on establishing a strategic vision for autism, a neglected disability that placed an onerous burden on many developed and developing countries. He was optimistic of WHO's success under Dr Chan's leadership.

Mr ESPINOSA SALAS (Ecuador), echoing the congratulations addressed to the Director-General, expressed the conviction that, under her continued leadership, the Organization would pursue its quest for institutional reform, its joint activities with regional health organizations and its timely action to tackle problems facing the international community, paying particular attention to those whom the democratization of health services would benefit most. His Government would support the work of WHO and wished the Director-General well for her second term.

Mr TOSCANO VELASCO (Mexico) wished the Director-General every success over the coming five years. She already knew the priorities, problems and challenges, including universal health coverage, climate change and noncommunicable diseases, that should be placed on the global

agenda. She would be able to turn them into opportunities for improving health conditions, with governments, nongovernmental organizations and society working together.

Dr SHEKU DAOH (Sierra Leone), speaking on behalf of the Member States of the African Region, congratulated the Director-General warmly on her nomination. The Board had taken a decision that would give global health continued hope, direction and vision. He expressed trust in her leadership capacity and experience of public health management. Huge public health challenges lay ahead, including WHO reform, but, with her administrative and professional skills, and supported by her team of advisers and Member States, she would be able to tackle them successfully. He expressed appreciation for the fact that she continued to place his Region's health priorities on the agenda.

Dr MILOSAVLJEVIĆ (Serbia), congratulating the Director-General, said that good leadership of WHO had been crucial over the previous five years, which had been difficult and demanding. He was optimistic for the future of the Organization as the reform process continued.

Dr AZODOH (Nigeria) congratulated the Director-General on her nomination, noting with satisfaction her achievements during her first term and her continued commitment to public health. The support of the Board bore testimony to her exemplary leadership and management of WHO. She encouraged the Director-General to continue her good work to ensure the complete eradication of various endemic diseases, particularly poliomyelitis, and commended her unstinting commitment to controlling malaria, HIV/AIDS and tuberculosis and to improving the health of women and children. It was to be hoped that the Director-General would remain committed both to improving access to affordable medicines and to ensuring vaccine security. Her determination to promote accountability, equity, prudent management and improved support for country health systems was welcome.

Mr ORGIL (Mongolia) fully supported the nomination of Dr Chan, who had demonstrated outstanding professional competence and performance and gained global recognition, successfully managing numerous public health emergencies and the impact of the global financial crisis. Her vision for WHO's priorities and strategies showed her commitment to strengthening health systems and capacity building, and improving the health of vulnerable groups, particularly women and those in least developed countries. Under her leadership, the WHO reform process would continue, benefiting all Member States. His Government would support her fully.

Dr DE ASSUNÇÃO SAÍDE (Mozambique), welcoming the Director-General's nomination, said that, in the difficult times ahead, her experience, competence and leadership would enable WHO to build strong partnerships and implement an agenda geared towards addressing public health issues and reducing the disease burden, particularly in those regions and countries in greatest need. He wished her great success.

Mr YUSOF (Brunei Darussalam), expressing appreciation for the smooth running of the nomination process, extended congratulations to the Director-General. The Board's strong support for Dr Chan demonstrated its confidence and trust in her credibility and capability. Confident that WHO would reach new heights under her continued leadership, his Government would continue to support her.

Dr LARSEN (Norway) shared the Director-General's views on global health and WHO, and therefore welcomed her nomination for a second term. Endorsing the priority she attached to health systems, tackling noncommunicable diseases and improving the health of women and African populations, he assured her of his Government's continued support.

Dr SEEBA (Germany) thanked the Director-General for the remarkable work she had done over the past five years, a difficult and challenging time for WHO. She had steered the Organization through the financial crisis, undertaken the ambitious but necessary task of reform, and been

instrumental in ensuring that topics such as strengthening health systems were placed high on the global health agenda. Germany would support her fully during her second term.

Dr PE THET KHIN (Myanmar), congratulating the Director-General on her nomination, assured her of his country's full support during her second term.

Dr DAULAIRE (United States of America) welcomed Dr Chan's nomination. His Government appreciated the opportunity to work with her for the next five years and would fully support her.

Dr SHEIKH YUSUF (Somalia), adding his congratulations on a well-deserved nomination, emphasized the need for WHO reform, beginning with the country offices.

Dr VALENTIN (Seychelles) congratulated the Director-General on her nomination and wished her every success in the discharge of her responsibilities. His country, which already had good health indicators, was endeavouring to make further progress with its scarce resources, and support from WHO was greatly appreciated.

Dr IKRAMOV (Uzbekistan), echoing the congratulations and affirming his country's support for the Director-General, commended her efforts to improve global health. Her knowledge and experience would contribute significantly to the process of reforming WHO.

Dr AL-HAKIM (Iraq)¹ congratulated the Director-General on her nomination, which he had supported on the basis of her outstanding efforts over the past five years and her ability in managing WHO and elaborating a clear-cut strategy and plan of work. It was fitting that she should be afforded the full opportunity to complete the tasks in hand and he therefore looked forward to a comprehensive review of the various aspects of that plan during her next term of office.

Mrs FARANI AZEVÊDO (Brazil)¹ congratulated the Director-General on her nomination. In her first term, WHO had undertaken several initiatives. Brazil particularly appreciated the adoption of the Global strategy and plan of action on public health, innovation and intellectual property and the Pandemic Influenza Preparedness Framework, and the establishment of the Working Group of Member States on Substandard/Spurious/Falsely-Labelled/Falsified/Counterfeit Medical Products. It was important for Member States to be fully engaged in such exercises, and she expressed appreciation to the Director-General and her team for their technical advice, support and encouragement.

She was encouraged by the Director-General's personal commitment to fighting inequities, her perception that people and governments needed capacity, not charity, her concern with the quality, safety and affordability of medicines, and her determination not to let WHO ignore the millions of people who did not have access to medicines, while respecting the need for innovation. She wished the Director-General success for her second term in office.

Dr NICKNAM (Islamic Republic of Iran)¹ congratulated Dr Chan on her well-deserved nomination. The Secretariat and Member States would continue to rely on her energetic leadership and invaluable contribution to achieving the Organization's objective. As a result of the reform process she had initiated, WHO would surely become more effective, responsive and dynamic during her tenure.

Ms FERNÁNDEZ PALACIOS (Cuba)¹ expressed her firm support for the Director-General's nomination, emphasizing her performance and commitment to the right of all peoples to health.

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

Ms QUACOE (Côte d'Ivoire)¹ said that the nomination of Dr Chan, for which congratulations were in order, reflected the universal recognition of her competence, leadership, commitment to public health, and devotion to tackling the problems besetting health throughout the world. Her Government would support the Director-General indefatigably, convinced that Dr Chan's commitment to the Organization's objective would bring results.

Dr WARIDA (Egypt)¹ expressed full confidence in the Board's decision to nominate the Director-General for a second term of office. After taking up responsibility five years earlier at a delicate juncture for WHO, she had ably addressed public health issues and steered the Organization through various global crises by dint of her impressive professional skills and courageous leadership to achieve tangible successes. For example, she had expertly spearheaded the international efforts to combat pandemic influenza and finalize a ground-breaking international agreement on pandemic influenza preparedness, averted conflicts of interest, and ventured to declare principles of health equity for all and to prioritize health needs in developing countries.

Mr HABIB (Indonesia)¹ congratulating the Director-General on a well-deserved nomination that reflected the confidence placed in her by Member States, expressed the view that she would be able to lead WHO over the following five years during which the challenges of improving health care for all would remain on the international health agenda. Dr Chan's leadership in the adoption of the Pandemic Influenza Preparedness Framework in 2011 had been appreciated. In coping with the difficult and complex health challenges that the global community would face, she would need Member States' support, guidance and commitment to help WHO to adapt. WHO reform was necessary. Indonesia would continue to support the Organization and the Director-General.

Dr JAMES (Singapore)¹ extended her congratulations to Dr Chan on her nomination. She had accomplished much in her first term. During the 2009 influenza pandemic, she had been an inspiring leader and played a crucial role in combating the crisis. Confronted by the global financial crisis, she had remained resolute in her commitment to fighting diseases and strengthening health systems, as well as helping countries to achieve the health-related Millennium Development Goals. Her vision and commitment in ushering in major reforms, necessary in times of financial austerity, would ensure that the Organization remained the global leader in health, and she would undoubtedly direct WHO to even greater heights.

Mr LEE Kyong-yul (Republic of Korea)¹ joined others in congratulating the Director-General. He looked forward to seeing her fulfil her vision and strategy, and welcomed her commitment to reforming the Organization.

Ms NGHINAMUNDOVA (Namibia)¹ echoed the congratulations addressed to Dr Chan, who, she was confident, would continue to steer the agenda of WHO to the benefit of all people, particularly during a critical period of reform. She assured the Director-General of her country's continuing support.

Dr SANGA (United Republic of Tanzania)¹ congratulated the Director-General on her nomination. Her Government looked forward to further efforts to promote the health of women and children in Africa, and would continue to support the Director-General fully.

Mr OSEI (Ghana)¹ warmly congratulating the Director-General, expressed sincere appreciation for her unwavering commitment to tackling issues adversely affecting women's and children's health. Her compassion was heartwarming and her passion for promoting better health outcomes through greater social equity was commendable. Her second term would doubtless yield dividends for public

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

health, particularly in Africa. He urged her to remain steadfast in building strong partnerships to overcome problems that might seem intractable.

Mr RAZAFINDRAZAKA (Madagascar)¹ congratulated Dr Chan on her nomination. Her human qualities, experience and skills were well known, and he was confident that, despite the current global crises, she would continue to fight for public health, particularly in developing countries.

Dr LUKWAGO (Uganda)¹ joined others in congratulating Dr Chan. Her statement to the Board in her interview had been tantamount to a contract between herself and the rest of the world on health-related matters. He congratulated the Board for the near-consensus in support of the Director-General's commitment to the global health agenda. Uganda fully expected her to perform and expand on the tangible gains made in her current term of office. He congratulated her.

Dr EL OAKLEY (Libya)¹ expressed his congratulations to the Director-General on her nomination for a second term, by a resounding majority, at a difficult time of administrative change for WHO. He expressed his country's gratitude for WHO's enormous support for the Libyan people both during and after the revolution of 17 February 2011.

Mr CHIRINCIUC (Republic of Moldova)¹ offered the Director-General congratulations on her well-deserved nomination. He looked forward to the implementation of the reforms she had instigated.

Draft contract: Item 3.2 of the Agenda (Document EB130/3) (resumed)

At the request of the CHAIRMAN, Mr ESPINOSA SALAS (Ecuador), Rapporteur, read out the resolution on the draft contract of the Director-General adopted by the Board in open session:²

The Executive Board,
In accordance with the requirements of Rule 107 of the Rules of Procedure of the Health Assembly,

1. SUBMITS to the Sixty-fifth World Health Assembly the attached draft contract establishing the terms and conditions of appointment of the Director-General;
2. RECOMMENDS to the Sixty-fifth World Health Assembly the adoption of the following resolution:

The Sixty-fifth World Health Assembly,
Pursuant to Article 31 of the Constitution and Rule 107 of the Rules of Procedure of the Health Assembly,

APPROVES the contract establishing the terms and conditions of appointment, salary and other emoluments for the post of Director-General;

II

Pursuant to Rule 110 of the Rules of Procedure of the Health Assembly,

AUTHORIZES the President of the Sixty-fifth World Health Assembly to sign this contract in the name of the Organization.

The meeting rose at 12:40.

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

² Resolution EB130.R5.

SIXTH MEETING

Wednesday, 18 January 2012, at 14:40

Chairman: Mr R. EL MAKKAOUI (Morocco)

WHO REFORM: Item 5 of the Agenda

The CHAIRMAN thanked the Secretariat for its hard work in preparing the documents on WHO reform in the short time since the Board's special session in November 2011. He proposed that item 5 would be taken up in three parts: programmes and priority-setting (documents EB130/5 Add.1 and Add.2); governance (documents EB130/5 Add.3 and Add.4); and managerial reforms – financing (documents EB130/5 Add.5 and Add.6), organizational effectiveness (document EB130/5 Add.7), and evaluation (documents EB130/5 Add.8 and Add.9).

It was so agreed.

Programmes and priority setting (Documents EB130/5 Add.1 and EB130/5 Add.2)

Dr SILBERSCHMIDT (Switzerland) said that the two reports provided a good starting point for discussion. In May 2013, the Sixty-sixth World Health Assembly would consider for adoption a Proposed programme budget 2014–2015 based on a consensus on priorities, and that consensus would have to be reflected in the Twelfth General Programme of Work. Given time constraints, would it be possible to adopt that programme of work formally in 2014 rather than in 2013? Working backwards from the Sixty-sixth World Health Assembly, the Board would consider the Proposed programme budget 2014–2015 and related priorities at its 132nd session in January 2013. The regional committees would normally consider that budget proposal beforehand, in the second half of 2012. Would it be possible to gain more time for the process by requesting the regional committees to focus on priorities rather than on the budget itself? That would mean that the main task of the Sixty-fifth World Health Assembly in May 2012 would be to decide the criteria for setting priorities rather than the actual choice of priorities. In that case, the four months between the current Board session and the Health Assembly could be best used by seeking agreement on the criteria for priority setting and the role of WHO in global health, which were not set out clearly in the relevant documentation.

WHO should have three main roles: the provision of global public health norms, standards and information, promotion of health security and convening of negotiations; provision of technical advice to all Member States; and the more engaged and resource-intensive provision of technical advice and assistance in the context of development cooperation for low-income and middle-income countries. Priorities would therefore need to be determined through an appropriate balance of top-down and bottom-up approaches; the resource allocation ratio should be seen not as a strict distinction between organizational entities but rather as the direction of 70% of resources to priorities based on country needs and 30% to globally determined priorities. Similarly, the proposal in paragraph 30 of document EB130/5 Add.1 for raising the proportion of WHO funds spent at country level to at least 50% could be amended to indicate that more than 50% of resources should go towards spending on behalf of countries, regardless of whether the relevant work was done at country, regional or headquarters level, or elsewhere.

Elements of the criteria for priority setting were scattered throughout the text of document EB130/5 Add. 1 (paragraphs 5, 8, 9, 19–21, 36, 38 and 42) but there was no coherent list, and some elements were missing, such as: work that only WHO could undertake; how to set priorities for the Organization's normative work; a clear description of the added value of the regional offices and of

their resources; and how to set priorities for the work of the governing bodies and use their resolutions as a means of setting priorities.

He welcomed the country typologies set out in paragraph 12 of document EB130/5 Add.1 and the seven categories for the next general programme of work (paragraph 18), which could replace the current 13 strategic objectives.

The terms of reference for the Member State-driven process proposed in paragraph 54 should be based primarily on the criteria for priority setting and not the priorities themselves. The schedule for the process would depend on whether the Secretariat had to prepare additional documents, in which case it would not be possible to hold the proposed meeting in February 2012. If it were decided that the work should proceed on the basis of the existing documents, that meeting could go ahead as scheduled.

Dr JESSE (Estonia) speaking on behalf of the European Union and its Member States and noting the short time available during the current session for discussion of WHO reform, said that it was essential to decide on the timeline for the Member State-driven process and to determine the criteria for priority setting. She asked the Secretariat to develop appropriate draft decision points for consideration and proposed that, to make the best use of the time available, a drafting group be set up that could meet in parallel with the Board. She had specific amendments to the terms of reference proposed in document EB130/5 Add.1 but would wait to submit them to a drafting group. In respect of the timing for the consultation of Member States, she favoured the proposal to hold the main meeting in late February 2012 (document EB130/5 Add.1, paragraph 55), so as to allow time for follow-up before any decisions were taken during the Sixty-fifth World Health Assembly in May 2012.

WHO must remain relevant to all countries and play the leading role in global health, focusing on areas where it had relative strengths compared with other international institutions. The normative and global mandates were the starting point.

Country needs should form the basis for priority setting, but other factors must also be taken into account, with an appropriate balance between countries' own health policies, plans and strategies on the one hand, and the Organization's technical support to countries and its normative and standard-setting functions on the other. The role of the regions and the coherence and alignment of the Organization as a whole should also be considered throughout the reform discussions. Document EB130/5 Add.2 provided a useful overview of current financial and human resource allocation and should be included in the debate on priority setting.

The typologies of countries required further careful consideration, drawing on the experience of other organizations, including the World Bank and UNDP, and the typologies chosen should be in line with agreed United Nations classifications. The seven categories suggested as a framework for the next general programme of work (document EB130/5 Add.1, paragraph 18) were too broad as a basis for priority setting, making it difficult to envisage what WHO would not be doing in the future. Moreover, criteria were needed before priority setting itself could start. She looked forward to further discussions in that area and welcomed the emphasis on the need for a systematic review, on the basis of the framework, of those areas in which WHO should do less or shift functions.

The proposal on priority setting and the suggestions for a new financing model were not interlinked, and further work was needed to do so. For example, how were efforts to increase resource mobilization at country level linked to priorities and the new financing model? Resource allocation targets should not be decided before priorities were set but should be linked to the agreed priorities; it was therefore premature to propose a target of at least 50% for spending at country level.

She welcomed the work undertaken in developing the results chain, which would help to demonstrate the impact of WHO's work. However, a clear hierarchy and distinction between objectives, categories and functions were essential. Moreover, impact measurement should cover not only areas that were easy to measure but also include, for example, normative work.

Dr REN Minghui (China) agreed that the next general programme of work and programme budget should take as their starting point the needs of individual countries in order to align them with the priorities set out in country cooperation strategies. He endorsed in principle the seven proposed categories (document EB130/5 Add.1, paragraph 18) as a framework for determining Organization-

wide strategic objectives and programmes at the various levels. He could not support, however, the country typologies (paragraph 12), which were not consistent with existing country-grouping criteria and agreed United Nations terminology; moreover, they lacked precision in their scope and some categories overlapped. For example, some countries could be considered to be in fragile circumstances while being thought of as countdown countries, and countries within the same group might have different health needs.

The Secretariat ought to be soon in a position to propose resource allocation at the country level. He agreed that at least 50% of the total budget should be allocated to countries; those resources should cover country-specific priorities and collaborative work by countries and WHO on global health priorities. He also agreed that headquarters and the regional offices should receive an appropriate share of resources based on their functions.

He endorsed the scope and terms of reference for the Member State-driven process set out in paragraph 54 of document EB130/5 Add.1 and expressed a preference for the main meeting to be held in late February 2012 (paragraph 55, option (1)). He requested clarification of an apparent inconsistency in the document: paragraph 52 stated that implementation of the Twelfth General Programme of Work would begin in 2014, whereas the Eleventh General Programme of Work would run until 2015. The timeline for development of the various instruments should be consistent so that programming and budgeting cycles could proceed in an orderly manner.

Dr OMI (Japan) said that priority setting was clearly tied to the allocation of financial and human resources. The target of at least 50% of total revenues for allocation to country offices was a step in the right direction but was ambitious and would necessitate strengthening the capacity of those offices to ensure that they had appropriately qualified staff. WHO was characterized by its international nature; making it even more international would enhance its efficiency and effectiveness. He therefore proposed that country offices should be required to recruit a certain proportion of foreign staff, with the precise level to be determined at a later stage.

He expressed concern at the physical and financial burden of meetings that would result from the options for the follow-up process set out in document EB130/5 Add.1 (paragraph 55) and suggested that further thought should be given to the proposed schedule.

Dr LARSEN (Norway) said that the main challenge for the Board at its current session was to establish terms of reference for the Member State-driven process, but document EB130/5 Add.1 did not give sufficient guidance on the formulation of criteria and processes for priority setting. The terms of reference should describe the current principles underlying priority setting and the current relationship between the priorities set at the three levels of the Organization. The process should include discussion of priorities in respect of: WHO's normative and convening roles relative to country support; how the governing bodies could best ensure that priorities were set democratically and not by donors; and criteria for presenting resolutions to the governing bodies with a view to developing a resolution-management mechanism and the more active engagement of the Board's Officers in that process.

The Secretariat should seek to address the weakness identified in paragraph 27 of document EB130/5 Add.1 in respect of a lack of analysis of functions and costs at the headquarters and regional levels. He expressed scepticism regarding the target of at least 50% of total revenues to be allocated at country level, as proposed in paragraph 30, given the need to strengthen WHO's normative and convening capacity through adequate resource allocation. The description of the seven categories (paragraph 18) was premature as the immediate focus should be on a concrete discussion of the criteria and process for priority setting.

He supported the holding of a meeting in February 2012 (paragraph 55, option (1)), and proposed that it be followed by a web-based consultation on the outcome before the Sixty-fifth World Health Assembly. The documents presented under the present agenda item were all closely linked and should be consolidated into a single set of reform proposals for consideration at the Health Assembly.

Dr ST. JOHN (Barbados) pointed out that mechanisms would be needed to ensure the smooth running of the Organization during the implementation of reforms and recalled the suggestion made by the member for Estonia to establish a drafting group. Clear criteria for priority setting were essential, as was an in-depth analysis of how priorities had been set in the past. Mechanisms for virtual meetings should be determined as it would be difficult for many participants to return to Geneva for a further meeting in February 2012. A bottom-up approach to priority setting was desirable but should not be exclusive and should take into account effective mechanisms used previously. Greater clarity was needed on country groupings (document EB130/5 Add.1, paragraph 12) and how the Secretariat would interact with the various groupings, including small island developing States, and with countries that straddled the groupings. She agreed that the capacity and financing of country offices would require strengthening to ensure timely and transparent accounting and evaluation of the impact of interventions. The proportion of revenues directed to each level of the Organization was perhaps less important than the quantum of work undertaken at each level and the extent of its impact on countries' needs, challenges and inequities.

Dr SEEBA (Germany) requested further analysis of WHO's current activities with a view to enhancing the transparency of WHO's work and providing the necessary basis for the reform debate, which would also need to take into account the role of other global health actors. As the Director-General had remarked, it was important to understand who was doing what. Priority setting was the key to the success of WHO reform and would involve, first, a decision on the Organization's overall mandate in relation to other actors and, secondly, development of guidance on how the limited regular budget resources should be allocated and for which programmes efforts should be made to mobilize additional funding. Priority setting should be based on the relative strengths of the three levels of the Organization. However, resources should follow functions, and the setting of targets for allocations at each level should not precede a comprehensive discussion on the different functions at the three levels.

Dr DANKOKO (Senegal), speaking on behalf of the Member States of the African Region, said that he appreciated the need for a global vision for WHO linking the definition of priorities with resource allocation and financing modalities in order to improve coherence and effectiveness. A bottom-up approach to priority setting was appropriate. However, further analysis of the distribution of human and financial resources by programme at country level was needed in order to determine the feasibility of developing the general programme of work and programme budget on the basis of individual country needs. Country typology and the need to share experiences should be taken into account, and he sought further clarification of the typologies of countries. Objectives, targets and indicators for determining the impact of WHO should be clear, precise and easily measurable.

He also requested clarification of option (2) for the intersessional process for defining priorities (document EB130/5 Add.1, paragraph 55), in particular the reference to a possible series of informal regional and/or thematic meetings.

Referring to governance, he emphasized that, in accordance with WHO's Constitution, the Health Assembly was the Organization's supreme decision-making body and took into account the outcomes of sessions of the regional committees and the Board and its Programme, Budget and Administration Committee. He was in favour of reviewing the sequencing of governing body meetings as part of the reform process in order to improve coherence, consistency and coordination: particular emphasis should be placed on harmonizing the work of the regional committees. Further analysis was required of ways of streamlining national reporting. He supported the proposals on engagement with other stakeholders and involvement with and oversight of partnerships.

Mr DESIRAJU (India) endorsed the principle that country needs should be the starting point for priority setting and pointed out that country cooperation strategies represented the best statements of such needs in the context of WHO's strengths and capabilities. However, use of the country cooperation strategies would place a considerable burden on WHO country offices.

The development of typologies of countries was desirable, but the classification set out in the report was based on levels of development and did not take disease burden into account. Consideration should be given to classifying countries on the basis of the seven categories of work identified.

As was recognized in paragraph 4 of document EB130/5 Add.1, programmes and priority setting must be viewed in the context of resource allocation and funding modalities, even though the Board was currently examining the different aspects separately. Some difficult questions must be asked. For example, if there were funding shortfalls where would cuts be made? Would the pledging process result in a level of donor funding similar to the current level? If the will of the Health Assembly was to prevail, donors would need to be assured of the purpose and transparency of the priority setting process, and Member States would require assurance of the rigour of that process.

The valuable information provided in document EB130/5 Add.2 would be enhanced by a breakdown of the assessed contributions and voluntary funds available for each programme.

He endorsed the comments of the members for Japan and Barbados concerning the timing of meetings in the process leading up to the Sixty-fifth World Health Assembly, but would be prepared to support any viable consensus on the matter.

Mr ESPINOSA SALAS (Ecuador), speaking on behalf of the Union of South American Nations, said that he appreciated the detailed information provided, but deprecated the insufficient time available to give it careful consideration; the Board had a unique opportunity to reorient the work of WHO in the interests of global health and had to devote time to a process of such importance.

The process should be driven by Member States; they were best placed to define the needs that would form the basis of the bottom-up priority setting which he hoped could be put in place. The countries of the Union stood ready to cooperate with others in achieving the agreed goals and would comment further on detailed aspects of the reform process in due course.

Document EB130/5 Add.1 provided a good starting point for the discussion on programmes and priority setting. He supported the proposal to set global priorities on the basis of country needs in framing the next general programme of work and programme budget, using a bottom-up approach. The document described current processes at the three levels of the Organization, but did not provide detailed background information on how the seven broad categories or priority areas for the development of strategic objectives had been determined. Similarly, regarding the country typologies, more detail should be provided on the mechanism used for classification purposes. Any classification of countries should be based on burden of disease rather than level of development. It was difficult to see the purpose of a classification that would not, as indicated in paragraph 13, serve as a new organizing structure or mechanism for allocating resources. Therefore, he sought clarification of the classification process and its impact on resource allocation.

Mr DÍAZ ANAIZ (Chile), continuing the statement started by the member for Ecuador, said that document EB130/5 Add.1 did not adequately explain how priorities would be set. Member States should determine priorities and any changes should be based on consultations with them. The Secretariat's role should be to determine the scope of priorities so as to allocate appropriately budgetary and extrabudgetary resources, and that process should be monitored by the Member States. He saw no justification for WHO accepting voluntary contributions for operations not included in the strategic plan.

Clarification was needed on the validation mechanism referred to in paragraphs 26 and 27, and on the current method of distributing funds between headquarters and the regional and country offices. He supported the proposal regarding the funding of WHO's work at country level and believed that the two questions contained in paragraph 28 were crucial and would require further analysis. The criteria for resource allocation referred to in paragraph 31 should be the responsibility of the regional and country offices, but there was no need to change current practices – although steps should be taken to strengthen the principles of transparency, cost-effectiveness, accountability and equity.

Regarding WHO's impact, he noted that the five levels of the results chain were not clearly defined. He favoured the creation of a mechanism to evaluate the public health impact of all WHO's activities, but expressed concern about the example given in paragraph 47 on the selection of priority outcomes within the European Region. He welcomed the proposal for a process of consultation with

Member States to discuss priority setting so that the agreed priorities could be used as a basis for developing the next programme of work.

Ms GOLBERG (Canada) said that, despite current constraints, WHO continued to have an essential role in enhancing global health, fostering global consensus, and building commitment and coordination to respond to the most pressing health needs, especially for the most vulnerable populations. Moreover, its country offices had demonstrated their value, not least in providing support to enhance the capacity of health ministries. It was therefore essential to ensure that WHO was strong, effective and efficient, positioned as the leading technical health agency, equipped to respond to complex health challenges in a globalized world, and able to set priorities and focus on achieving results. The Organization should be able to exercise catalytic leadership and strategic convening power to galvanize international collaboration and multilateral partnerships for health. It should also be able to manage its financial and human resources in alignment with its functions. Her Government therefore strongly supported WHO reform and was working with many partners to reach consensus on the three key themes of governance, priority setting, and managerial effectiveness and accountability.

Changes in governance should include better and more strategic use of the governing bodies, in particular the Board and its subcommittees, with better coordination with the regional committees, changes in the scheduling of meetings, agendas that focused on critical issues and remodelling of collaboration with external partners.

Priority setting was perhaps the most difficult process to reform. There was currently a hiatus between the strategic direction set in governing body decisions and the resources available for implementation. The proposed country-driven approach and the establishment of groupings of countries for the identification and qualification of priorities were steps in the right direction, but WHO's leadership in identifying global and emerging needs and threats and its normative and standard-setting work were equally important.

In respect of managerial reforms, it was not sufficient to improve operational and budget planning. WHO's organizational and managerial culture should be modified, but any such reforms should ensure that the Director-General retained the flexibility to shape the Organization in a manner consistent with her vision and responsibilities. The proposed financing mechanism should stimulate discussion on improving the alignment between voluntary contributions and WHO's priorities.

The reform process should result in improved health outcomes for populations and stronger and more effective international collaboration to advance global health, supported by an agile WHO, equipped to tackle public health challenges.

Mr AL-ABDULLA (Qatar), referring to the need to increase linkages between regional committees and the global governing bodies, expressed support for the alignment of agenda items proposed in paragraph 3.7 of document EB130/5 Add.3. In that context, it would also be necessary to support the regional offices with the necessary financial, technical and administrative resources; strengthen their capacities for study, research and analysis; and propose further measures for facilitating communication between those offices and Member States.

Concerning the timeline for governing body meetings, he supported the proposed option 1 – moving the Programme, Budget and Administrative Committee meeting to early December and the Board session to the end of February; as advocated in paragraph 2.9 of the document – so as to give Board members more time to consider and consult. He also favoured the proposal to extend the length of the Board's session in May from one day to three for the reasons set out in paragraph 2.11 of the document. In addition, the Health Assembly should be convened only once every two years, as a cost-reduction measure; in the intervening period, discussions could instead be conducted through the regional committee sessions, a mechanism that would also have the benefit of increasing the focus on regional and country activities.

He supported the draft WHO evaluation policy set out in document EB130/5 Add.8, notably in view of its scientific precision, incorporation of the principles of impartiality, independence and transparency, inclusion of different types of evaluations, methodology and coverage of financing, accountability and oversight, as well as the matter of the use and follow-up of recommendations.

On the issue of promoting engagement with other stakeholders, he reiterated the importance of establishing partnerships with existing health agencies and institutions so that WHO could provide positive guidance on setting priorities for their work and activities. He endorsed the suggestion and the rationale, as contained in paragraph 16 of document EB130/5 Add.4, for the regular inclusion in the Board's agenda of an item on partnerships.

Mr TOSCANO VELASCO (Mexico), welcoming the proposal for the development of priorities based on country needs, emphasized that the guiding principles for the strategic allocation of resources were based on equity and support to those countries most in need. However, it was not clear whether the parameters of the validation mechanism required updating. Although its use of fixed and needs-based components represented current realities, he expressed concern that the data used to estimate the ratios were out of date and that the proposal did not therefore take into account current funding criteria or needs. As a result, it would be appropriate to use the seven categories proposed by the Secretariat as a basis for strategic planning, to ensure that the ratios were continuously assessed and updated.

Echoing the comments of the members for India and Senegal, he requested clarification on the parameters used to define the country groupings, particularly with regard to countries in fragile circumstances. Resource allocation should be based on the headquarters, regional and country levels, taking into account funding for the long-term strategic plan, with reallocation permissible, according to set criteria, between countries. For the dates of consultations he preferred option 1, proposed in paragraph 55 of document EB130/5 Add.1. He appreciated the information presented in document EB130/5 Add.2, but requested a report on programme performance, showing the relationship between progress on the strategic objectives and staff financing in the individual regions and countries.

Dr DAULAIRE (United States of America) said that the work undertaken thus far provided a solid foundation for progress on WHO reform. Document EB130/5 Add.1 proposed that priority setting be based on country needs. However, there should be clarity and alignment across the three levels of the Organization, with a two-way flow: global objectives and normative functions should inform and guide regional and country-based objectives, while country needs should guide global efforts, and WHO's core functions and relative strengths must be taken into account. As was noted in paragraph 35 of the report, WHO's normative work was a particular strength and should be placed on a firmer footing, although, as had been indicated by the member for Estonia, that might not be consistent with the target of spending at least 50% of total revenues at country level, as proposed in paragraph 30, and needed further thought. He endorsed the need, also mentioned in paragraph 35, to determine how the results and effectiveness of normative work should be evaluated.

He broadly endorsed the seven categories for priority setting set out in paragraph 18 but expressed concern at the potential diminution in importance of health security and communicable diseases. He proposed that category (4) should be amended to read "Health security and the effective management of humanitarian disasters". However, apart from category (1), which mentioned HIV/AIDS, tuberculosis and malaria, there was no other category that addressed communicable diseases, which were a major public health concern in many parts of the world, as was the growing threat of antimicrobial resistance. The Secretariat should prepare a document that matched the seven categories to areas of work within the Organization to help Member States to understand which clusters and staff would undertake which activities, and where cross-cutting activities would require collaboration or alignment across the Organization. In view of the need for intensive work on those matters during the Board's current session and before the Sixty-fifth World Health Assembly, he supported the holding of the main consultative meeting in late February (option (1), paragraph 55).

Ms ARTHUR (France) welcomed the level of engagement by all parties in the WHO reform process and was encouraged by the initial decisions taken at the Board's special session in November 2011. That positive approach should be sustained in tackling other questions pertaining to the continued credibility of WHO's leadership in international health.

Priority setting was a crucial area of reform, but she said that it was difficult to offer a detailed reflection on the Secretariat's proposals, such as the seven broad categories for the next general

programme of work, given the late receipt of the document. The reform exercise should enable WHO to refocus on those areas of activity in which it had unique legitimacy and know-how. The choice of priorities should be based on the advice of public health experts, validated by Member States, and programmes should be financed in a transparent and coordinated manner.

The proposed collective financing model envisaged a public pledging conference for Member States and donors. The Secretariat considered that such a process would be more binding on contributors and create positive competition. It would have positive aspects, including the exclusion of donors from any role in priority setting, and benefits in terms of transparency in the breakdown of funding by donor, programme, objective and office, but the cost of such a conference had not been estimated, and less costly and equally transparent formats should be considered.

Dr AZODOH (Nigeria) requested more information on the criteria to be used for priority setting and the mechanisms for follow-up meetings. She encouraged further discussion of programmes and priority setting, which should take place within the Board in order to ensure better coordination and follow-up and equal regional representation.

Dr AL-HALKI (Syrian Arab Republic), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that with respect to priority setting he accepted the proposed groupings of countries, which at least fulfilled minimum wishes, although no typology would be fully satisfactory. The seven suggested categories for the general programme of work were practical in terms of both number and coverage of priorities for the performance of WHO's functions and should be duly reflected in the next programme of work. Concerning resource allocation, the proposed increase in the proportion of funds spent at country level to at least 50% of total revenues in any biennium was right and proper, given the importance of WHO's work with countries.

The proposals on managerial reform covered most of the key aspects and would undoubtedly advance the reform process insofar as achievement of the overall objectives depended on the implementation of financial and managerial reforms. The documentation on the managerial and financial situation gave an overview of the nature of the existing challenges and broadly facilitated understanding of the reform proposals. In that connection, he affirmed the importance of technical capacity building for country offices, which should be afforded greater powers and staffed in accordance with needs; the transfer of various programmes, operations and functions from WHO headquarters to less costly locations that were nonetheless easily accessible; and the results-based management system, given its proven effectiveness and high returns, in particular with respect to planning review, budget preparation and resource allocation. Harmonization with national planning periods and with other health agencies in Member States must also be taken into consideration.

Dr GULLY (Canada) said that priority setting lay at the core of WHO reform, and document EB130/5 Add.1 contributed many positive elements to what was a complex endeavour. He agreed that the process should be based on country needs, but it would also be necessary to include a top-down analysis to ensure that priorities at all levels were appropriately reflected. The Board could play an active and strategic role in that regard. The new approach should be strongly anchored in results-based management based on a solid results chain. Programme and priority setting must therefore ultimately be structured around identified outcomes and WHO's contribution to and role in achieving those.

To make the best use of the time available, the Board should avoid detailed consideration of the seven proposed categories for the next general programme of work, which were not priorities in and of themselves and should remain broad to capture activities relating to all WHO's constitutional responsibilities. It was more important to identify concrete activities that would lead to identified outcomes and targets. Different issues would require varying balances between the five areas of work, which was where priority setting was needed. Criteria were required for that balance of activities rather than for identification of issues. The priority-setting mechanism must be respected by all, and the practice of using resolutions to raise the profile of particular issues should be discontinued. That would require discipline and more focused strategic discussion in the governing bodies.

Resource allocation at the three levels of the Organization was a complicated exercise and the 70:30 ratio represented a reasonable balance. However, it should be used as a guide only, leaving room for adjustments as priorities were established. Some country coordination activities would have to be conducted at headquarters, while others would be delivered and led by the regional offices.

Some grouping of countries was necessary and a perfect classification would be difficult to devise. Rather than spending time on the details, the Board should agree that some form of grouping was needed and that it should be aligned with the classification proposed in the document. The main questions were how best to move to a strategic discussion on the choice of priorities within the proposed framework, what role WHO should play in supporting and contributing to activities to address those priorities, and how the priorities should be tied to the impact WHO wished to have.

He favoured holding a meeting at the end of January, which should be seen as a consultation open to all Member States but not a decision-taking meeting. The meeting should be facilitated by the Chairman of the Executive Board, who would need to guide the Board subsequently in considering the meeting's results. The Secretariat should prepare documents for consideration at the meeting on: an analysis of country strategies that quantified country needs; the activities that WHO should focus on; what areas of work related to specific health issues and where WHO was best placed in relation to other global actors; and identification of cross-cutting global needs where WHO had a critical convening and normative role, for example implementation of the International Health Regulations (2005). The consultation should provide guidance on key priority activities and, in turn, goals and targets, and a costed general programme of work that took into account previous discussions of the value of combining the general programme of work with the medium-term strategic plan.

Mr ESPINOSA SALAS (Ecuador), speaking on behalf of the Union of South American Nations and referring to document EB130/5 Add.2, said that transparency should be taken into account throughout the reform process. More information was needed on the actual allocation of resources and its relationship to the distribution of human resources within the regional and country offices. In addition, information was needed on the impact of the allocation of voluntary contributions on the implementation of the strategic plan. It was vital that the strategic plan was well structured and contained clearly defined priority activities.

Dr BHATTARAI (Nepal)¹ said that the reform agenda discussions should focus on strengthening WHO's ability to deliver programmes that had a real and immediate impact on people, and ensuring appropriate links between priority setting and resource allocation. Reforms should enrich WHO's effectiveness in supporting Member States and its normative role. Priority setting should be guided primarily by an analysis of country needs, in particular those of the least developed countries, as ensuring adequate public health services provided a foundation for socioeconomic development and was crucial for the attainment of the Millennium Development Goals. Contributions in the area of health were also central to attaining the goal of the Programme of Action for the Least Developed Countries for the Decade 2011–2020 adopted by the Fourth United Nations Conference on the Least Developed Countries (Istanbul, 30 May–3 June 2011), which would enable half the 48 countries concerned to graduate from that category by 2020.

He welcomed the target for spending at country level and the proposal that resources should be allocated according to country needs. The current over-reliance on voluntary contributions resulted in a mismatch between agreed priorities and available resources, and he therefore supported the proposal to link the priority-setting and resource allocation processes more closely. The strengthening of country offices, which were at the forefront in delivering WHO programmes, was a vital area for reform and should create an environment in which WHO could reach populations in order to address health inequities.

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

Public health was no longer an exclusively technical issue confined within national borders, as recent threats to global health had shown. Security, economic stability, human rights, equality and equity were all important factors and should be taken into account in the reform process.

Dr NICKNAM (Islamic Republic of Iran)¹ called for more consultations with Member States before a decision was made on the seven categories of country needs. Assessing other competing categories should also form a part of the Member State-driven process. Turning to the scope of work and terms of reference of that process, he welcomed the general approach, but said that the objectives should not be confined to those listed in paragraph 54 of document EB130/5 Add.1: they should incorporate a degree of flexibility. Referring to the areas of work which, according to paragraph 20 had been discontinued, he said that, in order to ensure transparency, a full list of those areas and the reasons for the cessation of activity should be made available. With regard to the proposed schedule for consultations, he preferred the second option, which would allow time for regional and informal consultations.

Mr LEE Kyong-yul (Republic of Korea),¹ endorsing the key features of reform highlighted by the Director-General at the previous meeting, including clear priorities, the delineation of jobs needed and the creative division of labour, said that reform was meant to be a continuous process, rather than a one-off task. Although in principle he agreed that the priority-setting process should not be one of exclusion, it was important to be able to exclude elements that were deemed unimportant. Document EB130/5 Add.1 contained all the necessary elements for reform, and the next challenge would be to convert those elements into implementable action plans. He preferred holding the next consultations in February 2012, in accordance with proposed option 1 (paragraph 55).

Dr GWINJI (Zimbabwe)¹ said that priority setting should be an integral part of the reform process and should be considered concurrently with aspects related to the mobilization and allocation of resources. It should be guided by the needs of individual countries but he expressed concern that the process would be based on a desk review of strategies and discussions within the Secretariat. Further information on the actual functioning of the process, including the role of the regional committees, was needed to give a clearer overview of the relevant proposals and their implications.

He welcomed the information provided on the allocation of resources, but said that it would be useful to see the human resources data disaggregated by region and country for both professional and general service staff. Moreover, given that more than three quarters of funding was specified funding, there should be greater emphasis on the link between priority setting and resource mobilization. He expressed support for the establishment of a working group to discuss priority setting, but emphasized that the period leading up to the meeting of the group should be used for consultations to ensure a clear understanding of the proposals and their links to other aspects of the reform process.

Dr DAHL-REGIS (Bahamas)¹ said that increased attention should be paid to the link between financing and programme budgeting. There was a need to engage with the private sector, but any such collaboration should be done in a managed and transparent environment. She asked the Secretariat to propose a structure for that important element. With regard to the country groupings, she said that the small island States group should include both developing and developed countries as they had shared vulnerabilities. Furthermore, the groupings should not be aligned with other United Nations agency designations. A mechanism should also be developed to assist those countries that did not have the capacity to assess their own priorities, as there should be a balance between a bottom-up and a top-down approach. She expressed concern that the proposed target of spending at least 50% of total revenues at the country level was not practicable.

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

Ms DABRE (Burkina Faso),¹ welcoming the work undertaken to date on WHO reform, said that the various contributions by Member States should feed into the formal adoption of reform proposals. The strategy should place greater emphasis on national and regional priorities and on an operational plan for independent evaluation of the reform process to ensure proper follow-up by Member States.

Miss OSUNDWA (Kenya),¹ highlighting the linkages between priority setting, resource allocation and funding modalities, said that it was important to hold further discussions on the funding modalities and the application of the various proposals, including on the predictability of WHO financing. However, she noted with concern the lack of general criteria for priority setting.

More information was needed on the criteria used for establishing the proposed country groupings, as it was possible that countries could fit into more than one category, or even into no category. Moreover, it was unclear why the groupings were necessary, since the proposed approach was to be based on individual country needs. She also requested clarification on the last part of paragraph 20 of document EB130/5 Add.1, which appeared to suggest that WHO could relinquish key functions to other actors. She expressed concern that the proposal by the member for Estonia for a parallel meeting to discuss reform during the current session of the Board could impose constraints on small delegations in terms of their ability to participate.

Mr CAVALERI (Argentina)¹ expressed support for the proposal contained in document EB130/5 Add.1 for a consultation process between February and May 2012, which would allow time for a more in-depth discussion and analysis of all aspects of the reform process. The first meeting should be held in late February, as proposed.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland),¹ endorsing the statements made by previous speakers on the need for clarity in the reform process, said that the priority-setting process should be seen as a means to reach a transparent and legitimate consensus on where WHO's focus should be from one biennium to the next. However, before the Member State-driven process began, it would be important to develop a list of criteria for discussion. At the special session of the Executive Board in November 2011, several possible criteria had been suggested, such as added value, public health impact and contribution to the Millennium Development Goals. Clarification was needed from the Secretariat on the next steps that should be taken in order to develop the list of criteria and thus begin the Member State-driven process.

Mr KOÇAK (Turkey)¹ stressed that, since the reform process was Member State-driven and open to all Member States, the priority-setting process should follow the same format. He welcomed the general approach to the setting of categories for the next general programme of work, as the use of categories would help to ensure that the work was effective, efficient and target-oriented. However, the categories needed to be further elaborated, reflecting the specific needs of Member States. On the proposed schedule for the consultation process, he favoured the option of a meeting in April 2012, as that would allow time for informal meetings and web-based consultations to refine the proposals.

More work was needed on governance, particularly with regard to proposals on the timing of meetings, corporate alignment, the role and responsibilities of the regions and the role and budgetary allocations of country offices.

Ms CHILDS (MSF International), speaking at the invitation of the CHAIRMAN, welcomed the effort to improve the functioning of WHO. The review of stakeholder relations was particularly welcome, but she noted the lack of timelines for that process. Furthermore, fundamental changes to WHO's core departments, such as the Department of Essential Medicines and Pharmaceutical Policies, had been set in motion before a decision had been reached on the main reform process. Those changes were potentially irreversible and could result in the loss of experienced staff. There had been a

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

significant reduction in contributions to that Department, which had resulted in decreased levels of technical support to countries. She urged Member States to ensure that core areas of normative work were strengthened and not weakened during the reform process, and that budgetary support was secured for all core functions.

Ms FABBRI (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN and also on behalf of the People's Health Movement, said that priority setting should be driven by the mandate of WHO rather than the availability of resources. Country-driven priority setting was often neutralized by the high number of vertical disease-based programmes driven by global public-private partnerships that were able to influence resource allocation at the country level. The success of new prioritization mechanisms would depend on measures to correct the distortions in resource allocation that resulted from tied donor funding. Moreover, programmes and priority setting required a participatory process and Member States should focus on the process and mechanism of priority setting rather than agreeing on specific priorities that might not reflect the priorities of many countries. She welcomed the introduction of the concept of country groupings, but the five proposed categories were simplistic and based almost entirely on economic variables, failing to take account of common health situations and priorities within regions. The concept of country groupings could better be applied both across and within regions and the success of such groupings would depend on the empowerment of regional offices and decreasing centralization within WHO.

Ms DENTICO (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN and also on behalf of the Democratising Global Health Coalition, said that the reform process was a significant political and strategic development, the objective of which was to fully implement the WHO Constitution. It was a matter of concern that not all Member States fully participated in the process. An independent analysis of the functioning of WHO was needed in order to identify problems and potential solutions. The reform agenda had gathered a disconcerting momentum, and it was unclear how Member States could retain full ownership of the process given their limited capacity to contribute. Yet it was precisely the Member States that should be in the driving seat in order to ensure full transparency and accountability. She urged WHO to adopt regulations that protected the Organization from undue private-sector influence, together with a comprehensive conflict-of-interest policy.

The DIRECTOR-GENERAL said that the Secretariat's documents on WHO reform had been meant to stimulate debate; it was not yet time to make decisions. She welcomed the views expressed by Member States on both the content and the process of reform. Regarding content, she noted the general view that country needs should drive the priority-setting process. She stressed, however, that the bottom-up approach based on country needs should be balanced by a top-down approach based on the overall normative work and convening role of WHO. The proposed country typologies were just one possible way to bring countries into groups and had been developed to facilitate elements such as South-South cooperation and building dialogue. Likewise, the seven categories proposed for the next general programme of work were an attempt to give a cross-cutting view of the functions and priorities of WHO, which was based on both the current activities and WHO's constitutional mandate.

On resource allocation, she acknowledged the wish of Member States to strengthen the country offices, but pointed out that document EB130/5 Add.2 showed that roughly 45% of funding was currently spent at the country level. The proposed increase in the allocation of funds to country offices had been developed in response to the importance attached by Member States to the role of the country offices. However, she noted that many participants felt that the current session was not the appropriate time to take a decision on the issue.

The development of a general programme of work was a constitutional requirement: the Director-General would periodically submit such a programme to the Board for its consideration. In the past, Member States had not been fully consulted on the issue, but the drafting of the most recent programme of work involved consultations with Member States and partners. There were two options

with regard to the programme budget 2014–2015: the development of a new general programme of work, which took into account the new challenges the Organization was currently facing, or the use of the existing Eleventh General Programme of Work, which did not include aspects that had arisen since it had been drafted.

Turning to the proposed timeline for establishing a Member State-driven process, she said that, if Member States so wished, a working group could be convened during the current Board session to enable Member States to provide input on the proposed scope and terms of reference, ahead of the main meeting envisaged for the process. Late February 2012 seemed to be the preferred option for the date of that meeting and she sought confirmation from Member States that they wished to proceed on that basis.

The CHAIRMAN, noting the emphasis placed by the Director-General on content and the need to take due account of country needs while not forgetting WHO's work on norms and standards, said that a decision on content was not needed immediately; the comments that had been made would guide the Secretariat in preparing documents for future discussions. He also noted the questions that had been raised about country typologies, WHO's functions, categories for the general programme of work, resource allocation for improving the performance of country offices, and the impact of WHO's activities.

He invited Board members to give their views on the question asked by the Director-General as to whether the next general programme of work should be redesigned to reflect Member States' concerns, and, if so, whether that new version should be used as the basis for preparing the next Proposed programme budget.

He said that he sensed that the Board was moving towards the idea of holding a meeting on WHO reform and priority setting in late February 2012. That would allow time for further consultation and the preparation of documentation for the Health Assembly. If that was the spirit of the meeting, he would ask the Secretariat to draft a decision along those lines to be considered the next day.

Dr SILBERSCHMIDT (Switzerland), referring to his earlier comments, explained that he had not intended to suggest that the Proposed programme budget 2014–2015 should be based on the current Eleventh General Programme of Work, nor did he wish to hold up the strategic reorganization of WHO.

Dr GULLY (Canada) approved of holding initial discussions on the Member State-driven process in a working group during the session and suggested that any decision on the scope of work and terms of reference of the process should be deferred until after those discussions had taken place.

The DIRECTOR-GENERAL said that, if Member States agreed, the suggestion by the member for Canada could be incorporated into a broader decision on the agreement to continue the Member State-driven process in late February.

The CHAIRMAN said that he took it that the Board wished to convene a working group on the sidelines of its current session before any decision point was formulated regarding the terms of reference and scope of work of the process.

It was so agreed.

Governance (Documents EB130/5 Add.3 and EB130/5 Add.4)

Dr JESSE (Estonia), speaking on behalf of the European Union and its Member States, stressed the need for reform proposals to include the agreed principle of limiting the number and strengthening the content of resolutions by replacing them, where appropriate, with summaries of discussions or agreed conclusions and by developing a standard framework for the formulation of future resolutions.

She recalled that the special session of the Board in November 2011 had considered proposals for developing a multiyear programme of work for the governing bodies. Those proposals could usefully be made the subject of further discussion in relation to the reform process.

The proposed revisions of the terms of reference of the Programme, Budget and Administration Committee would not strengthen the Committee's oversight, monitoring and evaluation role. The revised terms of reference should define the objectives of the Committee and the criteria for the selection of members (which could include Member States not represented on the Board); provide guidance for new members; and describe how the Committee interacted with other bodies. The role of the Committee would also benefit from improvement in the quality and timing of reports.

With respect to the timing of meetings of the governing bodies, she supported the idea of separating the meetings of the Programme, Budget and Administration Committee and Executive Board, but proposed a more radical change to the current schedule of governing body meetings than that outlined in document EB130/5 Add.3, to allow for better meeting preparation and a more consistent budgetary and planning cycle: the regional committees could meet in January to hold initial discussions on budget proposals, followed by meetings of the Programme, Budget and Administration Committee and the Executive Board in the second quarter of the year. The final adoption of budgets could take place at a Health Assembly later in the year, which would be followed by a more substantive Executive Board session that could focus on monitoring and oversight matters and for which documents should be made available well in advance. Such a schedule would allow for budgets to be adopted much closer to the date on which they would become operational.

The proposals for better harmonization of the work of the regional committees and increased alignment between them and the global governing bodies were welcome but could have gone further.

She approved the proposals for the development of a framework to guide engagement with the private, for-profit sector and philanthropic organizations, but stressed the importance of setting clear and indisputable principles for guiding relations with nongovernmental organizations and other civil-society actors, as the credibility and independence of WHO must be maintained at all times.

Dr ST. JOHN (Barbados) said that document EB130/5 Add.3 would have benefited from deeper discussion of the Programme, Budget and Administration Committee in respect of not only its terms of reference but also of how its work linked with the work and timing of other governing body meetings. Would that Committee have any role in the reform process and could it, in future, address the late submission of resolutions or ensure that the stated financial implications of resolutions were correct? She approved of the proposal to separate the meeting of the Programme, Budget and Administration Committee from Executive Board sessions in order to allow more time for consideration of the Committee's decisions by the Board.

She agreed in principle with the expressed need for clearer guidelines on engagement with other stakeholders. Was the Standing Committee on Nongovernmental Organizations deemed a suitable tool in that regard and, if not, what adjustments could be made so that it was?

Mr PRADHAN (India) expressed a preference for revising the annual schedule of governing body meetings in accordance with the first option set out in paragraph 2.9 of document EB130/5 Add.3, as it would be advantageous for the Board to have a full picture of the previous year's work, including that of the Programme, Budget and Administration Committee. Owing to the possible practical difficulties faced by delegations, India did not support extending the length of the Board session after the Health Assembly in May from one to three days.

The proposals to improve harmonization of the work of the regional committees were commendable but he asked to what extent the discussions in those committees would inform the agenda of the Health Assembly, as the capacity of Member States to raise other issues of concern at the Health Assembly might be limited if discussions could only focus on what had cleared the regional committees, the Programme, Budget and Administration Committee and the Executive Board.

A detailed review of the principles governing WHO's relations with nongovernmental organizations was both necessary and desirable; WHO had to reach out to greater numbers of civil society organizations in order to enhance its capacity for public health promotion and service delivery. Greater clarity was needed, however, on how changes in relations with partners would impact the Member State-driven decision-making processes of the Organization, as document EB130/5 Add.4 did not adequately address issues of institutional conflicts of interest.

Dr GULLY (Canada) said that the proposals outlined in the documents, although welcome, did not go far enough to make governance of the Organization as streamlined and effective as it should be. He sought more concrete improvements in the way the governing bodies operated and interacted.

The revisions to the terms of reference of the Programme, Budget and Administration Committee would have benefited from expanding its role to include guidance to the Board on the financial implications of resolutions.

He supported the proposal by the member for Estonia for bolder changes to the schedule of governing body meetings and agreed with the suggestion to hold regional committee meetings in January and February, an Executive Board session in May and the Health Assembly in October. He did not, however, support the proposal to extend the length of the Board session immediately following the Health Assembly from one to three days, as that would limit the capacity of both the Secretariat and Member States to prepare adequately for substantive discussions on issues. Instead, the governing bodies should consider increasing their intersessional work, particularly through cost-effective, electronic means.

He agreed with the proposal that the regional committees should approve the implementation plans for global policies and strategies and adapt them to the regional context, rather than repeating the process of policy and strategy development.

He expressed the hope that Member States would continue to discuss the important issues of governance and priority setting in other arenas, and through additional focused consultations, possibly in the context of an intersessional process in which Geneva-based missions could participate.

He supported the development of comprehensive policy frameworks to guide interaction with the private sector and philanthropic organizations, as proposed in document EB130/5 Add.4, and favoured the inclusion of a standing item on partnerships in the Executive Board agenda so as to increase Member States' engagement with and oversight of WHO's partnerships. In addition, WHO should enhance its collaboration with civil society and other partners to ensure greater transparency, inclusiveness and mutual benefit.

Dr OMI (Japan) said that a crucial aspect of governance reform was the harmonization of the roles of the regional committees, the Executive Board and the Health Assembly, given the lack of coordination that had been noted several times in recent years. Discussions on the governing bodies should also include a review of the respective roles and responsibilities of the Director-General and the Regional Directors.

Engagement with other stakeholders was not an issue that should necessarily be taken up by the Board at its current session, given the large number of reform-related issues that required its attention; he suggested that the Programme, Budget and Administration Committee was a more appropriate forum for that discussion.

He supported the option of holding the meetings of the Programme, Budget and Administration Committee and the Executive Board in December and late February, respectively (paragraph 2.9 of document EB130/5 Add.3), in order to allow more time to review the outcome of the former before the latter took place.

Dr SILBERSCHMIDT (Switzerland) agreed that it was necessary to strengthen the role of the Programme, Budget and Administration Committee, particularly as the programmatic aspect of its work, as defined in its current terms of reference, had been largely neglected.

With respect to revising the annual schedule of governing body meetings, he favoured the proposal to move the Executive Board meeting to February, so as to allow more time for Member States to prepare for discussions following the meeting of the Programme, Budget and Administration Committee in December. He also supported extending the post-Health Assembly session of the Board from one to three days, but questioned whether it was still necessary to hold a longer Health Assembly every other year for the purposes of discussions on the budget when a shorter, six-day Health Assembly every year would allow more resources to be allocated to the other governing bodies. Referring to the annual meeting schedules proposed by the members for Estonia and Canada, he asked

the Secretariat to explore the feasibility, advantages and disadvantages of other scheduling options. Switzerland was willing to provide logistical support in that connection.

He supported the proposals for better links between the regional committees and the global governing bodies, but stressed that increased harmonization between the regions should not hinder innovation in the practices of any one region. National reporting reforms of the kind outlined in section 4 of document EB130/5 Add. 3 were desirable, and he welcomed the recommendation that concrete proposals be developed on that subject. Increased stakeholder engagement was also welcome, but given the specific characteristics, roles and interests of nongovernmental, private-sector and other organizations, WHO should avoid differentiating between categories of stakeholders. Potential conflicts of interest should be managed in an appropriate manner, ensuring that the Secretariat was protected and that Member States adhered to their responsibilities.

He approved of increased oversight of WHO's partnerships by the Board but said that additional time should be allocated for that purpose, perhaps at a three-day Board session in May. The Sixty-fifth World Health Assembly should also consider developing criteria to govern the submission of resolutions.

Dr REN Minghui (China) expressed support in principle for the proposed amendments to the terms of reference of the Programme, Budget and Administration Committee. He also agreed with the proposal to move the meeting of that Committee to December and the Board session to the end of February. That would enable the Secretariat to produce a full management report for the whole of the previous year for consideration by the Board, thereby facilitating the latter's monitoring and follow-up functions. However, given the need for the Programme, Budget and Administration Committee also to examine the situation for the whole of the preceding year, he was concerned that there might not be enough time for that examination and for the Secretariat to respond to requests from the Committee before its recommendations and reports were reviewed by the Board.

Whether the May session of the Board should be extended depended on the nature of its content; if only administrative matters were to be discussed there would be no need for an extension but if, on the other hand, more substantive discussions were envisaged, an extension would be appropriate. That session should focus on matters of implementation, monitoring and follow-up. He expressed disappointment that suggestions made previously at the recent special session of the Board to hold a one- or two-day meeting of the Programme, Budget and Administration Committee before the meetings in May had not been included in the Secretariat's report.

To facilitate the discussions at the Health Assembly and to address issues related to the limited speaking time available, consideration should be given to the possibility of allowing statements to be submitted in writing beforehand, for publication on WHO's web site.

He agreed in principle with the proposals to improve linkages between the regional and global governing bodies but said that the wording of paragraph 3.7 of document EB130/5 Add.3 was too broad; clarity was needed on precisely which policies and strategies would be discussed by the regional committees before the Board and Health Assembly discussions. It would not be appropriate for all policies to be discussed at all levels of the governing bodies as that could have a negative impact on the decision-making process. The rules of procedure of the regional committees, as well as current national reporting mechanisms, needed careful review and the Secretariat should analyse how both could be streamlined.

The Board needed to give careful consideration to ways of enhancing the participation of nongovernmental organizations at governing body meetings and to the extent to which the views expressed by those organizations should inform health policies and strategies. The current process for the accreditation of nongovernmental organizations seemed appropriate and the Standing Committee on Nongovernmental Organizations should continue with its role in that process. However, a more general policy framework on relations with those and other civil society organizations needed to be developed; many of those bodies could act as sources of funding and partnership for WHO and, assuming that an appropriate system to manage conflicts of interest was in place, those relationships could help to ease some of the financial difficulties faced by the Organization and to improve the availability of the products needed to tackle many global health scourges.

Dr LARSEN (Norway) expressed support both for the revisions to the terms of reference of the Programme, Budget and Administration Committee, as proposed in document EB130/5 Add.3, and for the proposal to move the Committee's meeting to early December. However, if the Board session were to move from January to late February, he doubted that the Secretariat would have sufficient time to prepare for the Health Assembly in May. He favoured extending the post-Health Assembly session of the Board to three days so as to strengthen its capacity for strategic oversight, but requested more information on how the Board's work would be divided between its two sessions. More substantial revisions to the schedule of governing body meetings, as proposed by the members for Estonia and Canada, were of significant interest and would merit more in-depth discussion. Any change to the meeting timeline should be evaluated by Member States after two or three years.

He supported the proposals for better alignment of the agendas of the regional committees and the other governing bodies and for the streamlining of national reporting mechanisms. Regarding engagement with other stakeholders, an extensive evaluation of WHO's participation in partnerships should be made, along with an assessment of the added value of WHO's current hosting arrangements.

Dr DANKOKO (Senegal) recalled his earlier statement in which he had underscored the Health Assembly's role as the Organization's supreme decision-making body and the need for it always to convene on the basis of the outcomes of the meetings of the other governing bodies. That approach was implicitly consistent with the proposal by the member for Estonia to change the schedule of governing body meetings and with the spirit of the new approach to defining priorities on the basis of country needs. It was also in line with the proposals for increasing linkages between the regional committees and the global governing bodies and for harmonizing the practices of the regional committees. The African Region favoured further analysis of issues relating to both national reporting and partnerships.

Mr TOSCANO VELASCO (Mexico) noted that the proposed amendments to the Programme, Budget and Administration Committee's terms of reference reflected the establishment of the Independent Expert Oversight Advisory Committee and the role of the Programme, Budget and Administration Committee in monitoring and evaluation. However, he proposed adding a paragraph to clarify that the latter Committee would still be responsible for following up on recommendations made by groups working on reform, as progress reports would be presented to the Committee at each of its sessions. Furthermore, the terms of reference should include matters related to the Financial Regulations, financial management rules and staff issues.

Referring to the proposed terms of reference on financial and administrative issues outlined in subparagraph 1.1(2) of document EB130/5 Add.3, he suggested including matters pertaining to the External Auditor's report so as to provide for an overview of all bodies reporting on oversight of planning and implementation. He asked for clarification of the meaning of the words "to an extent that" in subparagraph 1.2(i) of that document.

He expressed support for the proposal to move the Programme, Budget and Administration Committee meeting to December and the Executive Board's session to the end of February, so as to provide more time for the review of documents. In addition, when the amendments to the terms of reference of the Programme, Budget and Administration Committee were adopted, the Board would need to review the guidelines for submission of reports from the External Auditor, the Office of Internal Oversight Services, the Joint Inspection Unit of the United Nations system and the Independent Expert Oversight Advisory Committee.

He agreed that the May session of the Executive Board was too short for a full discussion of the many items on the agenda, but understood that extending the session would have significant financial implications. He therefore proposed two options: first, that the session should last two days and that, where possible, Member States should cover their own travel expenses; or secondly, that the session should last one day, as was current practice, but with an agenda restricted to electing new Board members and reviewing decisions taken at the Health Assembly, and not including any health matters.

He agreed that the alignment of priorities between the global and regional levels was necessary, in conjunction with programmatic alignments, and reiterated that the participation of external observers would not give rise to conflicts of interest.

With regard to streamlining national reporting, he agreed that concrete proposals should be submitted by May 2012. However, in addition, he proposed that a technology platform for information exchange should be developed as part of a pilot project covering a whole region or a group of countries with access to information technology, which could be replicated in all countries in the future. Finally, he suggested eliminating oral reports and standardizing reporting formats within a single electronic system.

Dr DAULAIRE (United States of America) expressed support for the proposed revisions to the terms of reference of the Programme, Budget and Administration Committee but said that they should also specify the need for the proposed new ethics office to report to the Committee, which should be included in section (2) of the terms of reference, on financial and administrative issues, as outlined in document EB130/5 Add.3.

Regarding the schedule of governing body meetings, he did not consider that there were strong enough arguments either to separate by several months the meeting of the Programme, Budget and Administration Committee and the session of the Executive Board, or to extend the post-Health Assembly Board session in May to three days.

He favoured a tighter yet still relatively flexible alignment between policy development and programme planning at the regional and global levels. However, rather than repeating the process of policy and strategy development, the regions should strive to adopt global policies and strategies. So as to determine whether enough had been done to promote reform of the linkages between the regional and global levels, and given its importance to overall organizational reform, he asked the Secretariat to draft a document that would draw together all the proposals on governance, managerial reform and priority setting.

He favoured strong engagement with stakeholders but requested clarity on whether Member States were being asked to approve the principles and frameworks referred to in paragraph 14 of document EB130/5 Add.4. There was general agreement that holding a stakeholder forum every two or three years would be unworkable, but he considered that it would still be possible to convene such forums as and when they were needed, to address complex or emerging health topics, as had been the case with the WHO Global Forum: Addressing the Challenge of Noncommunicable Diseases, held in Moscow in April 2011.

He urged caution about differentiating between the various types of nongovernmental and civil society organizations, given the danger of excluding certain stakeholders or not appropriately acknowledging their specific spheres of interest or activities as part of a transparent consultative process.

A periodic review of all partnerships should be done to define the level of WHO's strategic involvement and the extent to which the partnerships' work met the interests of the Organization.

Ms ARTHUR (France) favoured increased engagement with other stakeholders and welcomed the proposals on managing conflicts of interest and guaranteeing the independence of experts in the field of public health. She had three reasons for supporting such initiatives: first, stakeholders needed to be involved in consultative processes in their respective areas of activity, but States had to reserve the right to make final decisions as they were accountable to their citizens; secondly, pandemic (H1N1) 2009 had raised issues of credibility, and public confidence in governments and their health-related decisions had waned, highlighting the need for greater transparency at national and international levels; and thirdly, WHO needed to retain its effectiveness as the acknowledged authority on health matters, with its value being shown through the legitimacy and credibility of its actions.

The CHAIRMAN said that circumstances beyond his control would prevent him from being present for the remainder of the session. He expressed thanks for the support he had received from Member States.

The meeting rose at 17:45.

SEVENTH MEETING

Thursday, 19 January 2012, at 09:15

Chairman: Dr B.-I. LARSEN (Norway)

WHO REFORM: Item 5 of the Agenda (continued)

Governance (Documents EB130/5 Add.3 and EB130/5 Add.4) (continued)

Mr ORGIL (Mongolia), supporting the proposed revised terms of reference for the Programme, Budget and Administration Committee, said that he favoured moving its meeting to early December and the Board session to the end of February, as proposed under option 1 (paragraph 2.9 in document EB130/5 Add.1). With regard to the regional committees, he supported the proposals on alignment and harmonization, in particular those concerning review of credentials, the rules governing the participation of observers, and the process for nominating regional directors.

Mr ESPINOSA SALAS (Ecuador), speaking on behalf of the Union of South American Nations and referring to the revised timeline for meetings of the governing bodies proposed in document EB130/5 Add.3, expressed a preference for option 1, which would enable the Board to be provided with more information for decisions on financial and administrative matters. However, in order to leave more time before the Health Assembly, the Board session might be held at the beginning rather than the end of February. He supported the proposal made at the second special session of the Executive Board to limit the number of resolutions submitted directly to the Health Assembly. He agreed with the proposal (document EB130/5 Add.1, paragraph 3.7) that some priority items on the agenda of the Board or Health Assembly would benefit from discussion in the regional committees to ensure that the priorities they identified were properly reflected in the agenda. With regard to streamlining national reporting, Member States needed to have access to systems that took advantage of modern information technologies. Accordingly, the Secretariat should be requested to do further research and present proposals to the Board at its session in May 2012 on a mechanism accessible to all Member States.

Mr DÍAZ ANAIZ (Chile), also speaking on behalf of the Union of South American Nations and referring to document EB130/5 Add.4 on promoting engagement with other stakeholders and involvement with and oversight of partnerships, requested clarification of the existing mechanisms to which paragraph 6 of the report referred, with a view to further evaluation. New modalities for cooperation and engagement with other interested bodies were important but should respect the primary role of Member States in decision-making and determining priorities. Although the current global health landscape was different and more complex than when WHO had been founded, the Organization must continue to exercise leadership in the health arena. Frameworks for engagement should be drawn up and submitted for consideration to the governing bodies, and in that connection it was important to strengthen the contribution of technical consultants. Drawing attention to the intergovernmental nature of WHO's decision-making process, he called on the Secretariat to clarify current and future interactions with for-profit organizations and not-for-profit philanthropic organizations, in order to facilitate the submission of comments on the suggested frameworks by Member States. Conflicts of interest must be avoided and the need for transparency recognized when developing frameworks. He sought clarification of the United Nations-wide functional mechanisms of interaction and coordination platforms to which paragraph 8 of the document referred. All Member States should have the opportunity to comment on paragraph 16.

Dr NICKNAM (Islamic Republic of Iran)¹ said that, with regard to the revised timeline for sessions of the governing bodies, he favoured option 1 set out in paragraph 2.9 of document EB130/5 Add.3. As for increasing linkages between regional committees and the global governing bodies and harmonization of the practices of regional committees, he broadly supported the proposals on harmonization, but considered that the proposals on alignment needed further clarification. The proposals on promoting engagement with other stakeholders and involvement with and oversight of partnerships, contained in document EB130/5 Add.4, although welcome, did not adequately address the issue of conflicts of interest. He would appreciate further clarification of the consultation and review to which paragraph 16 referred.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland)¹ said that the reports contained several good proposals. She would be content to endorse the proposed revised terms of reference for the Programme, Budget and Administration Committee set out in document EB130/5 Add.3, but could also consider any amendments submitted. The governance deficit in WHO was not merely a technical issue relating to terms of reference, but a question of how Member States discharged their governance responsibilities. She would therefore like further thought to be given to ways of ensuring greater engagement in the work of the Programme, Budget and Administration Committee by all its members.

The Secretariat should be bold and radical in exploring options for the sequencing of governing body meetings, and consider linkages with the programme and budget cycle. She urged the Secretariat to implement the sensible proposals on harmonizing regional procedures and processes (paragraphs 3.10–3.12 of document EB130/5 Add.3) and report on the results at a later date. The Secretariat should provide more concrete proposals on streamlining national reporting with a view to encouraging greater compliance by Member States; the use of electronic correspondence could help to expedite the reporting process.

Referring to document EB130/5 Add.4, she expressed disappointment that stakeholder involvement had become rather minimalist in scale. The critical role of all key global health actors must be recognized if the momentum in tackling global health problems was to be maintained.

Mr BESANÇON (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN and also on behalf of the World Medical Association Inc., the International Council of Nurses, the International Pharmaceutical Federation, the World Confederation for Physical Therapy, the World Dental Federation, the World Organization of Family Doctors, the International Federation of Medical Students Associations and the International Pharmaceutical Students' Federation, welcomed the proposals contained in document EB130/5 Add.4 and the strong emphasis placed on the added value of engagement with stakeholders. Such engagement would facilitate the more effective contribution of the health workforces views, help to ensure that evidence-based health policies were applicable to the daily practice of health-care professionals, and enhance the capacity of organizations and health-care professionals to implement necessary change.

If a distinction were to be made between different types of nongovernmental organizations, he urged that a further category be added, namely organizations representing current and future health-care professionals.

Dr COSTEA (International Special Dietary Foods Industries), speaking at the invitation of the CHAIRMAN, welcomed the WHO reform process. Complex global health challenges could best be met through strong multisectoral partnerships involving governments, civil society and the private sector. His organization was ready to aid progress in any way possible on WHO's agendas, to respect the WHO policy frameworks guiding interaction with the private sector, and to contribute, as needed, to improving the health and nutrition of infants and young children.

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

The CHAIRMAN, summing up the discussion, noted that differing views had been put forward on the proposed revised terms of reference of the Programme, Budget and Administration Committee and the timeline for meetings of the governing bodies. General support had been expressed for the proposals contained in paragraphs 3.7–3.12 of document EB130/5 Add.3, although some speakers had asked for further suggestions on harmonization and alignment between the regions and headquarters. He suggested that the Secretariat prepare a new report, for consideration by the Health Assembly, based on the views expressed during the Board's discussions and any further written comments received from Member States before the end of February.

Further discussion was necessary to find common ground on WHO's engagement with other stakeholders, including industry and different categories of nongovernmental organizations. Those discussions might be held during the Sixty-fifth World Health Assembly. Consensus had been reached on the importance of partnerships and on the need for better management and greater oversight by the governing bodies, in particular the Executive Board. A review of WHO's hosting arrangements had been suggested, as had further efforts to harmonize work with hosted partnerships.

The DIRECTOR-GENERAL, recalling that the ultimate decision-making power rested with Member States, which were the shareholders and owners of WHO, said that the discussions on governance had elicited some extremely valuable comments. Many speakers had expressed satisfaction with the proposals for the revised terms of reference for the Programme, Budget and Administration Committee, but would be receptive to further suggestions, and she looked forward to receiving additional input in writing from Member States before the end of February. More work was needed on the sequencing of governing body meetings, and the Secretariat would consider further the wide variety of proposals made. There was consensus that the Secretariat should make suggestions to facilitate national reporting. Noting the desire of Member States to assume ownership and oversight of partnerships, she said that the Secretariat would review current practice, experience and lessons learnt and consider how to manage partnerships hosted by WHO and other bodies.

Stakeholder participation should be Member State-driven. In the current global health environment, many sectors, including civil society and public–private partnerships, had to be engaged. It was essential to guard against conflicts of interest and the exercise of undue influence on the normative and standard-setting role of WHO and, more importantly, on the policy-making role of the Executive Board. No entities came to WHO without an interest, but some interests were clearer than others. In the name of accountability and integrity, steps should be taken to enhance transparency and hold each entity to account. She invited Member States to submit further suggestions for incorporation in a report by the Secretariat on that subject.

Dr SILBERSCHMIDT (Switzerland), referring to priority setting, said that he would welcome a proposal from the Secretariat on limiting the number of draft resolutions submitted to the governing bodies and asked what elements of the discussion would be taken up by the Sixty-fifth World Health Assembly and the Board at its 131st session. Given the volume of work, he would prefer the 131st session of the Board to be slightly longer than usual.

The DIRECTOR-GENERAL recalled that Member States themselves had determined the criteria for the submission of agenda items; the challenge lay in their application. A balance had to be struck between the enforcement of discipline and the sovereign right of Member States to propose items for the provisional agenda and draft resolutions.

Dr JESSE (Estonia) agreed that the proposals discussed at the special session of the Board in November 2011 to improve the strategic focus and priority setting of the governing bodies¹ appeared

¹ See paragraphs 72 and 73 of document EBSS/2/2.

to have been omitted from the current discussions on reform. She would welcome the preparation of a report by the Secretariat for the Board's consideration at the session in May 2012.

The DIRECTOR-GENERAL said that the Secretariat would produce a consolidated report on the three elements of reform, incorporating the outcome of the Member State-driven process on priority setting, showing linkages and indicating areas where consensus had been reached and it was possible to move forward, and those areas where further discussion was needed. It had also been requested to provide proposals or possible criteria regarding agenda items or resolutions. The Secretariat could look at the criteria Member States had used in the past, but it was for Member States to reflect on those criteria and propose additional points.

The CHAIRMAN, clarifying the procedure to be followed, said that the priority-setting aspect of the reform would be discussed in a Member State-driven process beginning with the drafting group to be convened immediately after the current meeting. On issues relating to the timeline of meetings, the terms of reference of the Programme, Budget and Administration Committee and harmonization between the regions and headquarters, the Secretariat would welcome further input from Member States before the end of February. The consolidated report incorporating written comments from Member States received before the end of February would be discussed at the Health Assembly in May. The number of resolutions and the governance function of the Executive Board could be discussed in the consolidated document, unless it was decided to consider those matters as one element of priority setting in the Member State-driven process. He invited comments on the proposal by the member for Switzerland to prolong the 131st session of the Board.

Dr DAULAIRE (United States of America), supported by Dr ST. JOHN (Barbados), said that the discussion of managerial reform should precede further consideration of the duration of the 131st session of the Board.

Dr IKRAMOV (Uzbekistan), endorsing the comments of the two previous speakers, added that greater use should be made of regional committees as a means of decreasing the number of resolutions. That matter could be included in the consolidated report.

Mr SAMRI (Morocco) welcomed the Director-General's intention to produce a consolidated document. Decreasing the number of resolutions should be a small part of the reform exercise, particularly as it was the sovereign right of Member States to submit resolutions in accordance with their national priorities and concerns. He would have reservations about extending the 131st session of the Board, partly because of the fatigue factor for small delegations following participation in the Health Assembly and parallel events.

The CHAIRMAN suggested that further consideration of the duration of the 131st session of the Executive Board be postponed pending discussion of managerial reform.

It was so agreed.

Mr KAZI (Bangladesh),¹ noting that resolutions should not be a means to raise the profile of any particular issue, said that criteria for the submission of resolutions should be linked to the discussions of priority setting in the context of the Member State-driven process. The establishment of an appropriate mechanism for the further consideration of WHO's relationship with industry could be taken up after discussions in the Health Assembly.

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

Mrs NYAGURA (Zimbabwe)¹ emphasized the need to set quantitative criteria for resolutions, and agreed that the matter should be discussed as part of priority setting.

The CHAIRMAN, noting that Member States would have an opportunity to discuss priority setting in the drafting group to be convened immediately after the meeting, said that he took it that the Board had concluded its discussion on the governance element of reform.

It was so agreed.

Managerial reforms

- **Financing** (Documents EB130/5 Add.5 and EB130/5 Add.6)
- **Organizational effectiveness** (Document EB130/5 Add.7)
- **Evaluation** (Documents EB130/5 Add.8 and EB130/5 Add. 9)

Dr OMI (Japan) expressed reservations about the holding of a pledging conference, as proposed in document EB130/5 Add.5. WHO might wish to reconsider inviting partner countries and agencies to make official financial pledges in an open forum, and it might not be realistic to expect both health and finance ministers to attend. On the subject of WHO's evaluation policy, he pointed out that WHO lacked a robust mechanism to evaluate the implementation of resolutions adopted.

Dr ST. JOHN (Barbados) said that the rules of engagement for any pledging conference should be clear; she requested information on how successful such initiatives had been in securing sustained funding in other organizations. She welcomed the documents on evaluation but pointed out that there should be greater recognition of the roles of the Office of Internal Oversight Services and the Joint Inspection Unit of the United Nations system in reporting and evaluation. She supported the proposed terms of reference for the first-stage evaluation, which could be performed by the External Auditor, and would welcome proposals for change-management mechanisms that allowed for reform while ensuring that the day-to-day business of the Organization was not neglected.

Dr JESSE (Estonia), speaking on behalf of the European Union and its Member States, said that the proposed new three-stage cyclical process for planning, financing and monitoring was a step in the right direction to enable WHO to achieve more predictable, transparent and flexible funding, and ensure that priorities informed financing needs. However, the budget must distinguish between assessed contributions, core voluntary contributions and voluntary contributions. The main part of assessed contributions should be allocated before voluntary contributions to ensure that assessed contributions were used to cover the core mandate of the Organization – not to fund financing gaps or missing programme support costs. She requested clarification from the Secretariat on how a pledging conference would increase predictability and on the involvement of the governing bodies in the proposed new financing mechanism, including the final allocation of pledges. Noting that some donors might be bound by budgetary rules that prevented them from making financial pledges, she suggested that alternatives to the pledging conference be considered, such as a parallel process of a pledging dialogue and the decision on the programme budget. Transparency of funding might also be achieved by collecting voluntary contributions through a list of technical programmes approved by the Health Assembly and the Board and posted on WHO's web site. At its meeting in May 2012, which could be extended, the Programme, Budget and Administration Committee should consider relevant parts of the revised documentation on programme budget and financing models that was to be submitted to the Health Assembly. Following a technical discussion on different programme budget options and the

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

advantages and disadvantages of a pledging system, the Committee should submit a report to the Health Assembly.

Turning to the proposed contingency fund for outbreaks, she did not favour creating new funding mechanisms, and suggested that consideration be given to establishing a reserve for outbreaks within the regular budget. She sought information from the Secretariat on the administration of the proposed contingency fund and on whether any contributions to it had been pledged or received.

She welcomed WHO's provision of support for country networks, cooperation and sharing of experience, the demand for which must come from Member States. However, the issue of organizational effectiveness was broader in scope and linked to the need for a transparent accountability framework embedded in the daily functioning of WHO at all three levels.

She supported efforts to strengthen the effectiveness of resource mobilization activities and ensure informed, consistent and coordinated approaches to donors, but stressed that resource mobilization at country level should not divert country offices from organizational priorities and results identified in the programme budget. More decentralized funding structures would have to be accompanied by the strengthening of accountability, transparency and results-based management at country level.

The information on financial and human resources provided in document EB130/5 Add.2 was highly relevant to the debate on organizational effectiveness. She asked why the resources allocated to one Assistant Director-General's Office (Table 1) were some six times greater than the resources allocated to all the other five offices. She also sought clarification of the disparities between staffing levels and costs in the country offices.

Mr PRADHAN (India) said that the suggestion to hold a pledging conference demonstrated a clear commitment to transparency on the part of the Organization, and the timeline proposed was adequate for dialogue with potential donors at organizational and national levels. The efforts to streamline the financing process, although welcome, would not in themselves avert the crisis of funding availability. A situation in which assessed contributions accounted for no more than 25% of programme revenue was inherently unstable, and Member States must, in a phased manner, increase their assessed contributions.

With regard to organizational effectiveness, he favoured establishing country groupings on the basis of disease burden, environment and vulnerability. Well-documented country cooperation strategies clearly identifying health priorities would help targeted resource mobilization, but there should be in-built flexibilities to ensure consistency with country priorities.

He sought clarification of the two-stage evaluation process agreed at the special session of the Executive Board in November 2011, and said that the Board should take a clear decision on the commencement of the first stage of the process. He also requested clarification of the usefulness of the process, which had not yet even begun, to the reform agenda, which was already under way.

Dr SEEBA (Germany), referring to the proposed new financing approach, said that a pledging conference would help to enhance transparency and had great potential for streamlining fund-raising. However, how could a centralized approach to fund-raising be achieved if WHO continued to raise funds on an individual basis after the main pledging conference? Donors should not be allowed to set the agenda and the decision on how available funds would be used must be taken in a democratic manner by all 194 Member States. The fact that no assumption would be made at the stage of the pledging conference about the allocation of assessed contributions meant that those contributions would be used to fill any gaps that remained after individual donors had decided what programme or project they wished to fund. That was unacceptable: the core resources of the Organization must be used to fund core functions, and decisions on how they were used could only be taken by the governing bodies. The programme budget should not be used as a fund-raising tool because it was an accountability mechanism. He asked how the new financing approach could help to prevent the further cross-subsidization of earmarked projects through assessed contributions.

Dr REN Minghui (China) commended the Secretariat's new three-phase mechanism for financing the programme budget, and supported the holding of a pledging conference in the last quarter of 2013. It was critical to ensure that financing was sufficient and predictable, and open pledging would help to enhance transparency and ensure that funds were more closely matched to WHO's objectives. He agreed that, in order to best ensure funding for the overall programme, no assumption should be made at the pledging stage about the allocation of assessed contributions, so that the latter could be used after pledging to fill budget gaps where necessary. Although the Secretariat's reports identified the need to monitor financing and report funding gaps after pledging to the Board and the Health Assembly, the measures to be taken to bridge funding gaps were not clear, and he requested clarification of the steps to be taken if the pledges in one field exceeded the allocations set in the programme budget. He also highlighted the need to keep non-State funders informed of the pledging process and budget shortfalls.

The contingency fund for outbreaks, which he supported, should be used not only in the event of outbreaks of disease but also for the management of risks such as budget shortfalls caused by exchange rate fluctuations. The fund should be clearly distinguished from the budget for strategic objective 5.

Steps should be taken to enhance effective resource mobilization at country level in line with the country cooperation strategy and national priorities. Following a pledging conference in 2013, the monitoring and reporting mechanism for financing should also be applied in a timely manner to the income received and budget shortfalls in all fields at country level so that resource mobilization efforts throughout WHO were consistent.

With regard to evaluation policy, he said that the selection of the independent evaluators and the definition of the terms of reference for an independent evaluation should be included in the roles and responsibilities of the Executive Board, as set out in paragraph 40 of document EB130/5 Add.8. He welcomed the consultations held to identify the appropriate entity to conduct the first stage of the evaluation, and agreed that the External Auditor should be asked to undertake that stage with the active cooperation of the Office of Internal Oversight Services, with a view to its completion before the Sixty-fifth World Health Assembly.

Dr GULLY (Canada) agreed that it was essential to ensure that WHO's priorities and available financial resources were more closely matched. His Government supported WHO's efforts to enhance the quality and effectiveness of operational planning and to manage a realistic programme budget through increased flexible funding based on the three-stage approach outlined in document EB130/5 Add.5, namely priority setting and planning; financing and resource mobilization; and monitoring and reporting. He welcomed the proposal for a collective discussion on aligning voluntary resources with WHO's priorities, but said that he was not convinced that the proposed pledging conference was the best approach. He sought further clarification on the purpose and expectations of that conference. The Secretariat should be encouraged to explore other options that would enable donors to signal their projected support for WHO and make it possible to match that support to agreed priorities.

He also sought further information on how and over what period the proposed contingency fund would be run, and the criteria for its activation.

He concurred with the key principles, norms and methodology of the evaluation policy (document EB130/5 Add.8). The development, as part of the planning and budgeting cycle, of an annual, Organization-wide evaluation work plan for approval by the Executive Board was essential. He supported the proposed terms of reference for stage one of the independent external evaluation of WHO (document EB130/5 Add.9, Annex) and urged consensus on the first-stage evaluation. He could accept implementation of that stage by the External Auditor with support from the Office of Internal Oversight Services.

Dr PE THET KHIN (Myanmar) welcomed the emphasis placed on evaluation policy with a view to improving performance. The findings and recommendations of previous evaluation reports should be taken into account, and mechanisms put in place to avoid duplication. The evaluation

guidelines established should facilitate, not hinder, the process, and regional and country offices should give serious consideration to ways of fostering a culture of evaluation, including the establishment of internal review and technical assessment units. In view of WHO's technical nature, he suggested that more than 5% of the overall programme budget be allocated to financing evaluation.

Ms ARTHUR (France) commended the many positive aspects of the proposed collective financing approach: phases 1 (priorities and plans) and 3 (monitoring and reporting) would bring greater clarity and coherence to the financing of WHO. However, she expressed concern about phase 2 (financing): the financial implications of a pledging conference were not clear, and the fact that resources could continue to be mobilized after the conference raised questions about its effectiveness in terms of transparency and predictability. All private gifts and donations should be subject to rigorous scrutiny in order to guarantee WHO's independence, guard against conflicts of interest and ensure that the priorities determined by Member States were respected. The collective financing approach should be considered further by the Programme, Budget and Administration Committee at its meeting in May 2012.

Ms MOE (Norway) said that the proposed new financing mechanism, together with the other reform proposals, would reduce the current imbalance between the adopted programme budget and the funds available to implement it. The financing process would also be more transparent and democratic. However, clarification was needed on how the mechanism would affect the three levels of the Organization; the functioning of the first phase; at what stage assessed contributions would be allocated to particular areas; whether pledges made at the conference would apply at the level of strategic objective or programme; and what else, besides the programme budget, would the pledging conference be linked to. She supported the proposal for targeted resource mobilization, but sought more information on how it would be done. To facilitate the assessment of WHO's finances during a budget cycle, biannual reports, including projections of income, could be submitted to the Board. The introduction of a new platform for reporting on resources received would improve transparency.

She broadly welcomed the new evaluation policy, but the Board might consider giving more prominence to the option of regular independent evaluations. The proposed model should also evaluate normative aspects and health system strengthening. She supported the view of the Joint Inspection Unit that the evaluation team should be selected on a competitive basis, in accordance with the norms and standards for evaluation of the United Nations Evaluation Group, and supported the Unit's input to the draft terms of reference. The evaluation should include a review of the fulfilment of programmatic goals.

Dr SILBERSCHMIDT (Switzerland) welcomed the proposal to hold a pledging conference, but wanted more details in particular about incentives. One suggestion would be to differentiate between programme support costs in order to make it attractive for donors to use the mechanism. More information was also needed on programme support costs which, officially, amounted to 13%, although the real costs were higher and the collection rate was only about 7%. A mechanism was needed to ensure that there was no future cross-subsidization of donor projects by assessed contributions.

With regard to the proposed pledging conference, the attribution of assessed contributions after such conferences would have to be confirmed by the governing bodies rather than by management alone. It was important to ensure that voluntary contributions were allocated only to the priorities decided by the Health Assembly and that assessed contributions did not go to donors' priorities. The same level of accountability must be applied for the use of assessed contributions as for voluntary contributions. Giving the Director-General greater flexibility might be appropriate in that context.

He asked how the Capital Master Plan would be financed. He supported the establishment of a contingency fund for outbreaks, but joined the member for Canada in requesting more details about its

structure and whether the sum of US\$ 100 million recommended by the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009¹ had been reduced to US\$ 15 million. With regard to resource mobilization, there was a potential contradiction between adopting a more coordinated approach and the proposals to enhance resource mobilization at country level. Greater transparency in resource mobilization was required. The current proposals focused entirely on development money and made no mention of how to finance global public goods provided by WHO or how to avoid conflicts of interest.

He emphasized the importance of establishing a systematic evaluation culture, but said that the necessary reform steps should be initiated without waiting for the results of an evaluation.

Dr DAULAIRE (United States of America) broadly supported the proposals on predictable financing. Reaching agreement on priorities would be the crucial first step. In the interests of transparency and collective ownership of the budget, a pre-budget dialogue could be held, followed by regular dialogues during the biennium. Regarding advance cost recovery, it appeared that WHO's actual costs were about 13% to 15%, but some donors limited overhead reimbursement to a maximum of 7%. His Government had consistently emphasized the need for WHO to fully recover its costs, and that assessed contributions should not subsidize the costs associated with voluntary contributions. Hence, it was important for the Programme, Budget and Administration Committee to analyse WHO's actual costs. In addition, the Secretariat should also report on current and future solutions for cost recovery. He supported the establishment of a contingency fund for outbreaks.

The proposed WHO evaluation policy would provide a firm foundation on which to build an Organization-wide evaluation culture. The evaluation function should conform to the norms and standards for evaluation of the United Nations Evaluation Group and be autonomous and operationally separate from management functions; it should also be adequately staffed and financed and its results made public. He submitted that it should be done by the External Auditor, with the involvement of external experts. He supported the Secretariat's continuing work to reform the human resources system, but expressed surprise that it was not mentioned in the documentation.

Dr DANKOKO (Senegal), speaking on behalf of the Member States of the African Region, said that the financing of WHO's activities was of paramount importance to all Member States. It was evident that sustainable and predictable financing could not be guaranteed without the cooperation of the donors and partners which currently provided most of the budget. Having studied the new, three-phase cyclical process for financing the programme budget, he requested further details on its structure and its effect on the functioning of WHO, as well as on the level at which flexible funding would be available. Careful attention should be paid to the question of assessed contributions. He had noted the steps needed to establish a contingency fund for outbreaks and asked for clarification on how it might be harmonized with existing regional funds.

He expressed support for the new WHO evaluation process, not least because it would improve transparency in the allocation of resources. Evaluations should be made regularly to strengthen the independence of WHO's actions and reassure its donors and partners. However, more information was needed on the composition of the evaluation management group and whether it would be financed from assessed contributions. He supported the view of the Joint Inspection Unit that, as the stage-one review formed part of the overall independent external evaluation, the team selection should be competitive, in accordance with the norms and standards for evaluation of the United Nations Evaluation Group. That would also enhance the credibility of the reform process. The Region's Member States would be willing to discuss the terms of reference for the first stage, which it was to be hoped would be launched on time.

¹ Document A64/10, Annex, section IV, Conclusions and recommendations, recommendation 13.

Ms DÁVILA-CHÁVEZ (Mexico) recognized that WHO's financing had to be more predictable in order to ensure that the Organization was able to fulfil its functions, but said that it would not be feasible to increase Member States' assessed contributions. Hence the current resources should be used more efficiently. The proposal to convene a pledging conference was interesting, but it was not clear that donors would accept the allocation of their contributions to priorities set by Member States or at what level of the Organization the contributions would be used. Donors tended to have specific targets for their funding, which might not coincide with the priorities defined by Member States. She supported the creation of a contingency fund for outbreaks to facilitate a rapid response to public health emergencies, particularly in countries with limited epidemiological monitoring capacity. She also requested information on the conditions for use of the fund and how the relevant decisions would be made. Consideration should also be given to whether Member States might provide technical or scientific cooperation in connection with the fund.

Strengthening the effectiveness of resource mobilization activities would enhance performance and cooperation in and among the different WHO offices and lead to better outcomes, particularly in the face of ongoing resource constraints. She welcomed the proposal for a WHO evaluation process, which should improve decision-making. Although it was appropriate that the Office of Internal Oversight Services should oversee the first stage of the process, it should be recognized that the entire reform process was driven by the desire of Member States for transparency and accountability and that the Office was only an instrument in achieving those objectives.

Dr JESSE (Estonia), speaking on behalf of the European Union and its Member States, expressed support for the evaluation policy outlined in document EB130/5 Add.8, with some qualifications. It should be clearly stated in paragraph 5 that the purpose of the policy was to define the overall framework and standards for evaluation work in WHO. Consideration should be given to carrying out evaluations every two years. The terms of reference for an evaluation as set out in paragraph 29 should be clearly connected to the relevant parts of the programme budget and the general programme of work. A systematic approach to external independent evaluation should also be included. Evaluations could be made an integral part of the programme budget so as to cover cross-cutting issues. Clarification was also needed on: the selection process for and composition of the evaluation management group (paragraph 30); how "impact",¹ the fifth of the OECD/Development Assistance Committee evaluation criteria, would be assessed, given that it had not been included among the evaluation criteria listed in subparagraph 8(a); and the level of involvement of the Board and the Programme, Budget and Administration Committee, which was not addressed in paragraph 43. The Board might also wish to consider commissioning a review of the impact of the new evaluation policy after the first three years of its functioning.

She welcomed the terms of reference for the first stage of the external evaluation and recommended that the External Auditor should be selected to perform it. She endorsed the view of the Joint Inspection Unit and the Independent Expert Oversight Advisory Committee that document EBSS/2/2 correctly identified the challenges facing WHO. To avoid duplication of work, the key task of the first stage, therefore, should be to propose a road map for the second stage. Regarding its scope, she sought more details on the issues to be dealt with under the three main topics, namely financing challenges, staffing matters and WHO internal governance. With regard to the terms of reference for the first stage of the evaluation (document EB130/5 Add.9, Annex), she suggested that subparagraph 3(a)(i), instead of referring to whether reform met Member States' expectations, should address relevant aspects of WHO's structure and internal procedures, as well as functions and long-term expected results. The words "and how to be able to measure the desired outcome including advising on relevant indicators" could be added at the end of the subparagraph. She welcomed the inclusion of updated reports in the 2012 planning process of the Joint Inspection Unit.

¹ *Principles for evaluation of development assistance*, Paris, Organization for Economic Co-operation and Development, 1991.

Mr ESPINOSA-SALAS (Ecuador), speaking on behalf of the Union of South American Nations, said that it was essential to establish a clear link between Member States' priorities and the Medium-term strategic plan, bearing in mind that the latter was central to decisions on activities, programmes and appropriate budget allocation. Transparency was vital in the case of voluntary contributions, which were mostly linked to priorities set by Member States. A significant proportion of such contributions should be used openly to support WHO's core functions. Voluntary contributions sometimes required the allocation of human and other resources that had already been assigned to priority areas, and were not always delivered. Consideration should be given to tightening up the management of all voluntary contributions as a way of improving the predictability of financing and its allocation to defined priorities. Fund-raising experts could contribute to that task, provided that their services were enlisted in a transparent manner.

He endorsed the creation of a contingency fund for outbreaks (document EB130/5 Add.6) that was not restricted to influenza. However, the link with the reform process required clarification. To avoid delays in the discussion and adoption of the proposal, he suggested that it be treated as a separate matter and given full consideration by the Health Assembly.

Dr NASHER (Yemen), highlighting two important points raised in previous discussions, said that WHO reform should be well publicized in order to convey information on the associated trends and effects to the public at large, other international organizations and their staff, and the world media. The second point was that coordination, consultation and meetings with organizations working in the field of health, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance, should form part of priority setting, funding coordination, rationalization of the resources available to combat disease, and health system strengthening. In that context, the role of WHO and such organizations should be clearly identified.

Mr DÍAZ ANAIZ (Chile), referring to document EB130/5 Add.7, pointed out that organizational effectiveness was closely linked to matters covered by the other documents currently under discussion. Coordination between headquarters and the regional offices was crucial, particularly in strengthening shared information networks in order to ensure that Member States' priorities were properly met throughout the different regions. The exchange of experiences among countries and regions facing different situations was extremely valuable. With regard to the allocation of resources, he emphasized that, for there to be coherence between Member States' expectations and the reform process, any expansion of the donor base should be linked in a transparent manner to the priorities set by Member States in the medium-term strategic plan, and should be properly monitored. That should apply to all levels at which donations were received in the linked WHO system. He supported the strengthening of capacity in regional offices so that country teams were given appropriate training and technical and legal support to mobilize resources, administer subsidies and prepare reports. Strengthened implementation and reporting should serve the purposes of not only donors and strategic communications, but also Member States.

Ms ARTHUR (France) supported the draft internal evaluation policy, which attempted to introduce the same high level of evaluation in financial matters as was generally applied to health programmes. The internal evaluation should receive funding at the level of 3% of the programme budget and should be properly supervised by the governing bodies. The Board might therefore wish to approve a work plan and an annual report for future evaluations. However, the proposal for evaluation management groups required further clarification. It was to be hoped that the independent external evaluation would begin soon, with precise terms of reference and under the guidance of an entity with knowledge of current human resource, governance and financing problems. In that respect, the Office of Internal Oversight Services would seem to be the best choice for the first stage, as the Joint Inspection Unit had already indicated.

Mr HOLM (Sweden)¹ welcomed the proposed financing model, including its pledging element. It was essential to have stronger linkages between agreed priorities and funding. The new model should contribute to ensuring that Member States took responsibility for approving WHO's priorities and objectives, and financing them. All funds received by the Organization must be allocated to agreed priorities and expected results.

Two issues needed to be addressed in discussions preceding the next Health Assembly. First, in order to strengthen the link between budget and funding and make the budget more realistic, the pledging process could be started before final decisions on the programme budget were taken. Secondly, in order to secure adequate voluntary funding, WHO needed to focus on its relative strengths and improve its reporting of results. Hence the financing model should be linked to improved results-based management and an effective and transparent resource allocation mechanism.

Contributing to making WHO an efficient organization was one of Sweden's five priorities for collaboration with WHO and it remained committed to working with other Member States to achieve that end.

Dr DAHL-REGIS (Bahamas)¹ welcomed the work that had been done on governance and oversight of partnerships. The date of 2014 set for the predictable financing mechanism to enter into force should allow sufficient time to deal with some of the concerns that had been expressed. The Programme, Budget and Administration Committee could play a unique role, as its Chairman set the agenda for its meetings. It could be asked to consider many of the structures to be discussed, and given more time in which to do so, before submitting them to the Board and the Health Assembly. Meetings of the Committee did not need to conflict with the consultative process.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland),¹ noting the progress made by the Secretariat on key aspects of managerial reform since the special session of the Executive Board in November 2011, said that she remained concerned that the suggestions for financing still did not clearly distinguish between assessed, core voluntary and earmarked contributions. She had understood that the main aim of a pledging conference would be to establish transparency when setting out the sources and types of funding against the agreed budgets for costed activities. If her understanding of the term was correct, it might be helpful to use a less misleading title than "pledging conference". On organizational effectiveness, she recognized the complexities inherent in an organization like WHO and would willingly participate in efforts to improve linkages between the three levels, as well as between headquarters directorates, in order to strengthen accountability. With regard to the evaluation process, the proposals contained in document EB130/5 Add.8 for instilling an internal evaluation culture in WHO were welcome, but greater specificity was needed. She agreed that the evaluation should be done by the External Auditor.

Mrs ESCOREL DE MORAES (Brazil)¹ said that documents EB130/5 Add.8 and EB130/5 Add.9 were important for the reform process because they gave expression to the need for an evaluation process based on the priorities decided by the Member States and articulated in a medium-term strategic plan. The process should be wide-ranging and should take account of the fact that the goals and indicators agreed by countries would depend on national situations and ideas. However, it could provide an opportunity for tackling the financing question, as doing so would lead to countries having a more realistic view of the feasibility and sustainability of the prioritized actions. It would not be appropriate to extend the evaluation to cover technical programmes, for which a different strategy would need to be defined.

She understood that the evaluation management group would be selected in a transparent manner and that all interested Member States would be consulted. Although the role of the Board would be important, final approval would need to come from the Health Assembly. An external

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

evaluation would be acceptable provided that the terms of reference were drawn up through a collective and transparent process and that conflicts of interest were avoided. The United Nations Evaluation Group should be charged with setting the standards and criteria, but she expressed reservations about its operational and methodological approach and the type of evaluation and therefore asked the Secretariat for more information about the various proposed evaluation bodies.

Mr BENICCHIO (OXFAM), speaking at the invitation of the CHAIRMAN, strongly supported WHO as the lead global agency in public health. Guided by its Member States, its services must be relevant and available to countries with differing income levels and health profiles. For WHO to maintain and improve its role in difficult times, it needed realistic levels of predictable financing from its donors. Member States were duty bound to set overall priorities for the long term, while ensuring that short-term risks were well managed. Member States needed to be vigilant in order to identify and protect WHO's core functions and the norms, standards and guidelines that countries depended on. His organization had particular concerns that inadequate funding could further damage the Department of Essential Medicines and Pharmaceutical Policies, which for more than three decades had enabled low-income countries to access affordable medicines. Many of its duties were in danger of being discontinued. Ad hoc outsourcing of those functions could do irreparable damage to WHO's credibility. Nongovernmental organizations, the pharmaceutical industry and related agencies, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, and public-private partnerships all depended on WHO's evidence-based and regularly updated tools to do their work. He called on the Secretariat, under the direction of the Board, to prevent further erosion of the core functions, which should be supported from the regular budget.

Ms DI GIROLAMO (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN and also on behalf of the People's Health Movement, commended the proposed evaluation process, which would be invaluable in guiding the reform process. It was important to await the findings of the independent evaluation before agreeing on the precise trajectory of reforms. The difficulties caused by the preponderance of earmarked funds over flexible funding were described in document EB130/5 Add.5, but no concrete proposal had been put forward for changing the current situation. It was essential for Member States to build sustainable financial mechanisms that ensured adequate and unfettered funding in accordance with Article 7 of WHO's Constitution.

The proposed pledging conference should not result in any undermining of programmes and priorities by allowing donors to pick and choose elements of different programmes. She called for clear safeguards, transparency and accountability in order to protect WHO from conflicts of interest and undue influence when receiving funds from non-State entities. Such safeguards should be included in the resource mobilization plan contained in document EB130/5 Add.5.

Mr WEBB (Office of Internal Oversight Services) said that the proposed evaluation policy was in line with best practices and the United Nations Evaluation Group's norms and standards. Replying, at the request of the DIRECTOR-GENERAL, to specific questions raised by, among others, the member for Estonia, he said that the members of the evaluation management group would be chosen according to a set of criteria similar to those that would be applied in the selection process for the evaluation team, namely, that any conflict of interest should be avoided and that members should possess evaluation expertise, competence and experience in the area being evaluated. They could be external consultants or experts and did not necessarily have to be staff members of the Secretariat. With regard to the criteria used for the evaluation process, he pointed out that one aspect of evaluation was to follow the results chain, including future impact. As the measures and indicators necessary for assessing that impact in terms of expected achievements were not yet in place, it had been considered inappropriate to mention that aspect at that stage. That did not mean that it could not be considered in any evaluation commissioned as it was one of the 13 criteria mentioned by the United Nations Evaluation Group as being relevant for evaluation design.

The DIRECTOR-GENERAL thanked speakers for their rich and diverse comments. Replying to the member for Estonia about the exceptionally large sum of money in the Office of the Assistant Director-General for Health Security and Environment, she explained that the amount represented not cash but commodities, including significant donations of medicines and vaccinations received during pandemic (H1N1) 2009. Those items had been monetized in accordance with best accounting practices, a procedure that admittedly might be confusing to persons unfamiliar with those practices.

Members had requested more information on the proposed pledging conference, the contingency fund, the use of assessed contributions, the use of programme support costs for cross-subsidization purposes, and resource mobilization, particularly at country level. Considerable support had been expressed for an evaluation policy that would generate an evaluation culture. Evaluation was an important management tool for overseeing the effectiveness and efficiency of the Organization's use of Member States' resources. As requested by the Board at its special session in November 2011, she had consulted three entities, namely, the Independent Expert Oversight Advisory Committee, the Joint Inspection Unit of the United Nations system and the External Auditor, in order to identify which was best suited to undertake the evaluation process. Document EB130/5 Add.9 summarized the results of the consultation and also showed a marked convergence between the three entities. However, given the perceived need for the evaluation to be conducted by an independent external entity, there appeared to be broad support for entrusting stage one of the process to the External Auditor.

Turning to the pledging conference, which might perhaps be more aptly referred to as a financing dialogue and which was proposed as a mechanism for predictable financing, she noted the general consensus that priorities should be set by all 194 Member States in a transparent manner; the funding to support the agreed priorities must be predictable and sufficient to cover the actions required, and there should be no conflict of interest. As she saw it, during the first stage the 194 Member States would decide on the priorities and the activities needed to achieve them. The Secretariat would not be permitted to accept any funding not directly linked to those priorities. However, because of the low proportion of the Organization's funding that came from assessed contributions, it would be up to Member States to make good the shortfall either by increasing their contributions or by opening up the financing dialogue to include other organizations in the United Nations system, not-for-profit philanthropic organizations, civil society and other entities. Currently, WHO organized bilateral meetings with individual donors, for example, Member States and the European Union. However, the fact that individual countries were unaware of the amount of each others' contributions or the areas they were funding gave rise to funding imbalances. Furthermore, although the priorities were set by health officials, the financing often came from other government departments which were unaware of those priorities. Open financing dialogues could provide a viable solution. An open dialogue would also make it easier to remedy funding imbalances arising from countries' different degrees of flexibility. Those countries with the flexibility to shift their priorities would be able to do so in favour of underfunded areas, but such an option was not available to those countries without such flexibility. The guiding principles for such financing dialogues would be transparency and accountability. With regard to the suggestion by the representative of Sweden that a pledging process or financing dialogue should be started before the programme budget was approved, she said that its potential advantages and disadvantages warranted further consideration. She assured the member for Chile that, in the future, regular reports on the use made of all forms of contributions would be sent to all Member States and donors under a streamlined reporting mechanism.

She envisaged the proposed contingency fund as a reserve fund: the Director-General had no authority to move funds from one area to another because of the nature of earmarking. She would not need such a fund if she had more flexibility. Under current arrangements, when a crisis occurred she did not have access to resources that would enable her to launch an immediate response. The member for Senegal had mentioned the need for harmonization with regional contingency or emergency funds. She wondered why such funds were more readily accepted in the regions than at headquarters. One recommendation of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009 had highlighted the lack of flexibility that hampered WHO's ability to manoeuvre during a crisis. The Review Committee had recommended a contingency

fund of US\$ 100 million, but, in the face of opposition from Member States, that figure had been reduced to US\$ 15 million, on the basis of the amount needed to manage pandemic (H1N1) 2009. If approval were not forthcoming, she would have to have recourse to the reserve fund, which would result in a 10% deduction from the budget.

With regard to the use of assessed contributions, it was not her intention to cross-subsidize programmes funded by voluntary contributions with assessed contributions. She would work with the Programme, Budget and Administration Committee to calculate precisely programme support costs, which currently stood, nominally, at 13%. Assessed contributions, which were WHO's only predictable source of funding, amounted to only 20% to 25% of the total budget. They were used for core functions, such as supporting governing body meetings and funding the Office of Internal Oversight Services and the Legal Office. However, in the future, close attention would be paid to identifying what were and were not core functions. Programme support costs were currently being used to finance part of the Capital Master Plan in accordance with the mandate agreed by the governing bodies. The Executive Board at its recent special session had asked the Programme, Budget and Administration Committee to carry out a costing exercise to identify support costs properly. Any significant reduction in programme support costs would force her to make up the shortfall from the assessed contributions.

Resource mobilization represented a significant challenge that would need changes in culture and practice. In the future, coordinated resource mobilization would mean the mobilization of resources exclusively for Member States' priorities, and not for national plans and development programmes. The points raised in the discussion would be used as the basis for a consolidated report if that was what the Board wished. In the meantime, a start would be made on the first stage of the evaluation by the External Auditor who would provide a road map for the second, more important stage. The External Auditor would maintain a close dialogue with the Office of Internal Oversight Services, which would provide any necessary documents. The Board had also suggested that the Programme, Budget and Administration Committee be involved in any discussions involving its work.

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

The meeting rose at 12:45.

EIGHTH MEETING

Thursday, 19 January 2012, at 14:40

Chairman: Dr B.-I. LARSEN (Norway)

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

Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level: Item 6.2 of the Agenda (Document EB130/9) (continued from the fourth meeting)

The CHAIRMAN drew the attention of the Executive Board to a revised version of the draft resolution, which read as follows.

The Executive Board,

Having considered the report on the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level,¹

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

The Sixty-fifth World Health Assembly,

PP1 Having considered the report on the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level;

PP2 Recalling resolution WHA55.10, which urged Member States to increase investments in mental health both within countries and in bilateral and multilateral cooperation, as an integral component of the well-being of populations;

PP3 Recalling further United Nations General Assembly resolution A/RES/65/95, which recognized that “mental health problems are of major importance to all societies and are significant contributors to the burden of disease and the loss of quality of life, and have huge economic and social costs” and which also welcomed the WHO Report on *Mental Health and Development*,² which highlighted the lack of appropriate attention to mental health and made the case for governments and development actors to reach out to people with mental disorders in the design of strategies and programmes that include them in education, employment, health, social protection and poverty reduction policies;

PP4 Noting the High-Level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, held 19–20 September, 2011, which recognized that mental and neurological disorders, including Alzheimer’s disease, are an important cause of morbidity and contribute to the global noncommunicable disease burden, for which there is a need to provide equitable access to effective

¹ Document EB130/9.

² Funk M et al (Eds). *Mental health and development: targeting people with mental health conditions as a vulnerable group*. Geneva, World Health Organization, 2010.

programmes and health-care interventions;

PP5 Recognizing that mental disorders can lead to disabilities, as reflected in the United Nations Convention on the Rights of Persons with Disabilities, which also notes that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others and that the *World Report on Disability*¹ charts the steps that are required to improve the participation and inclusion of people with disabilities, including persons with mental disabilities;

PP6 Recognizing that mental disorders fall within a wider spectrum that also includes neurological and substance-use disorders which also cause substantial disability and require a coordinated response from health and social sectors;

PP7 Concerned that millions of people worldwide are affected by mental disorders, that in 2004, mental disorders accounted for 13% of the global burden of disease, defined as premature death combined with years lived with disability, and that, when taking into consideration only the disability component of the burden of disease calculation, mental disorders account for 25.3% and 33.5% of all years lived with a disability in low- and middle-income countries, respectively;

PP8 Concerned also that exposure to humanitarian emergencies is a potent risk factor for mental health problems and psychological trauma and that social structures and ongoing formal and informal care of persons with severe, pre-existing, mental disorders are disrupted;

PP9 Recognizing that the treatment gap for mental disorders is high all over the world, and that between 76% and 85% of people in low- and middle-income countries with severe mental disorders receive no treatment for their mental health conditions and that the corresponding figures for high-income countries are also high – between 35% and 50%;²

PP10 Recognizing that a number of mental disorders can be prevented and that mental health can be promoted in the health sector and in sectors outside health;

PP11 Concerned that persons with mental disorders are often stigmatized and underlining the need for health authorities to work with relevant groups to change attitudes to mental disorders;

PP12 Noting that there is increasing evidence on effectiveness and cost-effectiveness of interventions to promote mental health and prevent mental disorders, particularly in children and adolescents;

PP13 Noting that mental disorders are often associated with noncommunicable diseases and a range of other priority health issues, including HIV/AIDS, maternal-child health, and violence and injuries, and that mental disorders often coexist with other medical and social factors, such as poverty, substance abuse and the harmful use of alcohol, and in the case of women and children, greater exposure to domestic violence and abuse;

PP14 Recognizing that the social and economic impact of mental disorders, including mental disabilities, is diverse and far-reaching;

PP15 Taking into account the work already carried out by WHO on mental health, particularly the mental health Gap Action Programme,

¹ World Health Organization, The World Bank, *World Report on Disability*. Geneva, World Health Organization, 2011.

² Demyttenaere K et al (2004). *JAMA*, **291**:2581–90.

1. URGES Member States:¹
 - (1) according to national priorities and within their specific contexts, to develop comprehensive policies and strategies that address the promotion of mental health, prevention of mental disorders, early identification, care, support, treatment and recovery of persons with mental disorders;
 - (2) to include in policy and strategy development the need to promote human rights, tackle stigma, empower service users, address poverty and homelessness, tackle major modifiable risks, and as appropriate, promote public awareness, create opportunities for generating income, provide housing and education, provide health-care service and community based interventions, including deinstitutionalized care;
 - (3) to develop, as appropriate, surveillance frameworks that include risk factors as well as social determinants of health to analyse and evaluate trends regarding mental disorders;
 - (4) to give appropriate priority and streamlining to mental health, including the promotion of mental health, the prevention of mental disorders and care, support and treatment in programmes addressing health and development and to allocate appropriate resources in this regard;
 - (5) to collaborate with WHO in the development of a Mental Health Action Plan;
2. REQUESTS the Director General:
 - (1) to strengthen advocacy and develop a comprehensive Mental Health Action Plan with measurable outcomes in consultation with and for consideration by Member States covering services, policies, legislation, plans, strategies and programmes to provide treatment, facilitate recovery and prevent mental disorders, promote mental health and empower persons with mental disorders to live a full and productive life in the community;
 - (2) to include in the Action Plan, provisions to address:
 - (a) protection, promotion and respect for the rights of persons with mental disorders including the need to avoid stigmatization of persons with mental disorders;
 - (b) equitable access to affordable, quality and comprehensive health services that integrate mental health into all levels of the health-care system;
 - (c) development of competent, sensitive, adequate human resources to provide mental health services equitably;
 - (d) the promotion of equitable access to quality health care including psychosocial interventions and medication and addressing physical health-care needs;
 - (e) enhanced initiatives, including in policy, to promote mental health and prevent mental disorders;
 - (f) access to educational and social services, including health care, schooling, housing, secure employment and participation in income generation programmes;
 - (g) involvement of civil society organizations, persons with mental disorders, families and caregivers in voicing their opinions and contribution to decision-making processes;

¹ And, where applicable, regional economic integration organizations.

- The financial and administrative implications of the draft resolution for the Secretariat were as follows.

<p>1. Resolution: Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level</p>	
<p>2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)</p> <p>Strategic objective(s): 3</p> <p>How would this resolution contribute to the achievement of the Organization-wide expected result(s)?</p> <p>The implementation of the resolution would increase political, financial and technical commitment in Member States to tackle mental disorders. It would also provide support for the development of services, policies, plans, strategies, programmes and legislation to enable people with mental disorders to live full and productive lives in the community through the adoption of a coordinated and integrated approach across all sectors including health, social services and housing, education and employment.</p> <p>Does the programme budget already include the products or services requested in this resolution? (Yes/no)</p> <p>No</p>	<p>Organization-wide expected result(s): 3.1, 3.2, 3.5 and 3.6</p>
<p>3. Estimated cost and staffing implications in relation to the Programme budget</p> <p>(a) Total cost</p> <p>Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).</p> <p>(i) One year to develop the action plan (covering the period 2012)</p> <p>(ii) Total: US\$ 180 000 (staff: US\$ 160 000; activities: US\$ 20 000)</p> <p>(b) Cost for the biennium 2012–2013</p> <p>Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000).</p> <p>Total: US\$ 180 000 (staff: US\$ 160 000; activities: US\$ 20 000)</p> <p>Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.</p> <p>The costs would be incurred at all levels of the Organization.</p>	

<p>Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)</p> <p>The cost will be covered by relocating funds within the approved Programme budget.</p> <p>If “no”, indicate how much is not included.</p> <p>(c) Staffing implications</p> <p>Could the resolution be implemented by existing staff? (Yes/no)</p> <p>Yes</p> <p>If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.</p>
<p>4. Funding</p> <p>Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)</p> <p>Yes</p> <p>If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).</p> <p>US\$ n/a; source(s) of funds: n/a.</p>

Mr DESIRAJU (India) said that the revised version of the draft resolution, which took into account the amendments that had been proposed, reflected the consensus among members, and he encouraged its adoption.

Dr JESSE (Estonia), speaking on behalf of the European Union and its Member States, proposed the following amendments to the draft resolution.

In the thirteenth preambular paragraph, she proposed the deletion of the phrase “and in the case of women and children, greater exposure to domestic violence and abuse” to be followed by insertion of a new paragraph to read: “Recognizing that certain populations are particularly vulnerable to develop mental disorders and to consequences thereof, among them women and children exposed to domestic violence and abuse, children of parents with mental disorders and children of parents with substance use disorders”. It had been well documented that children of parents with mental disorders were themselves at particular risk of such disorders.

In subparagraph 2(1), she proposed the insertion of the phrase “including the deinstitutionalized care,” after “covering services” as the prior reference to “deinstitutionalized care” in subparagraph 1(2) was addressed to Member States and not the Director-General.

Ms GOLBERG (Canada) said that the additional preambular paragraph proposed by the member for Estonia might lead to the stigmatization of children whose parents had mental disorders. She therefore requested the deletion of the phrase “children of parents with mental disorders, and children of parents with substance use disorders”. Even though those children might indeed be at risk, she did not see the value of including that reference in the draft resolution.

Dr JESSE (Estonia) said that she could not withdraw the amendment without consulting the relevant experts.

Dr THAKSAPHON THAMARANGSI (Thailand)¹ suggested that, in subparagraph 1(4), the word “to” after “streamlining” should be replaced by “of”, to make sure it was clear that mental health was to be included in other policies.

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

Dr DAULAIRE (United States of America) suggested the wording “to give appropriate priority to and streamlining of mental health”.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland),¹ referring to the use of the word “advocacy” in subparagraph 2(1), explained that it had a specific meaning in her country under the Mental Health Act 2007, which should not be confused with the general meaning of “advocacy” as contained in the draft resolution.

The CHAIRMAN suggested that consideration of the agenda item be postponed pending further discussions.

It was so agreed.

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

Prevention and control of noncommunicable diseases: Item 6.1 of the Agenda (Documents EB130/6 and EB130/7)

- **Outcomes of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control**
- **Implementation of the global strategy for the prevention and control of noncommunicable diseases and the action plan**

The CHAIRMAN drew attention to the Secretariat’s two reports and the following draft resolution on prevention and control of noncommunicable diseases: follow-up to the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, which read:

The Executive Board,

PP1 Having considered the reports on prevention and control of noncommunicable diseases: outcomes of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and the First Global Ministerial Conference on Healthy Lifestyles and Non-communicable Disease Control¹ and on implementation of the global strategy for the prevention and control of noncommunicable diseases and the action plan;²

PP2 Recalling the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases,³ the Moscow Declaration adopted at the First Global Ministerial Conference on Healthy Lifestyles and Non-communicable Disease Control, and resolution WHA64.11 of the World Health Assembly;

PP3 Acknowledging the Rio Political Declaration on Social Determinants of Health, adopted by the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, 21 October 2011), which expressed the determination to achieve social and health equity through action on the social determinants of health and well-being by a comprehensive intersectoral approach;

¹ Document EB130/6.

² Document EB130/7.

³ Resolution 66/2.

PP4 Reaffirming the leading role of WHO as the primary specialized agency for health and its leadership and coordination role in promoting and monitoring global action against noncommunicable diseases (as described in paragraphs 13 and 46 of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases);

PP5 Reaffirming the central role of WHO recognized in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases for monitoring and evaluation and guiding multisectoral engagement;

PP6 Recognizing in particular the call made in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (paragraphs 61 and 62) to develop a comprehensive global monitoring framework, including a set of indicators, capable of application across regional and country settings, and to develop recommendations for a set of voluntary global targets for the prevention and control of noncommunicable diseases, and to complete this work before the end of 2012;

PP7 Recalling resolution WHA61.14, which endorsed the 2008–2013 action plan for the global strategy for the prevention and control of noncommunicable diseases, and recognizing the progress made under the action plan up till now;

PP8 Reiterating the concern that the rapidly growing magnitude of noncommunicable diseases affects people of all ages, gender, race and income levels, and further that poor populations and those living in vulnerable situations, in particular in developing countries, bear a disproportionate burden and that noncommunicable diseases can affect women and men differently;

PP9 Noting with concern the growing double burden of communicable and noncommunicable diseases in Africa, and the need for integrated approaches to their prevention and control;

PP10 Noting with concern that an estimated 36 million of the 57 million deaths in the world in 2008 were due to noncommunicable diseases such as cardiovascular diseases, cancers, chronic respiratory diseases and diabetes, and that nearly 80% of those deaths occurred in developing countries,

1. URGES Member States:

- (1) to implement the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases;
- (2) to draw upon, based on national contexts, the policies, strategies, programmes and interventions and tools recommended by WHO in order to, in accordance with paragraph 45 of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, promote, establish or support and strengthen, by 2013, as appropriate, multisectoral national policies and plans for the prevention and control of noncommunicable diseases;
- (3) to strengthen their commitment to implementing noncommunicable disease programmes in accordance with national priorities, including increased efforts on prevention, diagnostics and treatment and to take steps to accelerate health-related donor harmonization and adherence to aid effectiveness principles, bearing in mind the growing concern about the double burden of communicable and noncommunicable disease in many countries and the need for an integrated response;
- (4) to participate fully in the WHO-led process of developing a comprehensive global monitoring framework, including a set of indicators, capable of application across regional and country settings, and of developing recommendations for a set of voluntary global targets for the prevention and control of noncommunicable diseases before the end

of 2012, and to consider incorporating elements of this work into national planning exercises at the earliest opportunity in accordance with national priorities;

2. REQUESTS the Director-General:

(1) to continue in an inclusive and transparent manner, the process under way to develop, in accordance with paragraphs 61 and 62 of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, a comprehensive global monitoring framework, including a set of indicators, capable of application across regional and country settings, and to develop recommendations for a set of voluntary global targets for the prevention and control of noncommunicable diseases, and to complete this work by the end of 2012, building on the outcomes of the consultation with Member States and organizations in the United Nations system (held on 9 January 2012), as follows:

- (a) by the end of January the Secretariat will provide Member States with additional information requested at that consultation;
- (b) by 15 February, a web-based consultation on a draft framework and indicators and targets will close, following which WHO will revise the draft documents for step (c);
- (c) by end-March, a second Member State consultation on the framework and indicators and targets will be held;
- (d) as part of this process, the Secretariat should also hold consultations with all interested stakeholders;
- (e) submission of a substantive progress report, including initial indicators and targets, to the Sixty-fifth World Health Assembly for consideration;
- (f) regional consultations will provide further input into the framework/target process as part of their broader discussions on implementation of the Political Declaration;
- (g) second half of 2012 the Secretariat will hold a Member State consultation to finalize work on the draft framework and targets;
- (h) submit the package of recommendations relating to paragraphs 61 and 62 of the Political Declaration through the Executive Board at its 132nd session to the Sixty-sixth World Health Assembly for consideration;

(2) to develop, in a consultative manner, WHO's input, called for in paragraph 64 of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases concerning options for strengthening and facilitating multisectoral action for the prevention and control of noncommunicable diseases through effective partnership, and submit them to the Secretary-General by the end of 2012;

(3) to submit a progress report and a timeline for WHO's input on options for strengthening and facilitating multisectoral action for the prevention and control of noncommunicable diseases through effective partnership to the Sixty-fifth World Health Assembly;

(4) to develop, in a consultative manner, a WHO action plan for the prevention and control of noncommunicable diseases for 2013–2020, building on lessons learnt from the 2008–2013 action plan and taking into account the outcomes of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, the Moscow Declaration on Healthy Lifestyles and Non-communicable Disease Control, the Rio Declaration on Social Determinants of Health, and WHO's ongoing reform;

(5) to build on work from the 2008–2013 action plan, which, inter alia, called for WHO to provide support to countries in enhancing access to essential medicines, to facilitate engagement by governments and the private sector, in accordance with relevant paragraphs of the Political Declaration of the High-level Meeting of the General

Assembly on the Prevention and Control of Non-communicable Diseases, for improved access to medicines;

(6) to submit to the Sixty-sixth World Health Assembly through the Executive Board a WHO action plan for the prevention and control of noncommunicable diseases for 2013–2020 for consideration and possible adoption.

The financial and administrative implications of the draft resolution for the Secretariat were as follows.

<p>1. Resolution: Prevention and control of noncommunicable diseases: follow-up to the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases</p>
<p>2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)</p> <p>Strategic objective(s): 3 and 6 Organization-wide expected result(s): 3.3, 6.2 and 6.3</p> <p>How would this resolution contribute to the achievement of the Organization-wide expected result(s)?</p> <p>It would contribute to achievement of the expected results mentioned above by giving further impetus to the development of a comprehensive global monitoring framework and of recommendations for a set of voluntary global targets for the prevention and control of noncommunicable diseases, in accordance with paragraphs 61 and 62 of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases.</p> <p>Does the programme budget already include the products or services requested in this resolution? (Yes/no)</p> <p>Yes.</p>
<p>3. Estimated cost and staffing implications in relation to the Programme budget</p> <p>(a) Total cost</p> <p>Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).</p> <p>(i) 2 years (covering the period 2012–2013)</p> <p>(ii) Total US\$ 2.5 million (staff: US\$ 1.5 million; activities: US\$ 1.0 million)</p> <p>(b) Cost for the biennium 2012–2013</p> <p>Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000).</p> <p>Total US\$ 2.5 million (staff: US\$ 1.5 million; activities: US\$ 1.0 million)</p> <p>Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.</p> <p>At headquarters and in all six regions</p> <p>Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)</p> <p>Yes</p> <p>If “no”, indicate how much is not included.</p> <p>(c) Staffing implications</p> <p>Could the resolution be implemented by existing staff? (Yes/no)</p> <p>Yes</p> <p>If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.</p>

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

No

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ 2.0 million; source(s) of funds: voluntary contributions from bilateral donors.

Dr DAULAIRE (United States of America), introducing the draft resolution, said that it was proposed by Australia, Barbados, Canada, Costa Rica, Kenya, Norway, Russian Federation, Switzerland and the United States of America. The High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases and its preparatory meetings had enabled Member States to collaborate, consider national and global responses, and adopt best practices for the implementation of evidence-based policies and programmes. He acknowledged the useful informal consultation on indicators and targets held by Member States in January 2012, which had established areas of convergence about the Organization's role in following up the Political Declaration of the High-level Meeting and had provided the basis for the draft resolution. The text sought to establish a process and timeline for three areas of WHO's work on noncommunicable diseases, and would commit Member States to action that would enable WHO to meet the deadlines contained in the Political Declaration.

The first area was the development of the comprehensive global monitoring framework, including draft global targets and indicators for noncommunicable diseases, called for in paragraphs 61 and 62 of the Political Declaration. That process should be transparent and inclusive. Progress should be reviewed by the Health Assembly in May 2012 so that the framework could be finalized later in the year. The second area was the request to the Director-General to engage in consultations on WHO's role in strengthening and facilitating multisectoral action through effective partnerships, although the primary role in that process would be played by the United Nations Secretary-General. The third area was the renewal of WHO's mandate through development of a new action plan for the global strategy for the prevention and control of noncommunicable diseases covering the period from 2013, when the current plan expired, to 2020. That would align the reporting cycle with that of the United Nations. The new plan should focus more closely on access to medicines, working in partnership with governments and the private sector. The draft resolution highlighted the connections between the three areas and the benefits of a transparent and inclusive consultation process.

Dr BELO (Timor-Leste) proposed two amendments to the draft resolution. In subparagraph 2(2), the phrase “and transparent” should be inserted after “effective” and similarly the phrase “while safeguarding public health from any potential conflict of interest” after “partnership”. Secondly, in subparagraph 2(5), the phrase “and as appropriate civil society” should be inserted after “governments”.

Dr OMI (Japan), expressing his support for the draft resolution, welcomed the increased international emphasis on the prevention and control of noncommunicable diseases. WHO should continue to provide support for evidence-based, country-specific policy planning, as well as helping to combat the scarcity of data on noncommunicable diseases through technical assistance and capacity building. National prevention and control programmes should be diverse in nature and the various activities should be implemented simultaneously, including, for instance, advocacy for healthy lifestyles and improved health-care systems for people with noncommunicable diseases. Deaths from noncommunicable diseases were seen mostly in low-income and middle-income countries, and in Japan those diseases had become a serious problem owing to the rapid ageing of the population. For

that reason, his country planned to submit a draft resolution on strengthening noncommunicable disease policies to promote active ageing.

Dr SILBERSCHMIDT (Switzerland) noted that the draft resolution provided a timeline for specific actions to be undertaken in response to the Political Declaration. The development of the new global monitoring framework and targets, being a standard-setting activity, should be protected from the influence of the private sector, but the latter must be involved in the third area of activity, namely the implementation of the new action plan for the global strategy for the prevention and control of noncommunicable diseases, because of its crucial role in addressing risk factors and dealing with the impact of noncommunicable diseases.

He appreciated the intention behind the amendments proposed by the member for Timor-Leste, but considered it inadvisable to amend text that had been reproduced from the Political Declaration. He suggested that the issue should be resolved informally.

WHO's workplan for the year ahead should cover the difficult, but crucial, issue of ensuring coherence between the activities related to the three areas of work described in the draft resolution.

Dr NASHER (Yemen), speaking on behalf of the Member States of the Eastern Mediterranean Region, highlighted paragraphs 3, 4, 30, 42, 43, 45(a) and (k), 56, 59 and 60 of the Political Declaration of the High-level Meeting. The Organization in general and the Regional Office for the Eastern Mediterranean in particular would continue to provide support for Member States and to work with governmental and nongovernmental organizations and WHO collaborating centres on the prevention of noncommunicable diseases, which was an indispensable part of health and socioeconomic development.

Dr JESSE (Estonia), speaking on behalf of the European Union and its Member States, said that the acceding State Croatia, the candidate countries Turkey, the former Yugoslav Republic of Macedonia, Montenegro and Iceland, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, and Serbia, as well as Ukraine, Armenia and Georgia associated themselves with her statement. She welcomed the increased international attention being paid to noncommunicable diseases following various high-level meetings. The 8th Global Conference on Health Promotion due to be held in Helsinki in June 2013 would build on the outcome of the High-level Meeting and on the Rio Political Declaration on Social Determinants of Health and provide a basis for discussions on development goals after the end-date of the Millennium Development Goals in 2015.

It was important not to lose the momentum gained so far, and all Member States, irrespective of their level of development, should be committed to the effective implementation of the global strategy for the prevention and control of noncommunicable diseases and the associated action plan. She asked the Secretariat for more information on its implementation of the action plan, with particular regard to the marketing of food and non-alcoholic beverages to children (referred to in subparagraph (f) of the section on promoting healthy diets and physical activity under Objective 3 in document EB130/7).

Tackling noncommunicable diseases was a priority for the European Union, which sought a mechanism for establishing voluntary global targets, monitoring and indicators. Results of that work would be included in the review of innovative approaches for chronic diseases that had been launched by the Member States of the European Union and the European Commission. The new WHO action plan for the global strategy for the prevention and control of noncommunicable diseases should be based on an analysis of progress made by Member States, take into account the outcomes of the High-level Meeting, and be consistent with existing strategies, plans and instruments. Implementation of the action plan and activities related to social determinants of health should remain a high priority for WHO.

In the draft resolution, she proposed replacing "15 February" with "end-February" in subparagraph 2(1)(b); replacing "end-March" with "before the Sixty-fifth World Health Assembly" in subparagraph 2(1)(c); inserting "on the development of a framework" after "progress report" in

subparagraph 2(1)(e) and replacing “initial” with “a set of” in that same subparagraph; and replacing subparagraphs 2(1)(g) and 2(1)(h) with a new subparagraph 2(1)(g), to read: “adopt the work on the global monitoring framework, including a set of indicators and targets, in a Member State consultation held before the end of 2012”. In subparagraph 2(4), she proposed replacing “and WHO’s ongoing reform” with “building upon and being consistent with existing WHO strategies and tools on tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity”. In subparagraph 2(5), the phrase “with the appropriate safeguard with the conflict of interest,” should be inserted after “private sector”.

Mr MAXTONE-GRAHAM (Papua New Guinea), speaking on behalf of the Member States of the Western Pacific Region, said that noncommunicable diseases were responsible for 80% of the 30 000 or so deaths every day in the Region from preventable diseases. Those concerns had been reflected in the Seoul Declaration on Noncommunicable Disease Prevention and Control in the Western Pacific Region (2011) and the Honiara Communiqué on the Pacific Noncommunicable Disease Crisis, adopted by the Ninth Meeting of Ministers of Health for the Pacific Island Countries in June 2011. In October 2011, the Regional Committee for the Western Pacific had adopted resolution WPR/RC62.R2 on expanding and intensifying noncommunicable disease prevention and control and requested the Regional Director to develop by 2013 a regional action plan, including targets and progress indicators, for the period 2014–2018.

Noncommunicable diseases were posing an increasing burden on his country; preliminary data from the WHO STEPwise approach to Surveillance of NCD Risk Factors indicated that 21.9% of the population had three or more risk factors for those diseases, and the prevalence of tobacco smoking was particularly high.

Despite some regional advances in implementing the global strategy, individual Member States still faced various challenges, including the lack of national capacity to deal with noncommunicable diseases, which required sustained funding to rectify the situation. Noncommunicable disease policies should be integrated into health planning and processes and the development agenda, and multisectoral action should be encouraged, through health-in-all-policies and whole-of-government approaches. National capacity should be built up in order to strengthen national health policies and plans, with special emphasis on monitoring and evaluation, reducing exposure to risk factors for noncommunicable diseases, and promoting access to primary health care. Resources should be increased for noncommunicable disease control and viable financing options should be explored.

He urged WHO to adopt a framework to guide countries in adopting a health-in-all-policies approach, addressing all the social determinants of health. Furthermore, synergies should be sought with work on other global health and development matters, including climate change. Health systems strengthening should focus on chronic conditions. He supported the draft resolution.

Dr ST. JOHN (Barbados), supporting the proposed follow-up process to the High-level Meeting, noted the three components of the new framework for surveillance of noncommunicable diseases: monitoring exposures, monitoring outcomes, and health system responses. Implementation of the framework at national level would require adequate surveillance capacities and integrated health-information and data-collection systems, including reliable registration of vital statistics. Improvements in death certification and the establishment of an epidemiology unit and health information systems would enhance her country’s capacity in that regard.

More accurate reporting was required, in particular for cancer, as data on incidence and type of cancer were essential in planning cancer control programmes. Cancer registries provided an unbiased description of cancer patterns and trends in a given population, and her Government would therefore continue to support the Barbados National Registry for Chronic Non-Communicable Disease.

The draft resolution, of which her country was a sponsor, should help WHO to fulfil its obligations and sustain the momentum given by the High-level Meeting, while maintaining its leadership of the multisectoral response. Global commitment was needed to change the global social environment.

Ms ARTHUR (France) welcomed the increased international attention being paid to noncommunicable diseases since the High-level Meeting, as they were one of the major challenges to development in the 21st century. The Political Declaration should facilitate the formulation of targets and policies to guide States' actions. WHO should take into account five areas in its work on noncommunicable diseases, in particular when updating the current action plan. First, the social and environmental determinants of noncommunicable diseases were particularly significant for prevention. Secondly, a response dealing with health issues alone was not enough. Any response to noncommunicable diseases must be multisectoral, but with health remaining the principal consideration. Thirdly, other stakeholders must be involved in the implementation of prevention and control programmes, but any collaboration with the private sector must be transparent and avoid conflicts of interest. Fourthly, the financial burden of the prevention and treatment of noncommunicable diseases and their consequences weighed heavily on both governments and patients; the latter must be guaranteed access to information with appropriate and affordable treatment. Universal health coverage would improve patients' access to the care they needed. Finally, several Member States had emphasized the value of using tools and activities taken from other WHO strategies relating to noncommunicable diseases, although they had also noted difficulties in implementing national prevention and control policies. Successes and challenges at the country level should be evaluated to identify best practices and contribute to the definition of indicators and targets.

Dr PE THET KHIN (Myanmar) supported the draft resolution. He recalled that work to implement the action plan for the global strategy had already been undertaken during two bienniums, yet the budget allocated to control of noncommunicable diseases remained considerably lower than that for communicable diseases. Had there been any increase in the budget for noncommunicable disease programmes? An increase would be necessary if the six objectives of the action plan were to be achieved at all levels of the Organization. The headquarters and regional office budgets and work plans at all levels must be reviewed.

Subparagraph (a) of Objective 2 (document EB130/7) on national policies and plans referred to technical support provided by the Secretariat for building public health capacity to implement noncommunicable disease interventions through primary health care. He asked that specific information on that technical support be included as an annex to the report.

The Political Declaration of the High-level Meeting made no provision for funding. WHO must ensure that it obtained the necessary funding for the activities it wished to implement.

Dr LEI Zhenglong (China) said that the High-level Meeting had provided an historic chance to tackle the prevention and control of noncommunicable diseases, but that follow-up was crucial. He therefore supported the draft resolution with the amendments proposed but would welcome inclusion of the following points in the Secretariat's report. The first related to the need for extensive publicity and advocacy activities to create a favourable social environment among communities, governments and relevant State agencies. The second was a suggestion that Member States should set up pilot projects to test strategies and models suited to their national context, which could gradually be extended. Thirdly, the Secretariat should develop a framework for evaluation of progress in Member States, create a basic database to evaluate global progress and introduce incentives to encourage Member States to contribute.

Mr PRADHAN (India) said the Political Declaration of the High-level Meeting recognized that the main noncommunicable diseases were primarily linked to known risk factors, including the use of tobacco and the harmful use of alcohol. National health ministries could not combat those diseases alone: other relevant ministries must also work on known risk factors in a whole-of-government approach.

The action plan with its six objectives was essential for enhancing Member States' capacity to control noncommunicable diseases at the primary, secondary and tertiary levels of health care. Work

should focus on health promotion and disease prevention, as well as on addressing risk factors and strengthening health systems.

The Political Declaration recognized the fundamental conflict between public health and the tobacco industry. There was a need for similar global and national actions to minimize the harmful use of alcohol, as it led to chronic disease, domestic abuse, unemployment and a lower quality of life. He therefore suggested that WHO initiate action to prepare an agreement similar to the WHO Framework Convention on Tobacco Control within a specified time frame.

Paragraphs 61 and 62 of the Political Declaration required the development of a comprehensive global monitoring framework and a set of voluntary targets for the prevention and control of noncommunicable diseases by the end of 2012. That development process should be inclusive, and incorporate the views of civil society and international agencies, as well as Member States.

He supported the draft resolution, but asked whether it was necessary to include the specific timeline contained in subparagraph 2(1), as the same deadlines were also stated in subparagraphs 2(2), 2(3) and 2(6).

Dr DE ASSUNÇÃO SAÍDE (Mozambique), speaking on behalf of the Member States of the African Region, said that the increasing burden of noncommunicable disease had a disproportionate impact on poor and disadvantaged populations, which affected economic development and contributed to widening health gaps within and between countries.

The *Global status report on noncommunicable diseases* had highlighted that deaths due to those diseases would increase in the current decade by more than 20% in Africa if no action were taken to curb the current trend. African health ministers had adopted the Brazzaville Declaration on Noncommunicable Diseases Prevention and Control in the WHO African Region (April 2011), which placed particular emphasis on the need to address the main risk factors, including tobacco use, harmful use of alcohol, physical inactivity and inadequate diet.

Training workshops on policy management for the prevention and control of noncommunicable diseases had enabled 16 Member States to develop and implement integrated noncommunicable disease action plans. Selected noncommunicable diseases had been incorporated into the second edition of the technical guidelines for integrated disease surveillance and response in the Region.¹ A regional database on noncommunicable diseases was being developed and cancer registries had been established in selected countries.

The continued implementation of the VISION 2020: The Right to Sight initiative had raised the profile of eye health in Africa, and comprehensive oral health initiatives had been integrated into action plans for noncommunicable diseases in eight countries. Indicators for noma had been developed, and countries in which it was endemic were implementing integrated and multisectoral approaches for prevention and control. Recommendations on the marketing of food and non-alcoholic beverages to children had been disseminated to try to prevent childhood obesity, which was increasingly common, even in countries where childhood malnutrition persisted. The Regional Office was spearheading the development of indicators and data-collection tools for noncommunicable diseases, including eye, ear and oral health, which had been included in the African Health Observatory.

Despite those developments, challenges remained, including monitoring noncommunicable diseases and their risk factors through surveillance mechanisms within national health information systems; reducing risk factors by establishing and strengthening intersectoral action; and improving health care for people with those diseases by strengthening health systems. Resources to implement and evaluate programmes were lacking. The lack of medicines, appropriate means of diagnosis, and

¹ World Health Organization and Centers for Disease Control and Prevention. *Technical guidelines for integrated disease surveillance and response in the African Region*. Brazzaville, Regional Office for Africa, and Centers for Disease Control and Prevention, Atlanta, Georgia, United States of America, 398pp, 2010.

low numbers and poor distribution of personnel trained in specific noncommunicable diseases such as eye, ear and oral health also hindered progress. As a result, he recommended the use of the flexibilities offered by the Agreement on Trade-Related Aspects of Intellectual Property Rights, and emphasized disease prevention and strengthening national capacity for medicine production.

He supported the draft resolution.

Mr MANCHA MOCTEZUMA (Mexico) said that in 2011 Mexico had hosted a regional ministerial meeting, whose outcome had been submitted to the High-level Meeting as a ministerial declaration. The Political Declaration of the High-level Meeting, which covered all aspects of disease prevention, demonstrated the high level of commitment from Member States and provided a valuable opportunity to make progress. It was important to tackle the social determinants of chronic noncommunicable diseases in order to encourage the alignment of the various sectors that impacted on the health sector, as well as access to medicines and strengthening of health systems, international cooperation, sharing of best practices and increased accountability in respect of information systems.

He supported the proposed amendment that the timeline for action in the draft resolution be amended. It was important to ensure greater flexibility in reviewing the indicators, as each country had different health structures and infrastructures and sources of health information. He endorsed the statement in the eighth preambular paragraph that noncommunicable diseases affected people of all ages. In Mexico, diseases related to nutrition, in particular, were common in children.

Dr GULLY (Canada) looked forward to working with the Secretariat, other United Nations agencies, funds and programmes, and Member States in implementing the Political Declaration of the High-level Meeting, for example through regional and global consultations on strengthening and facilitating multisectoral action, the new action plan for 2013–2020 and the development of a global monitoring framework.

Having participated in the informal consultations on the global monitoring framework held in January 2012, he supported the draft resolution, which reflected the outcome of that meeting. His country's experience in establishing surveillance systems in a complex setting demonstrated the value of a broad consultation process involving technical experts. The proposals in the draft resolution made good use of the time available to develop a comprehensive global monitoring framework, including a set of indicators that were applicable across regions and countries, and to develop recommendations for a set of voluntary global targets for the prevention and control of noncommunicable diseases.

Turning to the amendments to the draft resolution proposed by the member for Timor-Leste, he agreed with the amendment to subparagraph 2(2), but asked for clarification of the definition of "civil society" in the proposed amendment to subparagraph 2(5).

With regard to the amendment proposed by the member for Estonia to replace subparagraphs 2(1)(g) and 2(1)(h) with a new subparagraph, he said that it was not within the remit of the Director-General to adopt the work on the global monitoring framework, and therefore proposed replacing "adopt" by "include".

Dr DÍAZ ANAIZ (Chile) supported the draft resolution. The global strategy for the prevention and control of noncommunicable diseases 2008–2013 contained clear technical guidelines for the prioritization of interventions, but also required action from stakeholders beyond the health sector and WHO, including the food industry, agriculture, commerce, transport, urban development, education and finance and taxation authorities. It was important to encourage changes in modern lifestyles, create alliances between key stakeholders, and adopt new legislation. That was a complex task which would require collaboration between countries and with FAO, WHO, the World Bank, WTO, nongovernmental organizations and other stakeholders. Those organizations should encourage the development of intersectoral strategies on the use of tobacco, healthy diets and physical activity, which were some of the risk factors for noncommunicable diseases. WHO's leadership would be required to foster the necessary political will at national level to encourage change and guarantee resources and technical assistance.

Any integrated national strategy required capacity building, behavioural change, attention to social, economic and environmental determinants, surveillance and monitoring of the burden of disease, and the promotion of high-quality research in developing countries such as Chile. His Government had launched a programme called *Elige vivir sano* (“Choose to live healthily”) which promoted healthy eating and physical activity. Chile had spearheaded the development of a surveillance model for noncommunicable diseases in Latin America, within the framework of the Common Market of the South, the first report of which had been published in December 2011. Although he was aware that the prevention of noncommunicable diseases was a national responsibility, he encouraged WHO to request that other multilateral international organizations consider the impact of their policies on noncommunicable diseases.

Mr YUSOF (Brunei Darussalam), commending the progress made towards achieving the objectives of the global strategy, stressed the need for more work to maintain the momentum. He supported the draft resolution. Given the limited resources of Member States, effective use should be made of existing regional and international forums to forge links with the food, beverages and pharmaceuticals industries and to capitalize on capacity-building and research opportunities. He applauded WHO’s initiative to establish a comprehensive global monitoring framework with realistic targets and indicators.

Ms QUACOE (Côte d’Ivoire)¹ said that noncommunicable diseases led to many premature deaths in Africa because of inadequate screening services, late diagnosis and the lack of adequate equipment, including radiotherapy equipment to treat cancer. There were not enough specialist health workers and they were not available in all areas. The supply of essential medicines was erratic and the cost was often beyond patients’ means. Efforts must be made to strengthen health systems, improve geographical coverage and equity in health services, ensure the supply of effective generic medicines and launch community-based initiatives to promote healthy lifestyles.

Ms PATTERSON (Australia)¹ expressed support for the global efforts agreed at the High-level Meeting to scale up action to combat noncommunicable diseases. Her Government supported WHO’s strong leadership role in that endeavour and would work with other Member States to fulfil the commitments made at the Meeting. It had provided funding to enable the Secretariat to support developing countries in implementing the current action plan for the global strategy for the prevention and control of noncommunicable diseases, and would contribute to the development of the next plan.

Ms ESCOREL DE MORAES (Brazil)¹ said that noncommunicable diseases, which caused millions of premature deaths and were increasingly prevalent in developing countries, remained at the top of the global health agenda. Her Government supplied patients with medication for hypertension and diabetes free of charge. It regarded the use of the flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights, the Doha Declaration on the TRIPS Agreement and Public Health, and WHO’s global strategy on public health, innovation and intellectual property as crucial to public policies aimed at ensuring the right to health, and it placed particular emphasis on tackling risk factors, such as tobacco and alcohol use, physical inactivity and unhealthy diets.

It was essential to strike a proper balance between prevention, treatment and diagnostics in activities for the implementation of the Political Declaration of the High-level Meeting. Prevention was important, but it was equally important not to lose sight of the millions of underprivileged people without access to affordable medicines and treatment. WHO had been assigned a key role in the follow-up to the Political Declaration, which included monitoring the socioeconomic determinants of

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

noncommunicable diseases and promoting effective intersectoral action; hence the need for close links with efforts to implement the Rio Political Declaration on Social Determinants of Health.

She supported the draft resolution as amended by the member for Timor-Leste.

Dr MAKUBALO (South Africa)¹ supported the draft resolution. Noncommunicable diseases placed a heavy burden on the health sector in her country. Recognizing the influence of social determinants, her Government had increased spending on health and initiated a programme for universal coverage of health care; it had prioritized the strengthening of the health system through capacity building for human resources, sustainable funding, reliable health information systems and securing access to affordable medicines. South Africa had taken part in the informal consultations to develop targets related to noncommunicable diseases. It was to be hoped that a realistic global monitoring framework would be developed. The next steps would call for preparation, commitment and sustainable funding at the national, regional and global levels.

Mr SAMAR (Algeria)¹ hailed the adoption of the Political Declaration of the High-level Meeting as a turning point in the fight against noncommunicable diseases. It recognized the global burden and threat of those diseases as a major obstacle to development in the 21st century, and highlighted the urgent need for comprehensive, coordinated and multisectoral measures at the national, regional and global levels. Noncommunicable diseases constituted a challenge of enormous proportions, especially in developing countries, which lacked the scientific, technical and financial capacity and infrastructure for early detection, treatment and care. Beside prevention, access to affordable medicines was necessary, but that would require technology transfer to enable medicines to be manufactured locally and the use of flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights.

To secure additional funding for health care, his Government had established a special cancer fund in the 2011 budget and imposed taxes on tobacco and other harmful products. A wide-ranging investment plan had been launched to strengthen the national health system, and a multisectoral programme to combat noncommunicable diseases had been set up, with the participation of civil society. The Government collected information on risk factors and health determinants. From the point of view of sustainable development and efforts to combat social inequalities, an integrated and solidarity-based, scientific approach underpinned by compliance with the commitments made to the countries of the South would help to reduce the socioeconomic and health-related impacts of those diseases. His country would play a full part in any further consultations on the subject.

Dr THAKSAPHON THAMARANGSI (Thailand)¹ supported the draft resolution with the amendments proposed by the member for Timor-Leste. Although the language was not taken directly from the Political Declaration, concepts such as transparency, conflict of interest, and civil society involvement figured among its core principles and must be taken into account in all future work on the issue. He therefore urged Board members to approve those amendments.

He also endorsed the comments by the representative of Brazil on the importance of taking into account the social determinants of health in efforts to tackle noncommunicable diseases.

Dr NICKNAM (Islamic Republic of Iran)¹ commended the Secretariat's establishment of a specialized tobacco control centre in one WHO region and the development of various tools at the global level, which had brought effective interventions closer to populations in need. With greater commitment to combating noncommunicable diseases evident at senior political levels, it was important to introduce cost-effective, evidence-based interventions to tackle relevant risk factors. Expressing the hope that the Secretariat's next report would present more information on progress at

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

the country level, he suggested that it should explore additional mechanisms and develop a plan to secure sustainable funding for the global strategy for the prevention and control of those diseases.

Mr KULIKOV (Russian Federation)¹ stated his Government's support for the draft resolution, noting that it had asked to be added to the list of sponsors.

Mr ADAMS (Union for International Cancer Control), speaking at the invitation of the CHAIRMAN, said that efforts to halt the epidemic of noncommunicable diseases relied on swift fulfilment of the commitments in the Political Declaration and clear decisions by the Sixty-fifth World Health Assembly. He therefore urged Member States to embark upon a consultative process, with the participation of civil society, leading to the adoption of a global monitoring and accountability framework; to adopt an initial set of realistic global targets at the Health Assembly and agree on a process and timeline for setting additional targets, bearing in mind that countries could set their own national targets at any time; to endorse the goal of a 25% reduction in preventable deaths from noncommunicable diseases by 2025; and to include noncommunicable diseases in the international development goals to be determined for the period after 2015, since they were a cross-cutting development priority and must be fully integrated into future global, regional and national frameworks. Member States should also support civil society's participation in the establishment of a multisectoral, global partnership to combat noncommunicable diseases, and provide WHO with the necessary resources to promote and monitor action. His organization pledged its continued support in pursuit of those objectives in order to secure a healthy future for all.

Mr MWANGI (Alzheimer's Disease International), speaking at the invitation of the CHAIRMAN, recommended that ageing be recognized as a key determinant of noncommunicable diseases, and that the proposed global monitoring framework and targets take into account people of all ages, young and old. He further requested that Alzheimer's disease and other dementias be recognized as the fifth major noncommunicable disease.

Mr PLEYER (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, urged the Board to take a bold step in calling for time-bound and measurable commitments to reduce the prevalence of noncommunicable diseases; to include those diseases in discussions on other national and international health priorities, such as health systems strengthening and social determinants of health; to acknowledge the influence of industry and marketing on noncommunicable disease policies and urge governments to take a more active role; and to encourage the meaningful participation of youth from an early stage in the related strategies, as young people would be responsible for their implementation in the future.

Ms GLAYZER (Consumers International), speaking at the invitation of the CHAIRMAN, expressed the concern that the voluntary targets associated with the proposed global monitoring framework were too narrow to deliver the whole-of-government, multisectoral approach advocated in the Political Declaration. Additional targets were required to meet the challenge posed by poor diets in developed and developing countries, and the updated action plan for the global strategy for the prevention and control of noncommunicable diseases should call for measures to tackle the marketing of food to children; to require clear consumer information, including nutritional values, on packaging; and to ensure comprehensive, monitored reductions in the content of salt, sugar and saturated fats in processed foods. WHO already recorded progress in such areas, but including those measures in the voluntary targets stemming from the High-level Meeting would help to foster a more comprehensive

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

approach and raise awareness of the importance of healthy eating and sound prevention policies targeting the diet-related risk factors for noncommunicable diseases.

Mr MWANGI (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, said that much remained to be done to fulfil the commitments in the Political Declaration. He called on Member States to ensure equitable implementation of the global strategy for the prevention, diagnosis, treatment and care of all chronic noncommunicable diseases; to prioritize the strengthening of health systems in terms of their service delivery, workforce, financing, medical products, technologies and information systems, as well as patient self-management; to make sure that the views of patients were solicited in the design, implementation, monitoring and evaluation of interventions; to encourage the active participation of patients' organizations in developing, implementing and monitoring legislation, policies, regulatory frameworks, strategies, guidelines and standards; to commit themselves to a plan to improve health literacy for all; to enhance research on the incidence and prevalence of noncommunicable diseases and their impact on the lives of patients, families and caregivers; to promote early diagnosis and treatment; and to ensure that all policies and programmes were based on the fundamental right to patient-centred health care, with an emphasis on individual needs, preferences and values and on patient autonomy.

Dr COSTEA (International Special Dietary Foods Industries), speaking at the invitation of the CHAIRMAN, expressed support for WHO's leadership role in the prevention and control of noncommunicable diseases. The special dietary foods industry supported exclusive breastfeeding for the first six months of life and the introduction of safe and appropriate complementary foods thereafter. Although global rates of breastfeeding had improved, the health and development of infants and young children in some countries was still undermined by nutritional deficiencies resulting from nutritionally poor complementary foods. Better information on the composition and nutritional value of such foods would help Member States to develop relevant national interventions to improve child nutrition, and her organization was committed to providing the necessary expertise. Its members would analyse data on their products intended for children aged 6–24 months in selected countries and a consolidated report would be sent to WHO and other stakeholders. The industry's investment in research and development ensured that special dietary foods met the nutritional, micronutrient and safety needs of infants and young children, according to national and international standards. She supported the objectives set out in document EB130/7.

Dr SEYER (The World Medical Association Inc.), speaking at the invitation of the CHAIRMAN and on behalf of FDI World Dental Federation, drew attention to paragraph 19 of the Political Declaration, which recognized that oral diseases posed a major health burden and could benefit from common responses to noncommunicable diseases, with which they shared common risk factors. Dental caries was the world's most common chronic disease in children, and cardiovascular diseases, respiratory infections, diabetes and cancer were all linked to oral diseases, which UNDP had described as "obstacles to development".

WHO should take action to ensure that oral diseases were incorporated into noncommunicable disease programmes and national health planning, based on guidance provided in resolution WHA60.17 on oral health; to include oral diseases at the same level as the four main noncommunicable diseases in the proposed comprehensive global monitoring framework, its indicators and targets; to add a target aimed at reducing the number of work or school days missed because of oral diseases, which would also address wider determinants of health and development; and to adopt a set of optional oral health targets and indicators for which the global oral health community could make precise proposals.

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, the World Confederation for Physical Therapy and FDI World Dental Federation, which

together made up the World Health Professions Alliance as well as his own organization, urged the Secretariat and Member States not to lose sight of person-centred care and public health when considering noncommunicable disease targets, indicators and a global monitoring system. He called for a common approach that addressed the link between noncommunicable diseases and social determinants of health, with a particular focus on prevention and risk factors; a holistic approach encompassing physical, mental and oral health and health services, addressing shared risk factors, the elimination of inequalities and access to health care as a basic human right; efforts to strengthen health systems through a comprehensive approach, with an emphasis on primary health care and prevention, specialized treatment and rehabilitation; and targets related to physical activity levels for children and adults, noncommunicable disease education and training, and oral health.

Dr BOULYJENKOV (Thalassaemia International Federation), speaking at the invitation of the CHAIRMAN, said that the global burden of haemoglobin disorders continued to increase and that epidemiological data underestimated the magnitude of the problem. Those data needed updating to reflect the migration of populations from affected countries. The Health Assembly had adopted several resolutions on haemoglobinopathies; those had facilitated the Federation's work and supported its activities at country level. However, the Federation wished to see a report on the activities of Member States to develop, implement and reinforce comprehensive national programmes for the prevention and control of sickle-cell anaemia, thalassaemia and other haemoglobinopathies.

Ms EGGERMONT (Medicus Mundi International – International Organisation of Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, said that the Political Declaration was lacking in clear and measurable targets and favoured untested, voluntary solutions over binding regulations. Regarding the follow-up to the Declaration, the comprehensive global monitoring framework and its indicators would have to be sufficiently flexible to be adaptable to country-specific needs; civil society must be involved in the target-setting process at the national, regional and global levels; and Member States must increase funding, without diverting resources from other activities, and use innovative, progressive taxation mechanisms. As for the strengthening of multisectoral action, she welcomed the proposed review of existing partnerships; urged WHO and governments to put into effect strong policies tackling conflicts of interest that were detrimental to public health; and supported the call by the member for India to develop a global framework for alcohol control. When updating the action plan for the global strategy for the prevention and control of noncommunicable diseases, the Secretariat must provide countries with guidance for adopting a health-in-all-policies approach that addressed the social, economic and structural determinants of health, which would promote the synergy required to tackle other global challenges, such as food insecurity and climate change. Emphasis should be placed on health system strengthening, with a particular focus on patient-centred primary health care, social protection and access to medicines and health services. Her organization welcomed the suggestion to use the flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights and urged that it be acted upon.

Dr SILBERSCHMIDT (Switzerland) said that, having studied the amendments proposed by the member for Timor-Leste, he fully endorsed them. He shared the stated views on the importance of managing conflicts of interest.

Regarding the proposal to replace subparagraphs 2(1)(g) and 2(1)(h) with a new subparagraph, he had consulted the members for Estonia and Canada and had decided that it was important to comply with the High-level Meeting's decision to have the whole package of recommendations relating to paragraphs 61 and 62 of the Political Declaration ready by the end of 2012. In view of the fact that the customary formalities called for its adoption by the Executive Board, as opposed to a Member States consultation, before it could be submitted to the Health Assembly, he proposed that the word "adopt" in the new subparagraph proposed by the member for Estonia be replaced by "complete"; that the words "in a" in the phrase "in a Member State consultation" should be replaced

by “based on”; and that subparagraph 2(1)(h) should remain where it was, with the beginning amended to read: “report on the recommendations relating to ...”.

Dr JESSE (Estonia), speaking on behalf of the European Union, thanked the member for Switzerland for his delegation’s assistance in finalizing the language and asked for time to consider the new text overnight.

The CHAIRMAN suggested that the Board postpone its consideration of the draft resolution until the following morning.

It was so agreed.

(For continuation of the discussion and adoption of a resolution and a decision, see the summary record of the ninth meeting.)

Strengthening noncommunicable disease policies to promote active ageing

The CHAIRMAN drew attention to a draft resolution on strengthening noncommunicable disease policies to promote active ageing, proposed by Brunei Darussalam, Canada, China, Japan, Mongolia, Papua New Guinea and Singapore, which read:

The Executive Board,

Having considered the reports on prevention and control of noncommunicable diseases and the need for integrated management of prevention and control of noncommunicable diseases in order to promote active ageing,¹

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

The Sixty-fifth World Health Assembly,

PP1 Having considered the report on the Outcomes of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control and the report on the implementation of the global strategy for the prevention and control of noncommunicable diseases and the action plan;

PP2 Recalling the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, the Moscow Declaration adopted at the First Global Ministerial Conference on Healthy Lifestyles and Non-communicable Disease Control (Moscow, 28 and 29 April 2011), and the resolution WHA64.11 on preparations for the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, following on the Moscow Conference;

PP3 Recalling the Millennium Development Goals (MDGs) Follow-up Meeting (Tokyo, 2 and 3 June 2011), with the participation of more than 110 countries, about 20 United Nations or regional organizations and civil society organizations, at which it was agreed that noncommunicable diseases are emerging global challenges not only for the post-2015 era, but which also threaten the achievement of the internationally agreed development goals including the Millennium Development Goals;

¹ Documents EB130/6, EB130/7 and EB130/8.

PP4 Noting that an estimated 36 million of the 57 million deaths in the world in 2008 were due to noncommunicable diseases, such as cardiovascular diseases, cancers, chronic respiratory diseases and diabetes, which are largely caused by four common risk factors, namely tobacco use, harmful use of alcohol, unhealthy diet and lack of physical activity, and that nearly 80% of those deaths occurred in developing countries;

PP5 Noting with profound concern that ageing is among the major contributory factors to the rising incidence and prevalence of noncommunicable diseases, which are leading causes of morbidity and disability;

PP6 Noting also the demographic change, with the world's population aged 60 years or more increasing at more than three times the overall population growth rate and rising to about 1200 million in 2025; that the ageing of populations has public health and economic implications, including rising rates of noncommunicable diseases; and also the importance of lifelong health promotion and disease prevention activities that can prevent or delay, for example, the onset of noncommunicable diseases;

PP7 Recalling resolutions WHA52.7 and WHA58.16 on active ageing that urged Member States to take measures that ensure the highest attainable standard of health and well-being for the rapidly growing numbers of older persons in both developed and developing countries;

PP8 Recalling further United Nations General Assembly resolution 57/167, which endorsed the Political Declaration and the Madrid International Plan of Action on Ageing, as well as other relevant resolutions on ageing;

PP9 Noting that the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases recognizes that mental and neurological disorders, including Alzheimer's disease, are an important cause of morbidity and contribute to the global burden of noncommunicable diseases, for which there is a need to provide equitable access to effective programmes and health-care interventions and that these disorders are prevalent among the ageing population;

PP10 Recognizing the importance of gender-based approaches, solidarity and mutual support for social development, of the realization of the human rights of older persons, of promoting quality of life, health equity and the prevention of age discrimination, and of promoting social integration of aged citizens;

PP11 Acknowledging the Rio Political Declaration on Social Determinants of Health, which expressed the determination to achieve social and health equity through actions on the social determinants of health and well-being with a comprehensive intersectoral approach;

PP12 Noting the WHO Framework Convention on Tobacco Control and related WHO strategies and action plans, underscoring the importance of addressing common risk factors for noncommunicable diseases;

PP13 Welcoming WHO's focus on prevention and control of noncommunicable diseases through public health action, a primary health care approach and comprehensive health systems strengthening;

1. URGES Member States:

- (1) to develop and implement policies, programmes and multisectoral action on noncommunicable disease prevention and health promotion in order to strengthen healthy ageing policies and programmes and promote the highest standard of health and well-being for older persons;
- (2) to strengthen intersectoral policy frameworks and institutional mechanisms, as appropriate, for integrated management of prevention and control of noncommunicable diseases, including health care and social welfare services, in order to address the needs of older persons;

- (3) to ensure that national health strategies on noncommunicable diseases contribute to the achievement of the Millennium Development Goals;
- (4) to promote, as appropriate, conditions that enable individuals, carers, families and communities to encourage healthy ageing, including care for, provision of support to and protection of older persons, taking into account physical and psychological aspects of ageing, the special needs of older persons and the opportunities for the participation of older people in communities;
- (5) to strengthen cooperation and partnership among Member States at all levels of government, stakeholders, academia, research foundations, private sectors and civil societies in order to implement plans and programmes effectively;
- (6) to highlight the importance of a primary health care approach in national health-care planning, and of enabling integration of health promotion and prevention and control of noncommunicable diseases into ageing policies;
- (7) to encourage making available measures and resources to provide health care and social protection for healthy and active ageing, paying special attention to the importance of training, education and capacity-building of the health workforce in collaboration with WHO and partners;
- (8) to further strengthen monitoring and evaluation systems for generating and analysing data disaggregated by age and sex, including data from noncommunicable disease surveillance, with the aim of developing equitable evidence-based policies and planning for older persons;

2. REQUESTS the Director-General:

- (1) to provide support to Member States in promoting and facilitating further implementation of commitments made at relevant United Nations conferences and summits on noncommunicable diseases and ageing;
- (2) to provide support to Member States in placing emphasis on health promotion and disease prevention throughout the life-course, including multisectoral approaches to healthy ageing, integrated care for older persons and support for providers of formal and informal welfare services;
- (3) further to provide support to Member States in raising awareness of healthy and active ageing by means that include ageing-specific policies and the mainstreaming of ageing in their national strategies;
- (4) to support the advancement of country level systems for monitoring noncommunicable diseases, as appropriate, and continue to develop a comprehensive global monitoring system for prevention and control of noncommunicable diseases to track trends and monitor progress in implementation of the Political Declaration;
- (5) to raise the priority given to prevention and control of noncommunicable diseases on the agendas of relevant forums and meetings of national and international leaders in advance of a post-2015 global development agenda;
- (6) to consider focusing *The world health report 2014* on the global status of ageing, recognizing the importance of strengthening information systems through the inclusion of older adults in the collection, analysis and dissemination of data and information on health status and risk factors;
- (7) to report to the Sixty-sixth World Health Assembly, through the Executive Board, on progress made in implementing this resolution.

Dr OMI (Japan), introducing the draft resolution, said that Myanmar and the Republic of Korea had joined the sponsors. The number of people older than 60 years was set to increase to an estimated 2000 million by 2050, of whom 80% would be living in developing countries. Ageing was a major contributing factor in the rising incidence and prevalence of the noncommunicable diseases which

were the leading causes of morbidity, disability and death. Strokes, for example, which claimed more than twice as many lives in low-income and middle-income countries as in high-income countries, not only affected the persons concerned but also required financial and other support from their families. The rapid increase of strokes in all countries was alarming. It was therefore time to integrate ageing issues into noncommunicable disease policies and programmes in order to reduce the disease burden through effective prevention and control, and to promote the highest standard of health and well-being for older persons.

Mr PRASAD (India) said that the draft resolution did not appear to contain any reference to affordable medicines, an important element for active and healthy ageing. He therefore proposed insertion of a new paragraph after the fifth preambular paragraph, reading: "Noting further that the populations would require access to affordable medicines to enhance healthy ageing". He further proposed that the words "access to affordable medicines and" be inserted after "paying special attention to" in subparagraph 1(7), and addition of a new subparagraph 2(2)bis, reading: "to support the Member States in developing policies and programmes for access to affordable medicines for the ageing".

Mr MCIFF (United States of America) proposed adding a new paragraph after the seventh preambular paragraph, reading: "Noting that noncommunicable diseases become more prevalent among older persons, there is an urgent need to prevent noncommunicable-disease-related disabilities and plan for long-term care".

Dr JESSE (Estonia), speaking on behalf of the European Union and its Member States, proposed the following amendments. The words "United Nations" should be inserted before "General Assembly" throughout the document.

In the fifth preambular paragraph, the word "preventable" should be inserted before "morbidity and disability". The end of the sixth preambular paragraph should be amended to read: "... the onset and severity of noncommunicable diseases and promote healthy ageing". In the ninth preambular paragraph, the phrase "and that these disorders are prevalent among the ageing population," should be deleted from the end of the paragraph and reinserted between "noncommunicable diseases," and "for which there is a need". The twelfth preambular paragraph should be deleted, as it singled out the WHO Framework Convention on Tobacco Control when there were several relevant strategies relating to noncommunicable diseases.

The beginning of subparagraph 1(1) should be amended to read: "to develop, implement, monitor and evaluate policies, programmes ...". In subparagraph 1(2), the words "health promotion" should be inserted between "including" and "health care". The beginning of subparagraph 1(3) should be amended to read: "to ensure, where appropriate, that national health strategies ...". The end of subparagraph 1(4) should be amended to read: "psychological aspects of ageing, and to focus on intergenerational approaches". A new subparagraph 1(4)bis should be added, reading: "to encourage the active participation of older people in society and local community;". In subparagraph 1(5), the word "societies" should be changed to the singular. In subparagraph 1(6), the phrase "in close collaboration with social services," should be inserted after "planning". In subparagraph 1(7), the words "health promotion" should be inserted after "to provide". The second and third lines of subparagraph 1(8) should be amended to read: "analysing data on noncommunicable diseases disaggregated by age, sex and socioeconomic status, with the aim of ...". In subparagraph 2(3), the phrase "and on the positive aspects of ageing" should be inserted after "active ageing".

Every occurrence of the phrase "Member States" should be accompanied by a footnote, reading: "and, where applicable, regional economic integration organizations".

Mr MANCHA MOCTEZUMA (Mexico) expressed concern that the draft resolution focused exclusively on ageing populations and did not take account of the fact, reiterated in the eighth preambular paragraph of the draft resolution on follow-up to the High-level Meeting, which the Board

had just discussed, that the increasing prevalence of noncommunicable diseases affected people of all ages. Infant, young child and even maternal nutrition were, as stressed in the earlier discussions, a key means of preventing the onset of those diseases, whereas once people reached old age and the diseases had taken hold, it was too late for prevention and the policies and programmes could only cover treatment and control. He therefore suggested that the scope of the draft resolution should be widened to include all age groups and the concept of early prevention.

Dr GULLY (Canada) drew attention to the fact that the Political Declaration had highlighted population ageing as a contributing factor in the rising incidence and prevalence of those diseases. It further emphasized the links with mental and neurological disorders and suicide, which were more common among older people. Canada's efforts to promote healthy ageing included continued support for health workers to work towards the well-being of ageing populations, and implementation of the WHO Age-friendly Environments Programme in communities across the country.

Turning to the draft resolution, he said that the twelfth preambular paragraph should be retained in its original form, as the wording was intended to single out a major aspect of noncommunicable disease control, namely tobacco control.

Dr OMI (Japan), expressing concern that the proposed amendment to subparagraph 1(4) might undermine the aim of providing support for the special needs of older persons, requested the member for Estonia to consider revising the proposed amendment.

Dr JESSE (Estonia), speaking on behalf of the European Union, agreed to withdraw the proposal to delete the twelfth preambular paragraph but said that she could not agree to alter the amendment to subparagraph 1(4) without consulting the other members of her regional group.

Responding to an amendment to the ninth preambular paragraph proposed by Mr MANCHA MOCTEZUMA (Mexico), the DIRECTOR-GENERAL said that the Board might wish to use the following wording at the end of the paragraph: "and contribute to the global burden of noncommunicable diseases, and that these disorders are prevalent among the ageing population, for which there is a need to provide equitable access to effective programmes and health-care interventions to all the younger age groups in the population".

Dr OMI (Japan), in order further to emphasize the point made by the member for Mexico, suggested inserting the phrase "starting at the earliest stage possible" after the words "throughout the life-course" in subparagraph 2(2).

Ms PATTERSON (Australia)¹ asked for her country to be included as a sponsor of the draft resolution.

The CHAIRMAN, in the absence of any objection, took it that the Board wished to adopt the draft resolution, as amended.

The resolution, as amended, was adopted.²

The meeting rose at 17:35.

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

² Resolution EB130.R6.

NINTH MEETING

Friday, 20 January 2012, at 09:15

Chairman: Dr S. OMI (Japan)

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

Prevention and control of noncommunicable diseases: Item 6.1 of the Agenda (continued)

- **Outcomes of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control** (Document EB130/6) (continued from the eighth meeting)

The CHAIRMAN drew attention to a revised version of the draft resolution on prevention and control of noncommunicable diseases proposed by Australia, Barbados, Canada, Costa Rica, Kenya, Norway, Russian Federation, Switzerland and the United States of America, which read:

The Executive Board,

PP1 Having considered the reports on prevention and control of noncommunicable diseases: outcomes of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases and the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control¹ and on implementation of the global strategy for the prevention and control of noncommunicable diseases and the action plan;²

PP2 Recalling the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases,³ the Moscow Declaration adopted at the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control, and resolution WHA64.11 of the World Health Assembly;

PP3 Acknowledging the Rio Political Declaration on Social Determinants of Health, adopted by the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, 21 October 2011), which expressed the determination to achieve social and health equity through action on the social determinants of health and well-being by a comprehensive intersectoral approach;

PP4 Reaffirming the leading role of WHO as the primary specialized agency for health and its leadership and coordination role in promoting and monitoring global action against noncommunicable diseases (as described in paragraphs 13 and 46 of the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases);

PP5 Reaffirming the central role of WHO recognized in the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of

¹ Document EB130/6.

² Document EB130/7.

³ Resolution 66/2.

Non-communicable Diseases for monitoring and evaluation and guiding multisectoral engagement;

PP6 Recognizing in particular the call made in the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases (paragraphs 61 and 62) to develop a comprehensive global monitoring framework, including a set of indicators, capable of application across regional and country settings, and to develop recommendations for a set of voluntary global targets for the prevention and control of noncommunicable diseases, and to complete this work before the end of 2012;

PP7 Recalling resolution WHA61.14, which endorsed the 2008–2013 action plan for the global strategy for the prevention and control of noncommunicable diseases, and recognizing the progress made under the action plan up till now;

PP8 Reiterating the concern that the rapidly growing magnitude of noncommunicable diseases affects people of all ages, gender, race and income levels, and further that poor populations and those living in vulnerable situations, in particular in developing countries, bear a disproportionate burden and that noncommunicable diseases can affect women and men differently;

PP9 Noting with concern the growing double burden of communicable and noncommunicable diseases in Africa, and the need for integrated approaches to their prevention and control;

PP10 Noting with concern that an estimated 36 million of the 57 million deaths in the world in 2008 were due to noncommunicable diseases such as cardiovascular diseases, cancers, chronic respiratory diseases and diabetes, and that nearly 80% of those deaths occurred in developing countries,

1. URGES Member States:

(1) to implement the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases;

(2) to draw upon, based on national contexts, the policies, strategies, programmes and interventions and tools recommended by WHO in order to, in accordance with paragraph 45 of the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, promote, establish or support and strengthen, by 2013, as appropriate, multisectoral national policies and plans for the prevention and control of noncommunicable diseases;

(3) to strengthen their commitment to implementing noncommunicable disease programmes in accordance with national priorities, including increased efforts on prevention, diagnostics and treatment and to take steps to accelerate health-related donor harmonization and adherence to aid effectiveness principles, bearing in mind the growing concern about the double burden of communicable and noncommunicable disease in many countries and the need for an integrated response;

(4) to participate fully in the WHO-led process of developing a comprehensive global monitoring framework, including a set of indicators, capable of application across regional and country settings, and of developing recommendations for a set of voluntary global targets for the prevention and control of noncommunicable diseases before the end of 2012, and to consider incorporating elements of this work into national planning exercises at the earliest opportunity in accordance with national priorities;

2. REQUESTS the Director-General:

(1) to continue in an inclusive and transparent manner, the process under way to develop, in accordance with paragraphs 61 and 62 of the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and

Control of Non-communicable Diseases, a comprehensive global monitoring framework, including a set of indicators, capable of application across regional and country settings, and to develop recommendations for a set of voluntary global targets for the prevention and control of noncommunicable diseases, and to complete this work by the end of 2012, building on the outcomes of the consultation with Member States and organizations in the United Nations system (held on 9 January 2012), as follows:

- (a) by the end of January the Secretariat will provide Member States with additional information requested at that consultation;
 - (b) by ~~15 February~~ **the end of February 2012 [ESTONIA]**, a web-based consultation on a draft framework and indicators and targets will close, following which WHO will revise the draft documents for step (c);
 - (c) ~~by end March~~ **before the Sixty-fifth World Health Assembly [ESTONIA]**, a second Member State consultation on the framework and indicators and targets will be held;
 - (d) as part of this process, the Secretariat should also hold consultations with all interested stakeholders;
 - (e) submit a substantive progress report **on the development of a framework [ESTONIA]**, including ~~initial~~ **a set of [ESTONIA]** indicators and targets, to the Sixty-fifth World Health Assembly for consideration;
 - (f) regional consultations will provide further input into the framework/target process as part of their broader discussions on implementation of the Political Declaration;
 - ~~(g) second half of 2012 the Secretariat will hold a Member State consultation to finalize work on the draft framework and targets; [ESTONIA]~~
 - ~~(h) submit the package of recommendations relating to paragraphs 61 and 62 of the Political Declaration through the Executive Board at its 132nd session to the Sixty-sixth World Health Assembly for consideration; [ESTONIA]~~
 - ~~(g) adopt complete [SWITZERLAND] the work on the global monitoring framework, including a set of indicators and targets, in based on [SWITZERLAND] a Member State consultation held before the end of 2012; [ESTONIA]~~
 - (h) submit the package of report on the [SWITZERLAND] recommendations relating to paragraphs 61 and 62 of the Political Declaration through the Executive Board at its 132nd session to the Sixty-sixth World Health Assembly for consideration;
- (2) to develop, in a consultative manner, WHO's input, called for in paragraph 64 of the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases concerning options for strengthening and facilitating multisectoral action for the prevention and control of noncommunicable diseases through effective **and transparent [TIMOR LESTE] partnership, while safeguarding public health from any potential conflict of interest, [TIMOR LESTE]** and submit it to the Secretary-General by the end of 2012;
 - (3) to submit a progress report and a timeline for WHO's input on options for strengthening and facilitating multisectoral action for the prevention and control of noncommunicable diseases through effective partnership to the Sixty-fifth World Health Assembly;
 - (4) to develop, in a consultative manner, a WHO action plan for the prevention and control of noncommunicable diseases for 2013–2020, building on lessons learnt from the 2008–2013 action plan and taking into account the outcomes of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases, the Moscow Declaration on Healthy Lifestyles and Non-communicable Disease Control, the Rio Declaration on Social Determinants of Health, ~~and WHO's ongoing reform~~

building on and being consistent with existing WHO strategies and tools on tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity [ESTONIA];

(5) to build on work from the 2008–2013 action plan, which, inter alia, called for WHO to provide support to countries in enhancing access to essential medicines, to facilitate engagement by governments and **as appropriate civil society and [TIMOR LESTE] the private sector with appropriate safeguards against conflict of interest [FRANCE]**, in accordance with relevant paragraphs of the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, for improved access to medicines;

(6) to submit to the Sixty-sixth World Health Assembly, through the Executive Board, a WHO action plan for the prevention and control of noncommunicable diseases for 2013–2020 for consideration and possible adoption.

The financial and administrative implications for the Secretariat of the draft resolution introduced at the Board's eighth meeting remained unchanged.

Dr JESSE (Estonia), speaking on behalf of the European Union, said that the amendments proposed by the member for Switzerland were acceptable. She proposed two additional amendments: the words "for consideration" should be deleted from subparagraph 2(h), and wherever reference was made to Member States, a footnote should be inserted referring "and, where appropriate, to regional economic integration organizations".

The CHAIRMAN took it that the Board agreed to adopt the draft resolution, as amended.

The resolution, as amended, was adopted.¹

- **Implementation of the action plan for the prevention of avoidable blindness and visual impairment** (Document EB130/8)

Mr TOSCANO VELASCO (Mexico) said that significant progress had been made in preventing avoidable blindness and visual impairment, yet the prevalence of both remained high, often as a result of lack of political awareness of the problem, human resources or eye-care services. He advocated a multidimensional, intersectoral approach to blindness and visual impairment that drew on work done at national and international levels on noncommunicable diseases and social determinants of health. His Government looked forward to receiving the findings of the research project on the prevalence, risk factors and repercussions of uncorrected refractive errors. It would be useful also to have information on the proportion of the population with refractive errors that had access to corrective lenses.

Given the scale of the problem, which could be expected to grow owing to the increase in noncommunicable diseases, a new action plan should be developed for 2014–2019, as the current plan would end in 2013. He therefore proposed that the Board consider the following draft decision:

The Executive Board,

Having considered the report on progress in implementing the action plan for the prevention of avoidable blindness and visual impairment;

Noting that the current action plan will end in 2013, and being convinced that work should commence now on a follow-up plan for the period 2014–2019 to ensure that it can be considered for adoption in a timely way and in alignment with WHO's planning cycles;

¹ Resolution EB130.R7.

Decides that a new action plan for the prevention of avoidable blindness and visual impairment for the period 2014–2019 be developed;

Requests the Director-General to develop a draft action plan for the prevention of avoidable blindness and visual impairment for the period 2014–2019 in close consultation with Member States and international partners, and to submit this draft action plan to the Sixty-sixth World Health Assembly in 2013 for consideration, through the Executive Board at its 132nd session.

Mr BENMAMOUN (Morocco) said that many challenges remained in the implementation of the plan of action, particularly with respect to surveillance; community-based screening and treatment services, especially for cataract; strengthening of public–private partnerships; and certification of the elimination of blinding trachoma. He supported the draft decision. The Board must consider what actions were to be taken after the current action plan came to an end in 2013, and work should begin on a new action plan for the period 2014–2019, which should be coordinated with other initiatives, particularly the action plan for the global strategy for the prevention and control of noncommunicable diseases. He called for more involvement by Member States and international organizations to consolidate the progress made and fight the causes of avoidable blindness and visual impairment, particularly in low-income countries.

Mr SHUKLA (India) said that, among the activities needed to overcome challenges in preventing avoidable blindness and visual impairment, integrating eye care into broader health plans was particularly important, given the increase in chronic, noncommunicable eye conditions. The report listed several obstacles to implementation of the action plan, but did not indicate what had been done to tackle them, such as increasing human resources, integrating eye care into health development plans or prioritizing action to tackle risk factors. As the current action plan would end in 2013, it was essential to draft a new plan for submission to the Sixty-sixth World Health Assembly.

Dr LEI Zhenglong (China) expressed concern at the slow progress in implementing some aspects of the action plan. Concerted action was needed by Member States and the Secretariat in order to implement the plan fully. Efforts should focus on preventing avoidable blindness among infants and children; furthering cooperation with nongovernmental organizations and enhancing support from the international community; and ensuring the availability of eye care within countries' basic health services. The Secretariat should intensify its support for prevention and control of avoidable blindness and visual impairment in developing countries through epidemiological studies, information systems development and professional training.

Dr GULLY (Canada), welcoming the work undertaken on the five objectives of the action plan, said that most cases of vision loss in his country were caused by factors linked to ageing, although diabetic retinopathy accounted for 2% of the total. His Government's approach to the problem was therefore anchored in health promotion and disease prevention, with the aim of reducing disability. Assuming that a new action plan for 2014–2019 could be developed with WHO's existing resources, he supported the draft decision. It was important to recognize the economic burden caused by avoidable blindness in developing countries. The new plan should take account of the Secretariat's existing programmes on health system strengthening and the supply of clean water, which might contribute to global efforts to reduce avoidable blindness.

Dr DAULAIRE (United States of America) also welcomed efforts by the Secretariat and international partners to implement the action plan, particularly activities to improve data collection and surveillance and expand research globally. Those activities would provide the crucial information needed to assess the disease burden borne by Member States. The Secretariat should encourage the provision of vision care that reflected the disease burden of individual Member States and was fully integrated into health-care systems. Awareness must be raised among the public and health-care

providers about how to prevent and detect various types of blindness and visual impairment, and how to identify causes and comorbidities. He supported the development of a new action plan for 2014–2019. Avoidable blindness and visual impairment were major public health issues, and the work of WHO through initiatives such as VISION 2020 and the Alliance for Global Elimination of Trachoma by the year 2020 should continue.

Ms BULLINGER (Switzerland) observed that some States had made a commendable political commitment to invest in improving eye health, but lack of resources and investment had delayed implementation of the action plan in some low- and middle-income countries. Although the overall prevalence of blindness was decreasing, the proportion of avoidable blindness was still high. More must be done if the action plan was to be fully implemented before 2013. Even so, visual impairment would remain a major public health challenge, and she therefore supported the draft decision. The Secretariat should draft the proposed new action plan in close collaboration with Member States and international partners. It should be based on experience and be closely linked to activities on noncommunicable disease and social determinants of health.

Dr ABDI (Somalia), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that, despite some progress, eye care had not yet become an integral part of health-care systems, nor had eye health been sufficiently integrated at all levels of health-care delivery, particularly in primary health care and health financing. In order to make further progress in preventing avoidable blindness, Member States, the Secretariat and other stakeholders should mobilize additional resources for eye health and blindness prevention; strengthen and integrate eye health services at all levels of the health system; strengthen policies and develop and implement comprehensive eye-care plans; reinforce monitoring and evaluation systems and link them with the health and development agendas; and promote and expand partnerships between the public and private sectors, nongovernmental organizations and others in the field of eye health and blindness prevention. He supported the preparation of an action plan for 2014–2019.

Dr DE ASSUNÇÃO SAÍDE (Mozambique), speaking on behalf of the Member States of the African Region, commented that visual impairment and avoidable blindness remained a major public health issue in the Region and had a great impact on social and economic development. He supported the draft decision.

Dr SHEKU DAOH (Sierra Leone), expressing support for the draft decision, agreed that blindness and visual impairment were a serious global public health issue. The action plan had been implemented to some extent, but many challenges had arisen. More donor commitment and a new action plan for 2014–2019 were needed.

Mr TOSCANO VELASCO (Mexico) said that Australia, China, Costa Rica, Germany, India, Papua New Guinea, Somalia and Thailand also wished to sponsor the draft decision, and he expressed appreciation to those who had supported it.

Ms PATTERSON (Australia),¹ welcoming the report, affirmed that eye health and vision care were important priorities for her Government.

The CHAIRMAN took it that the Board wished to take note of the report and adopt the draft decision proposed by the member for Mexico.

It was so agreed.

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

The decision was adopted.¹

Nutrition: Item 6.3 of the Agenda (continued)

- **Maternal, infant and young child nutrition: draft comprehensive implementation plan**
(Document EB130/10) (continued from the second meeting, section 2)

The CHAIRMAN drew attention to a draft resolution on maternal, infant and young child nutrition: draft comprehensive implementation plan, proposed by Chile, Ecuador, Peru and Poland, which read:

The Executive Board,

Having considered the report on maternal, infant and young child nutrition: draft comprehensive implementation plan,² as well as the report on nutrition of women in the preconception period, during pregnancy and the breastfeeding period,³

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

The Sixty-fifth World Health Assembly,

PP1 Having considered the report on maternal, infant and young child nutrition: draft comprehensive implementation plan, as well as the report on nutrition of women in the preconception period, during pregnancy and breastfeeding;

PP2 Recalling resolutions WHA30.51 and WHA31.47 on the role of the health sector in the development of national and international food and nutrition policies and plans; WHA46.7 on the follow-up action to the International Conference on Nutrition; WHA35.26, WHA37.30, WHA39.28, WHA41.11, WHA43.3, WHA44.33, WHA45.34, WHA46.7, WHA47.5, WHA49.15, WHA54.2, WHA55.25, WHA58.32, WHA59.21, WHA61.20 and WHA63.23 on infant and young child nutrition; and WHA46.7 and WHA59.11 on nutrition and HIV/AIDS;

PP3 Conscious that poor availability of, or access to, food of adequate nutritional quality or the exposure to conditions that impair absorption and use of nutrients has led to large sections of the world's population being undernourished, having poor vitamin and mineral status or being overweight and obese;

PP4 Aware that anaemia, mainly due to iron deficiency, affects 468 million women of reproductive age, also that 20 million children are born annually with low birth weight, 171 million children under the age of five years had stunted growth and 43 million children younger than five years were overweight globally in 2010;

PP5 Concerned that maternal and child undernutrition account for 11% of the global burden of disease and has a negative impact on cognitive development, school and physical performance and productivity;

PP6 Convinced of the impact of a well-balanced and culturally acceptable women's diet before conception, during pregnancy and breastfeeding, supplying a sufficient amount of energy, protein and vitamins, as well as micro- and macro-nutrients (e.g. iron, iodine, calcium and vitamin D) on the life and health of both mothers and

¹ Decision EB130(1).

² Document EB130/10.

³ Document EB130/11.

children;

PP7 Conscious that improper nutrition before conception may cause pregnancy disorders, contribute to the risk of several diseases, and exert a direct influence on child mortality and morbidity, and aware that taking folic acid in the pre- and peri-conception period plays a significant role in protection against congenital malformations, including neural tube defects in newborns;

PP8 Convinced of the need to eliminate use of alcohol, tobacco and psychotropic substances, and to control better the intake of medicines in pregnant women, as they may increase the risk of low birth weight, congenital malformations or miscarriage and increase morbidity in children;

PP9 Mindful that breastfeeding is the best source of nutrition for infants in the first six months of life and a major contribution for proper health and development for up to two years of age and beyond, as well as that appropriate nutrition in the first years of life has a significant influence on health and intellectual development at subsequent development stages;

PP10 Recognizing that policies often do not address the complexity of the challenges of maternal, infant and young child nutrition and do not produce the expected impact;

PP11 Recognizing that effective policies and programmes on nutrition exist but are not implemented on a sufficiently large scale;

1. ENDORSES the comprehensive implementation plan on maternal, infant and young child nutrition;
2. URGES Member States:
 - (1) to develop national targets and to commit resources in order to achieve, by the year 2022:¹
 - (a) a 40% reduction in the prevalence of stunting in children under the age of five years globally;
 - (b) a 50% reduction in the prevalence of anaemia in women of reproductive age globally;
 - (c) a 50% reduction in the prevalence of low birth weight globally;
 - (d) no further increase in the prevalence of childhood overweight;
 - (e) an increase in exclusive breastfeeding rates of infants under the age of six months to 50% at global level;
 - (2) to put into practice the comprehensive implementation plan on maternal, infant and young child nutrition and, in particular:
 - (a) to revise nutrition policies to include nutrition actions in the overall country health and development policy and establish effective intersectoral governance mechanisms in order to expand the implementation of nutrition actions;
 - (b) to review sectoral policies in the agriculture, social welfare, education and trade sectors in order to determine their impact on nutrition;
 - (c) to include effective and safe nutrition actions in maternal, child and adolescent health services and ensure universal coverage of these actions, particularly to underprivileged populations;
 - (d) to develop or strengthen legislative measures for controlling the marketing of breast-milk substitutes;

¹ From 2010 baseline data.

- (e) to implement a comprehensive approach to enhancing the capabilities of health workers and managers to deliver nutrition actions;
- (f) to implement sustainable financing mechanisms for funding the expansion and the sustained implementation of nutrition programmes;
- (g) to develop or strengthen surveillance systems for the collection of information on indicators of inputs, outputs and outcomes, and impact of nutrition actions;

3. REQUESTS the Director-General:

- (1) to review, update and expand WHO's guidance and tools on effective nutrition actions, analyse their cost-effectiveness, illustrate good practice of delivery mechanisms and adequately disseminate the information;
- (2) to develop guidance and describe successful examples of multisectoral policy measures on nutrition;
- (3) to support Member States, on request, in strengthening national health and development policies that include proven nutrition actions; developing technical and managerial capacities and capabilities in nutrition; strengthening legislative, regulatory or other effective measures to control the marketing of breast-milk substitutes and monitoring their implementation;
- (4) to develop guidelines on the marketing of complementary foods;
- (5) to engage with multiple partners at global and country levels for expanding nutrition actions;
- (6) to report to the Health Assembly, through the Executive Board, in even-numbered years on progress in applying the comprehensive implementation plan on maternal, infant and young child nutrition, together with the report on progress in implementing the Code of Marketing Breast-milk Substitutes.

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

1. Resolution: Maternal, infant and young child nutrition: draft comprehensive implementation plan	
2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)	
Strategic objective(s): 9	Organization-wide expected result(s): 9.1, 9.2, 9.3 and 9.4
How would this resolution contribute to the achievement of the Organization-wide expected result(s)?	
The resolution would: support Member States' commitment to nutrition in collaboration with several partners, with clearly measurable targets (see indicators 9.1.1 and 9.1.2); highlight the need to implement evidence-based interventions (Organization-wide expected result 9.2); identify specific areas for prioritization and scaling up in the health sector (Organization-wide expected result 9.4); and clarify reporting requirements and stimulate better surveillance (Organization-wide expected result 9.3).	
Does the programme budget already include the products or services requested in this resolution? (Yes/no)	
Yes, most of the products are already included.	
3. Estimated cost and staffing implications in relation to the Programme budget	
(a) Total cost	
Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).	
(i) 10 years (covering the period 2012–2021)	
(ii) Total: US\$ 32.4 million (staff: US\$ 23.9 million; activities: US\$ 8.5 million)	

(b) Cost for the biennium 2012–2013

Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000).

Total: US\$ 8.28 million (staff: US\$ 4.78 million; activities: US\$ 3.5 million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

Headquarters: US\$ 1.07 million (staff); US\$ 1.2 million (activities)

Regional offices/country offices: US\$ 3.71 million (staff); US\$ 2.3 million (activities).

Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

No

If “no”, indicate how much is not included.

Although the implementation of the comprehensive implementation plan on maternal, infant and young child nutrition is already included in the approved Programme budget, the resolution calls for further action by the Secretariat in two areas:

- (a) the development of guidance on multisectoral policy measures on nutrition;
- (b) the development of guidelines on the marketing of complementary foods.

The cost of such additional activities would amount to approximately US\$ 600 000, which would require an increase in the approved Programme budget. Otherwise, it might be possible to accommodate the cost if other activities were suppressed or delayed, such as the work on nutrition in emergencies.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

Although most of the Secretariat activities requested by the resolution can be implemented by current staff, the provision of support to Member States in strengthening national health and development policies that include proven nutrition actions would require additional human resources in the regional offices. In particular, two additional staff members in the professional and higher categories would be needed in the Regional Office for Africa (one at grade P.4 and one at grade P.3) and one additional staff member per region in the regional offices for the Americas, South-East Asia and the Western Pacific (all at grade P.3). These extra staff members are not included in the above costing. They would be sought through reprogramming in regional and country offices.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

No

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

For the biennium 2012–2013, US\$ 4.6 million are available for the implementation of the resolution, as part of currently available resources. Additional funding of US\$ 3.68 million would need to be secured through active fundraising.

He also drew attention to a draft decision on the same subject proposed by Canada, Chile, Ecuador, Peru and Poland, which read:

The Executive Board,

Having considered the report on maternal, infant and young child nutrition: draft comprehensive implementation plan,¹ as well as the report on nutrition of women in the preconception period, during pregnancy and the breastfeeding period,² expressing appreciation for the work completed to date, and noting the draft resolution contained in document EB130/Conf.Paper No. 4,

1. Requests the Secretariat to conduct, as soon as possible, further consultations regarding the targets within the existing draft comprehensive implementation plan via a web-based process open to all Member States,³ as well as multilateral organizations, to provide further guidance in the finalization of the comprehensive implementation plan;
2. Decides that the Secretariat should finalize the implementation plan on maternal, infant and young child nutrition in time for consideration, as set forth in resolution WHA63.23, by the Sixty-fifth World Health Assembly in May 2012;
3. Encourages informal consultations among Member States on the basis of the draft resolution contained in document EB130/Conf.Paper No.4 proposing the endorsement of the comprehensive implementation plan at the Sixty-fifth World Health Assembly.

At the request of Mr ESPINOSA SALAS (Ecuador), the CHAIRMAN invited the representative of Peru to explain why the draft decision was being proposed.

Mr WIELAND (Peru)⁴ said that it was clear from the Board's earlier discussion of the matter that the draft comprehensive implementation plan on maternal, infant and young child nutrition, contained in Annex 1 to document EB130/10, required further work. It was therefore proposed that the Board should, by means of the draft decision, request the Secretariat to undertake further consultations with the aim of finalizing the comprehensive implementation plan in time for consideration by the Sixty-fifth World Health Assembly.

The CHAIRMAN took it that the draft resolution had been withdrawn and that the Board wished to adopt the draft decision.

The decision was adopted.⁵

Implementation of the International Health Regulations (2005): Item 6.7 of the Agenda (Document EB130/16)

Dr DAULAIRE (United States of America), noting that 2012 was the deadline for all countries to have in place the national core capacities set out in Annex 1 to the International Health Regulations

¹ Document EB130/10.

² Document EB130/11.

³ And, where applicable, regional economic integration organizations.

⁴ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

⁵ Decision EB130(2).

(2005), observed that much remained to be done as many countries were likely to miss the deadline. His Government stood ready to assist the Secretariat, the regional offices and other Member States in filling critical gaps, and would work closely with the Secretariat and other international partners to enhance the global community's preparedness for and response to international health threats, regardless of origin or source.

The Board should reiterate the importance of the Regulations and of making good shortfalls in capacity as quickly as possible. As the Regulations were one of the few WHO instruments considered as legally binding, their timely implementation was fundamental to the Organization's credibility. He requested the Secretariat to prepare a report for submission to the Sixty-fifth World Health Assembly, providing an update on progress towards compliance with the Regulations, an analysis of the factors that appeared to be hindering countries from meeting their obligations, and recommendations for support that WHO could provide in that regard.

Complete, universal and timely implementation of the Regulations required the collaboration and assistance outlined in Article 44 thereof, and he encouraged the Secretariat to continue to work closely with States Parties to identify areas of need and opportunities to address them. The Secretariat should also work with States Parties to enhance information-sharing systems, such as the Event Information Site for IHR National Focal Points, and ensure the continued security of the portal. All States Parties must meet their obligations by openly and transparently sharing information about public health emergencies of international concern. His country had done so, having reported several relevant events to WHO.

Dr AL-HALKI (Syrian Arab Republic), speaking on behalf of the Member States of the Eastern Mediterranean Region, noted with appreciation the application of the Regulations in the context of the recent nuclear emergency in Japan and the close cooperation between WHO and IAEA, supported by the Radiation Emergency Medical Preparedness and Assistance Network. Implementation of the Regulations was the shared responsibility of States Parties and partners; with global health security and the protection of threatened economic interests at stake, there was no room for lessening transparency in the notification of health emergencies.

Ensuring the technical capacity needed to implement the Regulations and the recommendations of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009 was a challenge that demanded time, commitment and a desire for change. Notwithstanding the support provided by the Secretariat, some Member States in the Region would be unable to meet the mid-2012 deadline for fulfilling the requirements set out in the Regulations, and would be requesting a two-year extension. Urgent measures were needed to promote full compliance with the core capacity requirements.

Dr BIRINTANYA (Burundi), speaking on behalf of the Member States of the African Region, said that the Regulations had strengthened solidarity among countries and were an important tool in a world where global public health emergencies were becoming more frequent. Core capacities were being assessed in the Region with a harmonized evaluation tool; the assessment would be completed by June 2012. National IHR focal points were available round the clock in 35 Member States, and points of entry had been designated for surveillance purposes in 19 countries. Most countries of the Region had action plans for implementation of the Regulations and for integrated disease surveillance and response. Training on various aspects of the Regulations was being provided, and simulation exercises had been organized in most Member States.

Nevertheless, challenges remained, particularly with regard to annual reporting obligations, mobilization of sufficient funds for implementation, and strengthening of intersectoral collaboration. As the 2012 deadline would not be met, he suggested that implementation levels should be assessed in order to determine by how long the deadline would need to be extended to ensure that all countries could comply with the Regulations.

Dr JESSE (Estonia), speaking on behalf of the European Union and its Member States, said that the acceding State Croatia, the candidate countries Turkey, the former Yugoslav Republic of Macedonia, Montenegro and Iceland, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, and Serbia, together with Ukraine and Armenia, aligned themselves with her statement. The European Union and its Member States were strongly committed to the Regulations as a comprehensive instrument for responding to international health threats. The European Union was considering a revision of its legislation on serious cross-border health threats, with the aim of improving coordinated responses.

As numerous countries were likely to apply for an extension of the implementation deadline, she underlined the concerns expressed in the report about the need for improved human resources capacity at points of entry and better responses to biological, chemical and radiological threats.

In 2011, the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009 had concluded that the world was ill-prepared to respond to a severe influenza pandemic or to any similar global public-health emergency. She therefore welcomed the adoption of the Pandemic Influenza Preparedness Framework and endorsed the Review Committee's recommendations on implementation of the Regulations and ensuring authority and resources for national IHR focal points. Transparent procedures and rapid information-sharing among focal points, WHO and other international organizations involved in the response to public health alerts were central to effective monitoring, assessment and management of health events.

The Secretariat should strengthen its direct support to States Parties by providing guidance to facilitate compliance with core capacity requirements. The activities of the International Health Regulations Coordination WHO Lyon Office were crucial in that regard, as was collaboration with other agencies and organizations working to strengthen national surveillance and response systems. Certification guidelines for airports and ports under Article 20.5 should be finalized and published as soon as possible in order to clarify the criteria and procedure for certification. WHO had an essential role in coordinating responses to health threats. She welcomed the Organization's cooperation with IAEA, particularly after the nuclear accident at Fukushima, Japan, in March 2011, and its collaboration with OIE and FAO to tackle health risks at the human-animal-ecosystem interface. Although WHO would be occupied with reform over the coming months, the Secretariat should remain focused on supporting States Parties in the implementation of the Regulations.

Professor PRASAD (India) said that his country would be unable to develop the required core capacities by the mid-2012 deadline. Most other countries in the South-East Asia Region would also be seeking an extension until June 2014. He asked the Director-General to facilitate assessment of national core capacities and support national implementation plans. It was also important to develop complementary regional plans in order to support the establishment of core capacities at national level, and for mechanisms to be introduced for intercountry support for implementation of the Regulations, including twinning arrangements for voluntary peer review, study tours, sharing of best practice and information, and risk communication and outbreak response. Support should also be provided for resource mobilization, including contingency funds to support emergency responses to public health emergencies. India had submitted its self-assessment questionnaire on implementation of the Regulations to the Secretariat.

Ms BONNIN (France), observing that implementation of the Regulations remained a work in progress, underlined the Secretariat's important role in enabling States Parties to meet their obligations. More detailed information on regional and international activities under way and additional technical documents on topics such as vector control and quarantine would be useful. The interpretation of Article 20 of the Regulations should be clarified to distinguish between ports that were designated points of entry, and therefore had the capacity required to deal with public health emergencies of international concern, and ports that were authorized to issue ship sanitation certificates, which was a routine health security activity. It was important for WHO to continue its

efforts with other international organizations to ensure the inclusion of provisions on points of entry, *free pratique* and sanctions in relevant international agreements.

Mr YUSOF (Brunei Darussalam) said that the previous year had demonstrated the importance of the Regulations in protecting public health, not only from pandemic and communicable diseases, but also from chemical and radiological hazards and emergencies. The Secretariat should continue to support States Parties in addressing the latter hazards, particularly those with few nuclear facilities, which therefore might lack relevant capabilities. Some countries would not meet all core capacity requirements before the 2012 deadline, and a two-year extension might not be sufficient. The Secretariat should therefore consider granting longer extensions.

Dr TAKEI (Japan) asked how the Secretariat planned to strengthen support and technical guidance for States Parties that requested an extension of the 2012 deadline, particularly in the area of core capacities to respond to chemical or radiological emergencies. His Government stood ready to cooperate with the Secretariat in that regard. The definition of “core capacity” in the Regulations should be clarified, and the Secretariat should consider preparing a checklist for the capacities set out in Annex 1 of the Regulations. Recalling that lack of a legal framework had been identified as a weakness of the Regulations, he sought the Secretariat’s views on that topic.

Dr PHILLIPS (Barbados), noting that his country had received assistance from ICAO in ensuring that airports designated as points of entry met the core capacity requirements, encouraged further collaboration between ICAO and WHO on improving public health emergency responses in the aviation sector. The experience of preparing for and hosting mass events such as the 2007 Cricket World Cup had proved beneficial, having allowed systems needed to meet core capacity requirements to be developed and tested. His country intended to implement the Regulations fully.

He expressed appreciation to the Regional Office for the Americas for providing technical advice to the countries of the Caribbean Community for the development of legal instruments to support implementation of the Regulations. Barbados had seconded two officers to the PAHO office for the Eastern Caribbean countries as its contribution to the strengthening of port health capacity in neighbouring islands.

Noting that only 60% of States Parties had reported in time for information to be included in the Secretariat’s report, he encouraged all States Parties to continue to engage in the implementation process and to take full advantage of the resources available to support them for that purpose. The regional offices should respond to the concerns expressed by various Members.

Ms MI Yanping (China) welcomed efforts to implement the Regulations, which had left States Parties better able to respond to international public health emergencies. China had made significant progress in establishing core capacities, but numerous countries would not be able to meet the 2012 deadline. The Secretariat should support countries in developing local tools for measuring and evaluating core capacities and should consider establishing minimum yearly scores for rating countries’ progress in establishing core capacities as a means of encouraging them to meet their obligations.

Mr DÍAZ ANAIZ (Chile) said that his Government was striving to identify human, financial and other resources in the health sector to improve surveillance and response capacities at designated points of entry. It assessed the capabilities of its National IHR Focal Point and identified areas for improvement in the development of contingency plans. Chile currently had 90% of the core capacities in place and therefore would not request an extension of the implementation deadline. It remained committed to global health security and would continue working to meet the challenges of implementing the Regulations.

Dr GULLY (Canada), noting that Canada had met the core capacity requirements of the Regulations, enquired how the Secretariat planned to encourage more States Parties to meet their obligations by the mid-2012 deadline, which was fast approaching. As reporting was crucial for assessing shortcomings and identifying where efforts should be concentrated, he also asked what mechanisms were in place to improve reporting rates and whether other tools existed for identifying priority areas for improvement. He endorsed the request by the member for the United States of America for a progress report, in which his questions could also be addressed.

Mr BENMAMOUN (Morocco) observed that the implementation of the Regulations had provided an opportunity for many countries to restructure their systems for detecting, verifying, assessing, notifying and responding to public health emergencies and other health events. Pandemic (H1N1) 2009 had also afforded an opportunity to enhance response capacity. His Government had taken the necessary measures to improve its core surveillance and response capacities. The Secretariat's report indicated that most countries had made progress in that regard since 2010, although, given the socioeconomic variations between States, differences in how they approached their obligations under the Regulations were to be expected. Moreover, the scores shown in the report were based on self-assessment, which was highly subjective. Continued technical and financial support was needed to strengthen countries' capacities. A global fund should be established for that purpose.

Mr MANCHA MOCTEZUMA (Mexico) reported that his country had taken many steps to implement the Regulations by the 2012 deadline, including strengthening its epidemiological surveillance and information system and enhancing its capacity to identify risk events and better target interventions. It had hosted international meetings on the subject, including one on the human–animal–ecosystem interface, which was an issue of concern in view of the high proportion of emerging diseases that were zoonotic. His Government had notified WHO of several health events, as provided in the Regulations, and had responded fully and promptly to requests for information. He joined other speakers in requesting the Secretariat to support States Parties in assessing their progress towards, and identifying obstacles to, full implementation of the Regulations.

Dr MEMISH (Saudi Arabia)¹ said that Saudi Arabia, which annually hosted mass gatherings, attached high priority to efforts to enhance core capacities under the Regulations and welcomed WHO's work to that end. His Government would continue to collaborate with headquarters, the Regional Office for the Eastern Mediterranean and other Member States to support the strengthening of core capacities in relation to mass gatherings.

Ms PATTERSON (Australia),¹ reaffirming her country's strong commitment to implementation of the Regulations, expressed support for the request by the member for the United States of America for a report to be submitted to the Sixty-fifth World Health Assembly, providing additional detail on progress and obstacles in implementation and outlining action to be taken by the Secretariat to support countries in complying with their obligations under the Regulations.

Dr ATTAYA LIMWATTANAYINGYONG (Thailand)¹ said that, despite commendable work to strengthen national capacities, challenges to full implementation of the Regulations remained, principally the lack of adequate human and financial resources for national programme management. In addition to timely communication between national IHR focal points, prompt and adequate information-sharing among IHR structures at all levels was important for the control of global outbreaks of disease. Her Government supported the establishment of trust-based horizontal regional networks, and urged the Secretariat and the regional and country offices to collaborate closely with

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

such networks, which could assist in collective capacity-building through South–South collaboration and could serve as a complement to slow-moving official bureaucratic mechanisms.

Dr DAHL-REGIS (Bahamas)¹ said that her country had benefited greatly from technical support from WHO (headquarters and PAHO), but that it would still face challenges in meeting the 2012 deadline. She took note of the offer of assistance made by the member for the United States of America, particularly for responding to public health threats and emergencies of a chemical or radiological nature. Her Government intended to enact appropriate legislation to implement the Regulations.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland)¹ expressed concern at the number of countries unlikely to meet the 2012 deadline for establishing core capacities. The report of the IHR Review Committee in 2011 had highlighted the challenges to implementation of the Regulations and the associated public health security risk. She therefore supported the request by the member for the United States of America for a report that would provide a better understanding of the situation and identify remaining challenges and possible solutions.

Mrs MELNIKOVA (Russian Federation),¹ stressing the importance of the Regulations, welcomed implementation efforts to date but drew attention to several problems that had hindered progress. The Event Information Site for IHR focal points did not always function properly; relevant documentation was not always provided in all official languages, which might account for low levels of reporting by Russian-speaking countries; and technical problems had been encountered in completing the self-assessment questionnaire. She appealed to the Secretariat to rectify that situation as various documents would be required for future work, especially on health security.

Dr NICKNAM (Islamic Republic of Iran)¹ said that additional technical support was needed from the Secretariat in order to improve the quality and quantity of human resources, enhance surveillance and response and strengthen collaboration between Member States with common borders, especially on points of entry and early warning and rapid response systems. In 2007, a WHO mission had recognized his country's preparedness in the area of syndromic surveillance, and his Government would be pleased to share its experience with others at subregional, regional and interregional levels.

Dr FUKUDA (Assistant Director-General) said that it was clear that Member States considered the International Health Regulations (2005) to be the basis for responding to events ranging from infectious disease outbreaks to environmental emergencies; they were crucial at national level and for international solidarity. Several speakers had also highlighted the importance of the Regulations in relation to global mass gatherings and the interface between animal and human health. Responding to remarks concerning reporting, he noted that information had been provided since the report had been issued; responses were currently available for 150 States Parties, as a further 33 had provided data, and the report would be updated before submission to the Health Assembly. As requested by several speakers, the Secretariat would also provide information on countries that were unlikely to meet the 2012 deadline, obstacles to implementation of the Regulations, and plans for overcoming them. Countries could apply for a two-year extension, and guidance was available on how to submit applications. The Regulations provided for a second extension of two years, if needed.

In addition, the Secretariat had issued a document clarifying the difference between ports designated as points of entry and ports authorized to issue ship sanitation certificates. Criteria for certification of points of entry and guidance on vector control were currently under development and should be available in the near future. The Secretariat was also preparing guidance on training and

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

information on best practices, and was organizing workshops on how the provisions of the Regulations could be incorporated into national legislation. The current core capacity assessment tool provided information on gaps, for example in relation to points of entry and radiation safety. Further work was needed to refine the quantification of core capacity, but it might prove difficult to rate progress towards the required level in terms of a single point score. Similarly, it would be difficult to compile a general checklist for implementation of the Regulations, since the situation in each country differed, but the Secretariat would strive to enhance its guidance in that regard.

The Secretariat would also work to strengthen collaboration with other international organizations, including FAO, ICAO and OIE, and would work with horizontal networks such as the Connecting Organizations for Regional Disease Surveillance network, which could complement implementation activities through information-sharing and capacity-building. Several speakers had referred to ongoing regional, subregional, multilateral and bilateral collaboration; such methods of working were of great value in enhancing core capacities.

The Board noted the report.

Global mass gatherings: implications and opportunities for global health security: Item 6.8 of the Agenda (Document EB130/17)

The CHAIRMAN drew attention to a draft decision on global mass gatherings proposed by the Islamic Republic of Iran, Libya, Morocco, Qatar, Saudi Arabia, Somalia, Syrian Arab Republic and Yemen, which read:

The Executive Board,

Having considered the report on global mass gatherings: implications and opportunities for global health security,¹

PP1 Recognizing that mass gatherings represent risks to health security, and have the potential to endanger the health of populations, raise levels of social anxiety and security alert, and cause economic disruption on a local, regional or global scale;

PP2 Building on the existing WHO resources to support the planning and conduct of mass gathering events;

PP3 Acknowledging the expertise of the Kingdom of Saudi Arabia in managing the largest annual recurring mass gathering event, attracting close to 10 million people from more than 180 countries across the globe,

1. Requests the Secretariat to develop multisectoral guidance on management of mass gathering events with specific emphasis on preventive measures including health education, taking into consideration the uniqueness of each gathering in terms of location, preparation, cultures and timing;

2. Decides that the Secretariat should work closely with Member States that are planning and conducting mass gatherings, in order to establish cooperation and communication between the concerned health authorities in each country, and therefore contribute to the strengthening of functional capacities required under the International Health Regulations (2005);

3. Encourages the participation of non-profit-making, nongovernmental and civil society organizations, in the development and implementation of health education related to mass gatherings;

¹ Document EB130/17.

4. Requests the Secretariat to raise awareness on the health impact of mass gatherings using a highly professional approach and state-of-the-art-technologies that can be regularly monitored and evaluated.

Mr BENMAMOUN (Morocco), speaking on behalf of the Member States of the Eastern Mediterranean Region and the sponsors of the draft decision, said that the issue of global mass gatherings was growing ever more complex. Examples of such gatherings included the hajj and umrah pilgrimages annually hosted by Saudi Arabia, which were attended by more than 10 million people from more than 180 countries, including elderly individuals requiring special care and attention. The distinguishing feature of those pilgrimages was the convergence of an enormous number of individuals in an area where space was extremely restricted.

The Regional Office for the Eastern Mediterranean was working with Saudi Arabia to establish an international centre for coordinating, with WHO's cooperation, appropriate preventive health measures on an international scale. The WHO Collaborating Centre on Mass Gatherings and High Visibility/High Consequences Events would also help to ensure coordination, providing expertise on various types of mass gatherings and on disease surveillance, infection control and disaster planning.

He invited the Board to adopt the draft decision with a view to supporting WHO's role in providing guidance on the management of mass gatherings, with due consideration of the essential part played by Member States and the engagement of all stakeholders, including civil society.

Ms MI Yanping (China) said that China had drawn the lessons from the 2008 Beijing Olympic Games and the 2010 Shanghai Expo that every event had unique characteristics and that public health risks should be assessed at least two years in advance, with continual updating of the information. Planning was complex; preparation to ensure the provision of properly managed services required a meticulous multisectoral approach, with the participation of various stakeholders, including the private sector. Health authorities should establish comprehensive and coordinated mechanisms for service management and exchange of information at all levels. Systems should be tested in advance and adjusted as necessary. Such activities would contribute to long-term urban health service development and capacity-building, as described in the 2010 publication on the health legacy of the 2008 Beijing Olympic Games, prepared with the support of the International Olympic Committee and the Chinese Government.¹ China would be happy to share its experience with other Member States. She supported the draft decision.

Mr MANCHA MOCTEZUMA (Mexico) said that Mexico had had considerable experience of organizing mass events and recognized that countries could not deal in isolation with the public health challenges involved, which were compounded by globalization, lifestyle and epidemiological changes, and the potential for deliberate acts of harm. With leadership from WHO and cooperation among Member States, it should be possible to develop the necessary technical tools for the planning and management of mass gatherings and reduce the potential for public health emergencies at such events, which could endanger local and international health security and place an inordinate strain on local health infrastructures. He welcomed the Secretariat's efforts to develop tools to guide and support host countries in strengthening their health information systems and surveillance capacity, which would help to safeguard the health of local populations and visitors alike.

Dr JESSE (Estonia), speaking on behalf of the European Union and its Member States, said that the acceding State Croatia, the candidate countries Turkey, the former Yugoslavia Republic of Macedonia, Montenegro and Iceland the countries of the Stabilisation and Association Process and

¹ Jin Dapeng, Ljunqvist A, Troedsson H (Eds). *The health legacy of the 2008 Beijing Olympic Games: success and recommendations*. Geneva, World Health Organization, 2010.

potential candidates Albania, Bosnia and Herzegovina, and Serbia, as well as Ukraine, Armenia and Georgia aligned themselves with her statement. The European countries were especially conscious of the health risks associated with mass gatherings, as there would be many mass gatherings in the Region during 2012, including the Olympic Games in the United Kingdom of Great Britain and Northern Ireland. She therefore welcomed the collaboration between the Secretariat and the European Centre for Disease Prevention and Control, in particular in the areas of preparedness, reinforced surveillance and risk assessment in case of outbreaks. Multisectoral collaboration at all levels was vital in preparedness and response activities. Immunization activities and proper hygiene measures were also important to limit the spread of diseases.

She requested further information on the role and activities of the Secretariat with regard to planning and preparedness for mass gatherings, and suggested that consideration of the draft decision should be postponed to allow more time for Board members to study the text and, if appropriate, propose amendments. Moreover, it was her understanding that Rule 11 of the Rules of Procedure of the Executive Board required that such proposals should be circulated 48 hours before their discussion.

Mr SHUKLA (India) said that mass gatherings, including religious and sporting events, were held frequently in his country. In addition, large crowds gathered daily on public transport systems. He endorsed the view expressed in the report that preparedness was crucial in order to maintain public health standards at such mass gatherings, and supported WHO's activities, including the Observer Programme and the Interdepartmental Mass Gatherings Group, in which his Government intended to participate. With a view to sharing best practices, the Secretariat should support the publication and dissemination of information for handling mass gatherings collected from around the world. He supported the draft decision but proposed that paragraph 3 be amended to include text to encourage the use of mass gatherings for the dissemination of health messages. He requested clarification of paragraph 4: who would conduct the monitoring and evaluation that had been called for?

Dr AL-HALKI (Syrian Arab Republic) pointed out that the public health risks associated with mass gatherings could increase levels of public concern and ultimately hamper economic activity. He expressed appreciation for Saudi Arabia's work on the public health implications of mass gatherings. The draft decision was aimed at ensuring cooperation among the relevant country authorities in the organization and planning of mass gatherings in order to safeguard public health. It merited support.

Dr DAULAIRE (United States of America) said that the analysis contained in the report was comprehensive and accurate and described most of the public health issues associated with mass gatherings. His Government was committed to ensuring global health security in relation to mass gatherings and had provided support to other Member States for various events, including the hajj. It was also participating in related international activities, including the WHO Virtual Interdisciplinary Advisory Group. He endorsed the call for more time to consider the draft decision and would be pleased to participate in informal consultations to clarify the text.

Dr BAYE LUKONG (Cameroon), speaking on behalf of the Member States of the African Region, said that preparations for mass gatherings could provide opportunities for health system development, but planning and responding to the health risks posed by such events could also strain the health systems of host nations, which might be required to manage mass casualties. They would also need robust surveillance and laboratory systems to detect contaminants or pathogens. Few health systems in the Region had those capabilities, or were equipped to ensure effective interventions during events taking place simultaneously in different geographical locations. The report therefore came as a stark reminder of the need to strengthen national health systems in the Region. Surmounting that challenge should become one of the Organization's core functions as it moved forward in priority-setting. Noting that mass gathering management also required multiagency coordination, she expressed support for the draft decision.

Mr AL-ABDULLA (Qatar), welcoming WHO's attention to the health implications of mass gatherings, suggested that the Organization should do research into the prevention of epidemics and other health emergencies triggered by such gatherings. Qatar was preparing to host the Fédération Internationale de Football Association World Cup in 2022 and had high expectations for the quality of the gathering, including its health-related aspects.

Dr GULLY (Canada) said that, as part of the preparation for mass gatherings in Canada, his Government had developed public health frameworks in collaboration with partners at all levels, and had found that such preparations provided an opportunity to develop and implement enhanced surveillance, communication and response protocols and to strengthen collaboration between the health and security sectors. He supported a sustainable approach to the management of mass gatherings so that improvements in capacity endured beyond the event. As was noted in paragraph 1 of the draft decision, the risks associated with each mass gathering were unique; nevertheless, the measures taken to address them should be adaptable to other such events. Guidance to Member States should include a monitoring and evaluation component, and he therefore proposed that paragraph 1 of the draft decision be amended by inserting the words "evaluation and monitoring" after "management" and that, in the light of that change, "that can be regularly monitored and evaluated" be deleted from paragraph 4. Additionally, the word "sustainable" should be inserted before "preventive measures" in paragraph 1, and paragraph 3 should be amended by replacing the words "the participation of non-profit-making" by "the Secretariat to reach out to".

Dr BELO (Timor-Leste) said that, although Timor-Leste had little experience in organizing mass gatherings, it was well aware of the implications of such events for global health. She therefore supported the draft decision and urged the Secretariat to continue working with Member States to promote international cooperation, develop protocols and encourage the sharing of experience in relation to the health aspects of mass gatherings.

Dr MEMISH (Saudi Arabia)¹ thanked the other sponsors and the Member States of the Eastern Mediterranean Region. The Regional Committee for the Eastern Mediterranean at its Fifty-eighth session (Cairo, 2–5 October 2011) had agreed to submit their recommendations to the Board. Saudi Arabia was privileged to host the hajj and umrah each year and had invested in a solid national multisectoral system to ensure the smooth running of those pilgrimages and the safety and well-being of the pilgrims. It also worked closely with international health authorities and partners around the world. Infectious disease outbreaks at mass gatherings could spread rapidly to all regions without effective coordination between the host country and countries to which participants were returning. Appropriate public health messages for participants were crucial in order to ensure the clarity and effectiveness of preventive measures. Such messages should be developed by WHO as the leader in health communication activities. He urged the Board to adopt the draft decision.

Dr EL OAKLEY (Libya)¹ supported the draft decision with the proposed amendments.

Dr NICKNAM (Islamic Republic of Iran)¹ said that accurate and timely communications about public health risks and events during mass gatherings were of the utmost importance, as they might affect the health of not only participants but also their compatriots after their return to their countries. Effective risk communication was therefore a major responsibility of the organizers of such gatherings.

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

Mr ALMASHAN (Kuwait)¹ said that mass gatherings could pose a serious threat to global health security in the absence of measures to contain the risks. Every effort must therefore be made to support countries that hosted such gatherings, in particular Saudi Arabia. He supported the draft decision.

Dr WARIDA (Egypt)¹ urged the Board to adopt the draft decision and called on the Secretariat to mobilize the resources needed for its implementation.

Msgr VITILLO (Holy See), speaking at the invitation of the CHAIRMAN, noted that the Holy See convened World Youth Day every three years and hosted national and regional gatherings in the intervening years – events that attracted hundreds of thousands of young people. It was therefore well aware of the importance of careful preparations in order to attend to the health needs of participants and to prevent and, if necessary, respond to health emergencies during such gatherings. The organizers of past World Youth Days had collaborated closely with national public health authorities, WHO headquarters, and regional and country office staff in preparing for and conducting such events, and would continue to do so in the future.

Mr BURCI (Legal Counsel), responding to the comment by the member for Estonia on the timing of consideration of proposals submitted to the Board, explained that Rule 11 of the Board's Rules of Procedure referred to documents such as, typically, reports from the Secretariat rather than proposals. Although there was a provision in the Rules of Procedure of the World Health Assembly concerning advance submission of proposals (Rule 50), there was no such provision in the Rules of Procedure of the Executive Board.

Dr JESSE (Estonia) suggested that the introduction of such a provision be considered in the discussions on WHO reform. She reiterated her need for more time to study the draft decision.

The DIRECTOR-GENERAL said that the Secretariat was working closely with Member States and organizations, such as the International Olympic Committee, involved in organizing mass gatherings. She welcomed the proposed draft decision but suggested that paragraphs 3 and 4 might require further discussion in informal consultations in order to clarify what was expected of the Secretariat. Paragraph 3 should perhaps encourage Member States, not the Secretariat, to work with nongovernmental and civil society organizations, because preparation for and hosting of mass gatherings were the responsibility of the organizing country.

The CHAIRMAN suggested that the Board should postpone further consideration of the draft decision, pending informal consultations among interested parties to clarify the text.

It was so agreed.

(For adoption of the decision, see the summary record of the eleventh meeting.)

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

Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level: Item 6.2 of the Agenda (Document EB130/9)
(continued from the eighth meeting)

The CHAIRMAN invited the Board to resume its consideration of the revised draft resolution on the global burden of mental disorders proposed by India, Switzerland and the United States of America, which had been introduced in the previous meeting.

Dr JESSE (Estonia), speaking on behalf of the European Union and its Member States, proposed the insertion of a new preambular paragraph PP13*bis* reading: “Recognizing that certain populations live in a situation that makes them particularly vulnerable to developing mental disorders, and the consequences thereof”. Subparagraph 2(1) should be amended by inserting the words “based on an assessment of vulnerabilities and risks” after “Mental Health Action Plan”. Finally, a new subparagraph 2(2)(a) should be inserted, reading: “assessment of vulnerabilities and risks as a basis for developing the Action Plan” and the existing subparagraphs 2(2)(a) and (b) would be renumbered appropriately.

The resolution, as amended, was adopted.¹

Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits: report on the work of the Advisory Group: Item 6.9 of the Agenda (Document EB130/18)

Dr JESSE (Estonia), speaking on behalf of the European Union and its Member States, the acceding State Croatia, candidate countries Turkey, the former Yugoslavia Republic of Macedonia, Montenegro and Iceland, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, and Serbia, as well as Ukraine, Armenia and Georgia, said that the adoption of the Pandemic Influenza Preparedness Framework by the Sixty-fourth World Health Assembly had marked an important step towards a more transparent and efficient WHO Global Influenza Surveillance and Response System and stronger international public health collaboration. The timely and open sharing of viruses, improved surveillance, technology and knowledge transfer and faster, more equitable access to effective vaccines and other benefits were crucial to the achievement of rapid and effective global pandemic responses. The Framework would play a key role in global influenza surveillance and public health responses to influenza, and would improve global health security.

Reports that countries were sharing influenza viruses within the WHO network were encouraging; all countries should be urged to support and further intensify rapid sharing. She welcomed the fact that the Advisory Group had met once and had a clear work agenda, and expressed the hope that the Secretariat and the Advisory Group would make substantial progress in 2012 and ensure transparency in all aspects of the Group’s work. The Group should be proactive in discussions with industry. All Member States should be involved in the establishment of its work programme and the membership renewal process. The European Union stood ready to collaborate in further work, including the 2016 review of the Framework.

Dr GULLY (Canada) said that the Framework set a precedent for collaboration between governments, multilateral organizations and industry to improve pandemic influenza preparedness and built on the lessons learnt from pandemic (H1N1) 2009. Although difficult at times, the Framework development process had resulted in greater cohesion among Member States. However, effective implementation would require hard work, diligence and monitoring. The role and mandate of the

¹ Resolution EB130.R8.

Advisory Group must be clearly defined, and the Group should engage actively with industry. The diversity of skills and experience of Group members would doubtless contribute to implementation of the Framework.

Mr DÍAZ ANAIZ (Chile), noting his Government's continued support for the sharing of influenza viruses, encouraged the Advisory Group to strive to reach global agreements on vaccine availability and the sharing of viruses and benefits. The Group should keep Member States apprised of its activities in that respect. With regard to the Group's guiding principles, it should take into account the opinions of developing and affected countries, industry and directly concerned parties. Priority consideration should be given to the opinions and situation of developing countries whose access to vaccines during pandemics varied significantly.

He requested the Secretariat to provide timely information on the threat of the swine-origin triple reassortant A influenza (H3N2) viruses so that countries might take rapid and coordinated preventive action.

Dr SHEKU DAOH (Sierra Leone), speaking on behalf of the Member States of the African Region, said that only sporadic cases of influenza caused by pandemic influenza A (H1N1) viruses had been reported in the Region since October 2011. Half the Region's Member States had enhanced their sentinel surveillance systems and laboratory capacity for the diagnosis of influenza A and 38 had developed H1N1 vaccine deployment plans and received sufficient vaccines and ancillary supplies to vaccinate up to 10% of their populations. Vaccination campaigns had taken place in at least 24 countries and some were continuing to provide routine vaccination against influenza for vulnerable groups, including the elderly. Challenges for the Region included the need to heighten awareness of the continued threat from pandemic influenza A (H1N1) 2009 viruses and the lack of capacity for influenza vaccine production. The Secretariat should take into account the Region's special needs, in particular in relation to benefit-sharing, and should ensure monitoring and follow-up of the implementation of the Pandemic Influenza Preparedness Framework.

Noting that the Advisory Group had indicated that its work in relation to Standard Material Transfer Agreement 2 would be more productive once the Secretariat had begun individual contacts with industry, he enquired how, in the meantime, the Secretariat would ensure that companies and research industries accessing viruses abided by the terms of the Framework.

Ms MI Yanping (China) commended the transparency, equity and fairness of the Pandemic Influenza Preparedness Framework and endorsed the report of the Advisory Group. The Secretariat and affected Member States had responded rapidly to pandemic (H1N1) 2009, with a transparent approach to sharing of viruses and technologies. With the virus strain provided through the WHO network, China had been able to conduct the necessary research and development and quickly produce a vaccine for administration to priority population groups, demonstrating the effectiveness of the Framework. The Global Influenza Surveillance and Response System and virus- and benefit-sharing mechanisms should be strengthened further in order to enable a more flexible and expeditious response to public health risks.

Professor PRASAD (India) expressed the hope that the Pandemic Influenza Preparedness Framework would provide a coherent international approach for ensuring the availability of influenza viruses and the sharing of related benefits, which included the strengthening of national surveillance systems. India had participated actively in the negotiations, which had not been easy and had required compromises by stakeholders. Cooperation from the pharmaceutical industry and adherence to the provisions of the two Standard Material Transfer Agreements would determine the Framework's credibility and success.

He welcomed the establishment of the Advisory Group, whose deliberations he would follow closely. The needs of developing and affected countries should be taken into account. The outbreak of influenza A (H5N1) and pandemic (H1N1) 2009 had shown that pandemics could strike any country,

and that there were shortcomings in global preparedness and response. Implementation of the Pandemic Influenza Preparedness Framework should help to fill those gaps and improve responses.

Mr MANCHA MOCTEZUMA (Mexico) said that Mexico was participating actively in the identification and sharing of influenza virus strains. His Government strongly supported the use of vaccines to protect populations, especially vulnerable groups. Mexico's experience of pandemic (H1N1) 2009 had underlined the importance of prevention and preparedness and, in particular, of strengthening the response capacity of hospitals, especially intensive and intermediate care units, not just through the supply of equipment but also through training of staff at all levels in the use of technology for managing patients with acute respiratory infections.

The meeting rose at 12:40.

TENTH MEETING

Friday, 20 January 2012, at 14:45

Chairman: Dr S. OMI (Japan)

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

Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits: report on the work of the Advisory Group: Item 6.9 of the Agenda (Document EB130/18) (continued)

Dr DAULAIRE (United States of America) welcomed the Organization's work on the global surveillance of, and response to, pandemic influenza, particularly the Pandemic Influenza Preparedness (PIP) Framework, which he supported. Questions on its implementation and procedures would undoubtedly be raised by stakeholders until the entity-specific Standard Material Transfer Agreements 2 had been negotiated and finalized. He encouraged the Secretariat to begin negotiations on at least one or two entity-specific agreements and urged WHO to ensure that its work during the interim period did not hamper the rapid sharing of PIP biological materials. Active consultation between the Secretariat and civil society stakeholders, including industry, would be important during implementation of the PIP Framework, and he encouraged the setting up of expert working groups, as needed, in which his country would gladly participate, in order to bolster the work of the Advisory Group.

Mr OTAKE (Japan) said that it was vital to respond quickly to pandemic influenza by sharing influenza specimens, hence the importance of the Pandemic Influenza Preparedness Framework. The key to the successful implementation of the Framework lay in its details. In order to ensure its fair and transparent functioning, due consideration should be given to the views of industry. It was to be hoped that the Partnership Contributions would be based on the size and capacity of the business concerned.

A breakdown should be provided of the US\$ 56.5 million operating costs for 2010 of WHO's Global Influenza Surveillance and Response System, which would help to determine its budget for 2012. Moreover, the amount of revenue from sources other than Partnership Contributions was not known. He sought further information, which would be necessary to engage other stakeholders.

He asked the Secretariat also to elaborate on the relationship between the Pandemic Influenza Preparedness Framework Advisory Group and the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009.

Dr NASHER (Yemen), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that avian influenza (H5N1) virus posed a major threat for many countries in the Region, where the laboratory and surveillance facilities needed for detection purposes were either non-existent or substandard. Timely access to sufficient quantities of pandemic influenza A (H1N1) 2009 vaccines had also posed a serious challenge owing to inadequate production capacity, a problem that was compounded in some countries by a lack of the regulatory mechanisms needed to ensure the rapid approval of safe and effective influenza vaccines. The result had been a delay in use of the vaccine and a drop in vaccination rates.

Timely sharing of information on influenza surveillance, and fair access to effective vaccines, medicines and technology were important elements of pandemic influenza preparedness. The need for additional technical and financial support to build the laboratory and pandemic influenza surveillance capacities required under the International Health Regulations (2005) was particularly urgent in those countries of the Region that were low-income or in situations of conflict.

He expressed appreciation for the positions articulated by WHO at the joint meeting of governments on pandemic influenza preparedness. He urged Member States to implement resolution WHA64.5 (Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits), in which the Health Assembly had adopted the Pandemic Influenza Preparedness Framework.

Mrs ESCOREL DE MORAES (Brazil)¹ said that the Pandemic Influenza Preparedness Framework Advisory Group had a central role in ensuring that the Framework was implemented and its regulations respected. The Group's decision to accord priority to Partnership Contributions and Standard Material Transfer Agreement 2 was sound. Half the operating costs of the Framework would be funded by the annual contribution from industry and the Advisory Group was well positioned to define the contributions to be made by individual companies and other stakeholders, and to make rules for resource allocation. Standard Material Transfer Agreement 2 formed the basis for benefit-sharing and vaccine production and should be finalized rapidly, with the Advisory Group participating directly in the negotiations. A reasonable level of benefits, including knowledge-sharing with developing countries, should be provided in order to increase and diversify vaccine-production capacity.

The Pandemic Influenza Preparedness Framework should be balanced, effective and transparent, favouring those countries that would not have the means to respond in an emergency. The negotiating process had demonstrated the importance of ensuring that decision-making at WHO was more democratic and should serve as an example for the Organization's other negotiations.

Mr GURITNO (Indonesia)¹ said that the adoption of the Pandemic Influenza Preparedness Framework with the first Standard Material Transfer Agreement in May 2011, in resolution WHA64.5, had demonstrated Member States' commitment to managing public health threats through the introduction of regulations based on fairness, equity and transparency. The projected series of meetings of the Advisory Group was welcome and Member States should do their utmost to ensure their effectiveness. Indonesia had shown its commitment to pandemic influenza preparedness by sharing its influenza A (H5N1) isolate under the Framework, which had led to the development of a vaccine. It had also provided genetic sequencing data and information for the influenza virus tracking mechanism.

Ms SMIRNOVA (Russian Federation)¹ welcomed WHO's leadership in pandemic influenza preparedness. The Advisory Group provided the Director-General with access to expert advice and helped countries to implement or step up their vaccination programmes and to develop influenza vaccines. It was incumbent on Member States to cooperate with each other on pandemic influenza preparedness and the importance of the Organization's work, particularly its collaboration with industry, should not be underestimated. The Russian Federation was eager to work with WHO on implementing the recommendations of the Advisory Group.

Dr ATTAYA LIMWATTANAYINGYONG (Thailand)¹ pointed out that practical action and positive outcomes were crucial to inspiring trust. The Framework's initial successes, such as sub-licensing agreements for the manufacture of oseltamivir, commitments from influenza vaccine manufacturers, and transfer of technology to developing countries, should be pursued and strengthened. The Framework was the foundation for promoting and sustaining virus-sharing activities by offering incentives and differential pricing to the partners involved. Inclusion of manufacturers from developing countries in the manufacturing base would help to ensure an adequate supply of vaccines at affordable prices.

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

Mr DURISCH (Stichting Health Action International), speaking at the invitation of the CHAIRMAN and also on behalf of Third World Network and the Berne Declaration, said that the Advisory Group should be guided in its work by the principles of equity and transparency. It should, for example, make available information pertaining to the process of determining Partnership Contributions, the terms and conditions of the Standard Material Transfer Agreements and the background of its members. Documents relating to the Advisory Group should be made public. Furthermore, commercial entities should be prevented from exercising undue influence on the Advisory Group, and public-interest nongovernmental organizations should be consulted at all stages of the decision-making process. Standard Material Transfer Agreements should be implemented immediately. According to media reports, efforts were allegedly under way to limit the sharing of data from research on influenza A (H5N1) virus that had produced a highly contagious strain. Such a move could affect the PIP Framework.

Dr FUKUDA (Assistant Director-General) confirmed that in 2012 work would focus on implementing the Standard Material Transfer Agreement 2 and agreeing on the use and distribution of Partnership Contributions. The Advisory Group's report had focused on its formation and first meeting; future reports would focus on a wider range of activities. Members of the Advisory Group, summaries of whose backgrounds and declarations of interest had already been published on the Internet, had been appointed in an individual capacity as experts rather than as country representatives.

Responding to the member for Japan, he explained that out of the US\$ 56.5 million annual running costs of the WHO Global Influenza Surveillance and Response System, Member States spent about US\$ 22 million on maintaining their National Influenza Centres and US\$ 18 million for maintaining WHO Collaborating Centres on Influenza. Other expenses, such as shipping costs and the cost of maintaining the WHO H5 Reference Laboratories, accounted for the rest. A summary of the data was available in a separate document on technical studies following resolution WHA63.1.¹

The International Health Regulations (2005) Emergency Committee concerning Influenza Pandemic (H1N1) 2009 was convened, as needed, to help to determine whether an emergency situation existed and to provide advice on dealing with it. The Advisory Group had a different function: to provide guidance to the Director-General on the implementation of the Framework and to advise, for example, on the use of Partnership Contributions.

Turning to the comments made by the representative of Brazil, he said that Partnership Contributions were cash donations from industry to the Organization and were calculated on the basis of half the running costs of the Global Influenza Surveillance and Response System. The Advisory Group provided guidance to the Director-General on how the funds should be spent, but the Contributions were intended to be used mainly to help countries to prepare for and deal with pandemic influenza outbreaks. Under the Framework, the Advisory Group was mandated to consult with industry and other stakeholders and would do so in 2012.

The DIRECTOR-GENERAL said that she appreciated the efforts made by the Member States and industry partners in the negotiations. She highlighted the importance of transparency within the Pandemic Influenza Preparedness Framework and explained that, before the appointment of the members of the Advisory Group, lengthy consultations had been held with the regional directors, who had drawn up a list of nominees. Appendix 2 of document EB130/18 stated that all members had completed the Declaration of Interest. Those declarations had been reviewed by the Legal Counsel who had found no conflicts of interest.

The CHAIRMAN took it that the Board wished to note the report on pandemic influenza preparedness contained in document EB130/18.

The Board noted the report.

¹ Document A/PIP/OEWG/3/2, Annex 1, Section 1.2, Table A1.9.

Poliomyelitis: intensification of the global eradication initiative: Item 6.10 of the Agenda (Documents EB130/19 and EB130/19 Add.1)

The CHAIRMAN drew attention to the draft resolution contained in paragraph 10 of document EB130/19 and its financial and administrative implications for the Secretariat (document EB130/19 Add.1).

Mr PRADHAN (India) announced that no case of poliomyelitis had been reported in India during the previous 12 months. That success resulted from various initiatives that had been introduced by the Government over the years, and sustained political will. In 2010, India had been one of the first countries to introduce the bivalent oral polio vaccine, and despite periodic shortages it had been able to procure sufficient quantities of the vaccine for national and regional supplementary immunization rounds. Improving supplementary immunization activities and coverage had been a key part of the fight against poliomyelitis. Plans to ensure immunization of migrant and mobile populations and populations in low-coverage areas had been implemented. A multipronged strategy involving improvement of routine coverage, sanitation and hygiene had been used in high-risk areas.

Given the risks that still existed, his country had developed an emergency preparedness and response plan. Surveillance of acute flaccid paralysis had been stepped up in all states sharing borders with other countries. He urged the Secretariat to continue providing technical support to India's Pulse Polio Programme until the disease had been eradicated.

Dr JESSE (Estonia), speaking on behalf of the European Union and its Member States, congratulated India for being free of poliomyelitis for a year and called upon the remaining countries where the disease was endemic to make long-term political and financial commitments to global eradication; failure to step up efforts towards eradication would erode the results achieved thus far.

In view of the financial constraints faced by WHO, the financial and administrative implications of the draft resolution should be further clarified. How would the Global Polio Eradication Initiative Strategic Plan, launched in 2010, meet the challenges that the current strategy had failed to surmount?

Dr DANKOKO (Senegal), speaking on behalf of the Member States of the African Region, said that the unprecedented commitment of African leaders to poliomyelitis eradication and their success in conducting synchronized vaccination campaigns during the period 2009–2011 had dramatically reduced the number of poliomyelitis cases. Recent outbreaks in some countries and re-establishment of poliovirus transmission in others were nevertheless causes for concern and had prompted the Regional Committee for Africa to adopt, in August 2011, resolution AFR/RC61/R4 on poliomyelitis eradication in the African Region, the aim of which was to interrupt transmission of wild poliovirus as rapidly as possible.

In its most recent report, the Independent Monitoring Board had drawn attention to the various obstacles to reaching the milestones in the Strategic Plan which, if not attained, could lead to a global catastrophe. He was convinced that such a scenario could be avoided if measures were taken to remove those obstacles, including labelling the fight against poliomyelitis as a global programmatic public health emergency and making a political commitment to mobilize national resources as a supplement to donor contributions. Some countries in the Region had already introduced supplementary measures, such as providing additional resources, increasing the frequency of national immunization days and stepping up surveillance activities.

He endorsed the draft resolution.

Dr TAKAOKA (Japan) regretted that the deadline for eradication had been extended to the end of 2013 and wondered why that decision had been made. Her Government was fully committed to achieving poliomyelitis eradication and, to that end, had agreed in 2011 to lend Pakistan US\$ 650 million to fund poliomyelitis vaccination campaigns under the new loan conversion system. The draft resolution failed to reflect a sense of urgency about eradication and she therefore proposed three amendments. In paragraph 2, the words "making polio eradication a national priority programme

and” should be inserted after “national public health emergency”. In the first line of subparagraph 4(1), the word “continued” should be replaced by “renewed”. The words “including the establishment of a special polio programme within the Organization” should be inserted at the end of that same subparagraph.

Dr PE THET KHIN (Myanmar) said that Myanmar was one of the Member States in the South-East Asia Region that was at moderate risk of wild poliovirus importation. The recent outbreak in China sparked by a virus originating in Pakistan had shown that poliomyelitis eradication was not only a national issue but also a regional and global concern. His Government was fully committed to implementing the Global Polio Eradication Initiative Strategic Plan 2010–2012 and, following the re-emergence in Myanmar of vaccine-derived polioviruses in 2006 and the introduction of wild poliovirus in 2007, had developed an emergency response action plan, which was updated every two years. It regarded routine and supplementary immunization as the single most important eradication strategy but was experiencing difficulties in achieving broad vaccination coverage as a result of limited access to services. It had therefore launched a national plan for intensification of routine immunization, to be headed by state and regional authorities, and would in 2012 be implementing the “Reaching Every District Strategy” in hard-to-reach areas, despite a significant funding shortfall.

Full implementation of the Strategic Plan 2010–2012 required all countries to accord priority to eradication activity funding. He was in favour of extending the Plan to 2018.

Dr LEI Zhenglong (China) said that the outbreaks of poliomyelitis in China in 2011 had highlighted the importance of continuing eradication efforts even after poliomyelitis-free status had been certified. In the draft resolution, he proposed that in subparagraph 3(1), the words “to eliminate the ‘blank immunization’ areas and” be inserted before “to maintain very high population immunity”. At the end of subparagraph 3(2), the words “and regular risk assessment” should be inserted after “sustaining certification-standard surveillance for polioviruses” and a new subparagraph 3(4) should be inserted, to read “to engage in multilateral and bilateral cooperation, including exchanging epidemic information, laboratory monitoring data, and carrying out the supplementary immunization activities simultaneously as appropriate;”. A new subparagraph should follow subparagraph 4(3), to read “to coordinate the relevant partners to promote the research, production and supply of vaccines, to enhance its affordability, effectiveness and accessibility;”.

Dr DAULAIRE (United States of America) said that India’s laudable achievement demonstrated that eradication was feasible but the unique challenges faced by the countries remaining endemic for poliomyelitis called for a new approach. He applauded the recommendations made by the Independent Monitoring Board, which had set a new standard for honest and straightforward programme evaluation. As human and financial resources were vital to the eradication strategy, the United States Centers for Disease Control and Prevention had recently launched an emergency operations centre to consolidate and leverage resources for polio eradication and would be scaling up its assistance to priority countries in the areas of outbreak prevention and control, bolstering management capacity, disease surveillance and vaccination campaigning. He urged all Member States to comply with the requirement for immediate notification under the International Health Regulations (2005).

In preambular paragraph 8 of the draft resolution, the words “and that some countries, such as the Kingdom of Saudi Arabia, require poliovirus vaccination for travellers coming from polio-infected areas, including administration of an additional dose of vaccine upon arrival,” should be inserted after “interrupted globally”. A new subparagraph 3(2bis) should be inserted, to read: “to review and, if necessary, align national guidelines and practice with WHO recommendations for the vaccination of travellers to and from polio-infected areas; countries at particular risk of recurrent importation and spread of poliovirus may consider additional steps to promote vaccination”. In the first line of subparagraph 4(3) the words “scientific vetting” should be inserted after “development”; the words “inactivated poliovirus” should be inserted after “poliovirus diagnostics and”; and the words “that include risk management;” should be inserted after “the end of 2018.”.

Dr GULLY (Canada) agreed that poliomyelitis should be regarded as a global health emergency. He urged Member States, previous funding partners of the Global Polio Eradication Initiative and others that had yet to support the Initiative to give immediate consideration to contributing to it. It was essential to prevent the reintroduction of poliovirus in poliomyelitis-free areas, and the determined efforts in that regard of some Member States, such as Saudi Arabia, merited recognition. He endorsed the amendments proposed by the members for China, Japan and the United States of America.

Dr LARSEN (Norway) praised India's success in achieving a poliomyelitis-free 12-month period, which proved that eradication was possible. He urged the remaining countries where poliomyelitis was endemic to draw on the lessons learnt in India.

Dr ABD JALIL (Brunei Darussalam) welcomed the significant progress made by many countries, and India in particular, towards poliomyelitis eradication. Nevertheless, outbreaks in regions that had previously been declared poliomyelitis-free and their impact on other poliomyelitis-free countries caused concern. His country, which had been poliomyelitis-free for more than a decade, had drawn up guidelines on response in the event of the import of wild poliovirus and an outbreak contingency plan. Aware that a high-quality surveillance system and ensuring population immunity from an early age were key strategies in controlling and eradicating poliomyelitis, his Government was continuing its acute flaccid paralysis surveillance activities and, in April 2012, would switch to the inactivated poliovirus vaccine. He endorsed the draft resolution.

Mrs BAMIDELE (Nigeria) said that, following the introduction of the Global Polio Eradication Initiative Strategic Plan in 2010, Nigeria had made significant advances towards poliomyelitis eradication by using multisectoral and innovative approaches, including increasing the number of immunization days and supplementary immunization activities in target areas, and by looking at the effects of political, economic and sociocultural factors on eradication efforts. Traditional leaders and faith-based organizations had been encouraged to become involved in those efforts, which had resulted in unprecedented community participation in the campaign. Nevertheless, in 2011, poliovirus transmission had continued during unsettled times in the northern areas of Nigeria and the number of cases had increased four-fold in comparison with the previous year. In response, 10 targeted national immunization-plus days had been held, resulting in 100% coverage in some affected areas. Following the adoption of resolution AFR/RC61/R4 on poliomyelitis eradication by the Regional Committee for Africa in September 2011, the President had made a commitment to increase funding for poliomyelitis eradication to US\$ 30 million annually and approved the establishment of a presidential taskforce. Action committees had subsequently been set up at the central, local and community levels, and a plan was being finalized for providing incentives to both mothers and children and using new social mobilization strategies for hard-to-reach communities. The presence of type 2 poliovirus meant the continued use of trivalent polio vaccine.

The amendments proposed by the member for the United States of America were, in her view, unnecessary in the light of the efforts being made by her Government, with the support of the Regional Office for Africa and other Member States. She could not support the draft resolution as she needed more time to study the proposed amendments.

Mr MANCHA MOCTEZUMA (Mexico) agreed that poliomyelitis should be regarded as a global health emergency. The implementation of eradication strategies and development of effective surveillance and accountability mechanisms were essential. India's achievement of one poliomyelitis-free year showed that eradication was possible. Poliomyelitis vaccination campaigns should be pursued as the disease remained endemic in some countries, threatening reintroduction of the virus elsewhere. As part of its poliomyelitis eradication programme his Government had set up a high-quality epidemiological surveillance system. It was maintaining high levels of vaccination coverage despite budgetary constraints, taking immediate control measures in suspected cases of acute flaccid paralysis, and monitoring signs of wild poliovirus transmission, from which the country had been free

since 1990. He endorsed the draft resolution and welcomed the amendments proposed by the member for Japan and the amendment concerning vaccination of travellers proposed by the member for the United States of America.

Dr DANKOKO (Senegal), speaking on behalf of the Member States of the African Region, reiterated his earlier position that, while it was possible to bring an end to the transmission of poliovirus rapidly, there was no need at that stage to restrict movement by requiring a vaccination certificate for travellers from countries where poliomyelitis was endemic. Instead, the international community should demonstrate its solidarity by providing as many financial, technical and human resources as possible to help countries to eradicate endemic poliomyelitis.

Ms QUACOE (Cote d'Ivoire)¹ said that, despite significant advances towards eradication of poliomyelitis, the fact that some countries had recently experienced outbreaks was cause for concern. To meet that challenge, equitable access to the poliomyelitis vaccine should be ensured, particularly for children under the age of five years living in underserved rural areas, impoverished urban zones, unstable countries and marginalized communities. Efforts should also be made to strengthen the monitoring and detection of cases of acute flaccid paralysis, ensure the availability of effective vaccines and bolster cross-border cooperation. She commended the Organization's efforts to provide technical support under the Global Polio Eradication Initiative.

Ms LANTERI (Monaco)¹ said that her Government accorded priority to poliomyelitis eradication and had been a partner in the Global Polio Eradication Initiative for 10 years. The section of the report on the recommendations, conclusions and concerns of the Independent Monitoring Board, whose transparency had been exemplary, were of particular interest. She welcomed India's success in interrupting transmission of poliovirus, but expressed concern at the increase in the number of cases in Africa in 2011. All countries should acknowledge the importance of keeping poliomyelitis eradication high on the global health agenda. Adoption of the draft resolution would facilitate that process.

Mrs ESCOREL DE MORAES (Brazil)¹ said that, in the framework of the STOP Polio Initiative of the United States Centers for Disease Control and Prevention, her Government had been working to build national capacity by training specialized teams to provide assistance to countries in which poliomyelitis was endemic, starting with Angola. Assisting in planning, implementation and evaluation activities, providing complementary immunization activities, developing data-management plans for national programmes, and preparing outsourcing information on the poliomyelitis and smallpox vaccination programmes were top priorities in that regard. Brazil had been poliomyelitis-free since 1989. Regular vaccination campaigns were conducted in order to prevent reintroduction of the disease.

Mrs MELNIKOVA (Russian Federation)¹ welcomed WHO's efforts to raise awareness of the need for poliomyelitis eradication, particularly in countries where the disease was endemic. Her Government supported the independent monitoring of eradication activities and supported the call for poliomyelitis eradication to be treated as a global health emergency. Funding for its eradication should be increased but spending should be strictly monitored through regular accountability reports. As part of its commitment to global eradication efforts, her Government had taken the following steps: cooperated with other countries in the Commonwealth of Independent States on strengthening their network of laboratories, purchased and provided equipment and vaccines for additional and supplementary vaccination campaigns in those countries, and entered into an agreement for monitoring the effective use of those resources. It would continue to provide such assistance.

She encouraged the Secretariat to develop new strategic approaches to poliomyelitis eradication and endorsed the draft resolution.

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

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland)¹ welcomed the Secretariat's frank and accurate summary of the situation and, in particular, the hard work of the Independent Monitoring Board over the past year. The widespread gains that had been made in poliomyelitis eradication should be protected and built on. The tiny percentage of countries that had not yet eliminated the disease were, however, the most intractable cases, in part because of their complex situations. The international spread of poliomyelitis to other countries through importation remained a concern.

India's recent achievement deserved special mention. Other affected countries would do well to follow its lead, for example by expanding their national immunization programmes.

Despite challenging economic conditions, a strong case could be made for supporting the Global Polio Eradication Initiative. In her country, that investment had proved to be cost-effective and her Government would be doubling its financial commitment to the Initiative over the next two years. The funding shortfall was nonetheless a substantial obstacle to progress and there was consequently an urgent need to broaden the donor funding base.

She endorsed the draft resolution and the work plan underpinning it.

Dr ATTAYA LIMWATTANAYINGYONG (Thailand)¹ said that Thailand, which had had been free of poliomyelitis since 1998, remained committed to global eradication. She commended the efforts of the Global Polio Eradication Initiative, development partners, Member States, in particular India, and WHO. Nevertheless, global eradication meant that all countries endemic for poliomyelitis must comply with the recommendations of the Independent Monitoring Board. The swift action of countries to contain outbreaks of imported wild poliovirus was greatly appreciated.

The draft resolution should place greater emphasis on the importance of adequate resources and the need to identify areas where routine immunization coverage was low or surveillance systems were not functioning well, so that appropriate action could be taken.

Mr CHIKH (Organisation of Islamic Cooperation), speaking at the invitation of the CHAIRMAN, said that the Organisation had recently stressed the urgency of stopping transmission of wild poliovirus by the end of 2012 and had called for political commitment and high-level oversight of vaccination campaigns. It had also urged its member countries and those of the G8 and G20 to provide emergency funding to the Global Polio Eradication Initiative. Most of the Organisation's members had succeeded in eradicating poliomyelitis, with the exception of Afghanistan, Nigeria and Pakistan, where the increase in cases presented a major national and global threat, made even more complex by the scarcity of vaccination coverage in conflict zones where cases among children had risen sharply. Following an appeal by the President of Afghanistan, the Taliban had agreed not to hinder immunization campaigns in conflict zones.

The ongoing outbreak of poliomyelitis on the border between Kenya and Uganda was of great concern, especially as all polioviruses imported into African countries had been found to be linked genetically with a virus originating in northern Nigeria. It was vital to involve religious and community leaders in the eradication campaign as they could help to ensure broader vaccination coverage in troubled regions. India's success should lead the countries with endemic transmission of wild poliovirus to intensify their eradication efforts.

His Organisation had been cooperating closely with the Global Polio Eradication Initiative and was involved in awareness raising and mobilization of political support at the highest level for vaccination campaigns. It would be stepping up its political advocacy to ensure that the necessary action was taken in the three Member States where poliovirus was still endemic.

Mr STENHAMMAR (Rotary International), speaking at the invitation of the CHAIRMAN, said that the success of the global eradication campaign would depend on unwavering commitment from

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

partners providing political, financial and technical support, extraordinary determination by countries that were still affected by poliomyelitis, and rigorous action to reverse the continued lack of progress in some countries. Because the Global Initiative was currently facing a funding crisis, stakeholders must ensure accountability at all levels with regard to immunization coverage, surveillance activities and resource management. Priorities for 2012 included responding to the recent increase in the number of poliomyelitis cases in Nigeria and ensuring that Pakistan's strong commitment at the highest level to improve vaccination coverage and its revised national emergency plan translated into practical measures.

Recent achievements such as India's declaration of a poliomyelitis-free year and Rotary International's attainment of its fund-raising goal of US\$ 200 million, bringing its total investment in poliomyelitis eradication to more than US\$ 1000 million, should renew resolve in the international community's efforts to eradicate poliomyelitis.

Dr AYLWARD (Assistant Director-General), responding first to the points made by the member for Estonia on the financial implications of the draft resolution, said that the Secretariat would shortly issue a text revised in the light of the comments made.

The current failure to meet targets meant that eradication activities would continue until 2013 and the budget allocated to them would be increased to more than US\$ 935 million. Furthermore, eradication efforts would henceforth be based on continuation of existing core strategies, more widespread use of best practices such as those seen in India, and an expansion of routine immunization programmes. The key to the plan would, however, be its oversight function. The Independent Monitoring Board did valuable work in that regard at the international level and in recent months Nigeria and Pakistan had also established reporting mechanisms for their eradication programmes.

With regard to the proposed one-year extension to the action plan for eradication mentioned by the member for Japan, he explained that such an extension would give countries another 24 months to interrupt poliovirus transmission. The action plan, which would be supported by emergency provisions during those 24 months, would incorporate the lessons learnt from India's recent experience. All the partners involved would endeavour to increase their technical and financial support to the countries where it was needed, particularly Nigeria and Pakistan.

Regarding guidelines on inactivated poliovirus vaccine, the Strategic Advisory Group of Experts on immunization had set up a working group to provide advice to the Director-General and immunization partners, and final recommendations would be available before the end of the year on long-term use of the inactivated poliovirus vaccine in eradication and post-eradication risk management.

The DIRECTOR-GENERAL affirmed her own commitment and that of the regional directors to eradicating poliomyelitis and expressed appreciation for the financial and technical support of the partners involved in that effort.

She acknowledged the work of the Independent Monitoring Board and welcomed its transparent, honest and sometimes hard-hitting reports. Such frankness, however difficult it was to accept, was essential if all the countries concerned were to meet the target of eradicating poliomyelitis. Despite their best efforts, many countries still faced difficulties, but the example of India should serve as inspiration: just two years previously India had been regarded as having insurmountable obstacles to eradicating poliomyelitis, owing to its high population density, sanitation problems and migrant populations, yet it had just announced that it had been free of poliomyelitis for one year. Other countries should strive to reproduce that success through strong political leadership at all levels, government ownership of eradication programmes, investment by government and development partners, and adequate planning, oversight and accountability mechanisms.

Intensified cross-regional cooperation was essential to the eradication of poliomyelitis in the remaining affected countries. Failure to achieve that goal would be the most expensive and devastating of all public health failures and she appealed to Member States to do what was necessary to attain the target.

She informed the Board that she had requested a meeting with the Prime Minister of Pakistan during the World Economic Forum in Davos, Switzerland, later in the month in order to discuss the particularly worrying situation in his country.

The CHAIRMAN took it that the Board would at a subsequent meeting review the revised version of the draft resolution incorporating the amendments made.

It was so agreed.

Mrs BAMIDELE (Nigeria) requested the Director-General to arrange a meeting with her country's President, who would also be attending the forthcoming World Economic Forum.

The DIRECTOR-GENERAL said that she would endeavour to arrange such a meeting and requested the assistance of the Nigerian delegation to that end.

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

Elimination of schistosomiasis: Item 6.11 of the Agenda (Documents EB130/20 and EB130/20 Add.1)

The CHAIRMAN drew attention to the draft resolution contained in paragraph 9 of document EB130/20 and its financial and administrative implications for the Secretariat (document EB130/20 Add.1).

Mr BENMAMOUN (Morocco) welcomed WHO's continued support for activities to control or eliminate schistosomiasis, which remained a serious public health problem in many countries. Morocco had successfully eliminated schistosomiasis under a national plan between 1994 and 2004. That experience had served as a guide for other national disease control programmes, including for trachoma.

Many countries had launched programmes to eliminate schistosomiasis, which would undoubtedly increase their motivation to consolidate gains and intensify efforts to prevent and control the disease. His country was ready to share its experience. He endorsed the draft resolution, which could serve as a springboard for discussion on elimination mechanisms and certification procedures.

Dr DAULAIRE (United States of America) affirmed his Government's support for schistosomiasis control, given the detrimental socioeconomic impact of the disease, especially in developing countries. Despite the failure to achieve the objectives set out in resolution WHA54.19 by the target year of 2010, Member States that had made progress in controlling the disease were to be commended. Progress had been made in increasing the availability of praziquantel and national programmes should be expanded to meet the growing demand for that medicine.

It was premature to call for elimination of schistosomiasis in all countries in the draft resolution. He proposed the deletion in paragraph 1 of the words "with the aim of eliminating the disease" and in paragraph 2 of the words "with the goal of elimination of the disease". In subparagraph 3(1), the words "to proceed towards the elimination of schistosomiasis" should be replaced with "and water, sanitation, and hygiene interventions, to intensify control programmes in most endemic countries and initiate elimination campaigns, where appropriate" and in subparagraph 3(2) the word "appropriate" should be inserted before "countries". A new subparagraph 3(3) should be inserted, to read "to prepare guidance for Member States to determine when to initiate elimination campaigns, along with methods for implementation of programmes and documentation of success."

Dr LEI Zhenglong (China) said that the report contained inaccurate information on the situation in China (paragraph 5); in fact, among the 12 provinces that had been endemic for schistosomiasis, five had eliminated the disease and three more had recently achieved the targets set for its control. The target year for controlling schistosomiasis nationwide was 2015. China actively supported control and

elimination efforts in African countries and would continue to cooperate with international partners to promote global targets for elimination.

In order to strengthen the draft resolution, he proposed that in paragraph 1 the words “to intensify control interventions and strengthen surveillance, with the aim of eliminating the disease” be deleted, and three subparagraphs be added: “1(1) to attach importance to prevention and control of schistosomiasis, analyse and develop applicable plans with progressive targets, intensify control interventions and strengthen surveillance, with the aim of eliminating the disease; 1(2) to take full advantage of non-health programmes to improve the environment, in order to cut the transmission of schistosomiasis and accelerate the elimination of the intermediate host; and 1(3) to ensure the provision of essential drugs;”.

In subparagraph 3(1), the words “by setting up a special programme” should be inserted after “particularly medicines,” and in subparagraph 3(2) the word “countries” should be replaced with “Member States,” immediately after which the words “to analyse the global schistosomiasis prevention and control status, epidemic model and key challenges so as to provide targeted recommendations and guidance,” should be inserted.

Dr ABDI (Somalia), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that with an estimated 200 million people infected worldwide, schistosomiasis remained a clear public health concern, not least because of failures to meet the targets set in resolution WHA54.19. Nevertheless, some progress had been made: 32 million people had benefited from preventive chemotherapy with praziquantel in 2010, several countries in the Region had reported no new case in recent years and others had attained low levels of endemicity which, in some cases, was a substantial achievement in view of the original breadth of the problem. South Sudan, Sudan, Yemen and, to a lesser extent, Somalia had the highest prevalence rates in the Region. In Yemen, a national schistosomiasis control programme, backed by WHO and the World Bank, had been launched in 2010 and would continue until 2015. He endorsed the draft resolution.

Dr SHEKU DAOH (Sierra Leone), speaking on behalf of the Member States of the African Region, affirmed that schistosomiasis remained a major public health concern, especially in sub-Saharan Africa, which accounted for more than 85% of the overall disease burden. Progress towards control and elimination had been insufficient; the target defined in resolution WHA54.19 had not been reached and expansion of treatment had been slow. However, access to praziquantel and other resources needed for schistosomiasis control was increasing and many countries endemic for the disease had strengthened surveillance systems and reported only a few cases.

The Regional Office had developed a draft strategic plan for schistosomiasis elimination, which would provide guidance to Member States for the development of their own national plans, but challenges remained, including inadequate funding, lack of cooperation among sectors and inadequate coordination among partners. He therefore recommended that the Secretariat continue to provide technical and financial support to countries and encourage Member States to commit themselves to making available the medicines needed for treatment. It should also support the work being done by a team of Senegalese researchers to assess the therapeutic efficacy of the schistosomiasis vaccine Bilhvax 3. He supported the draft resolution.

Dr JESSE (Estonia), referring to subparagraph 3(2) of the draft resolution, in which the Director-General was requested to report regularly to the Health Assembly, asked the Secretariat how often the reports would be provided.

Ms CADGE (United Kingdom of Great Britain and Northern Ireland)¹ said that effective tools for the elimination of schistosomiasis were available and intensified efforts towards that objective

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

should be supported. The timing of the draft resolution was appropriate, as it coincided with increased global commitment to the control of schistosomiasis and other neglected tropical diseases. Ensuring access to adequate and safe water supplies and sanitation facilities was an essential component of control and elimination programmes and, although resolution WHA54.19 had recognized that, the report and the draft resolution had failed to do so.

Where possible, schistosomiasis control measures should be integrated into other disease control programmes and into health systems in general as that would make the use of resources more efficient and optimize programme benefits. Progress towards control and elimination was likely to vary both between and within countries. Several countries with a high disease burden had yet to initiate sufficiently broad programmes to have a meaningful impact. Some countries had “hotspots” of infection, which were difficult to control. Targets for elimination should take account of those differing circumstances.

Dr NIPUNPORN VORAMONGKOL (Thailand)¹ emphasized the public health burden of schistosomiasis, a disease for which 800 million people were at risk and which caused the loss of more than 70 million disability-adjusted life years. The groups most at risk of infection included school-age children and individuals in particular occupational categories such as fishing, most of whom were from poor backgrounds. The international community had failed to achieve the target set in resolution WHA54.19 to ensure the regular administration of chemotherapy to at least 75% and up to 100% of all school-age children at risk of morbidity by 2010. Lessons learnt from that public health failure should influence future treatment strategies. Anthelmintic agents such as praziquantel were highly effective, but could not prevent reinfection; at-risk populations required repeated rounds of treatment.

The draft resolution was not a good road map for the future; rather than continuing with the same measures as used previously, future action should be oriented towards increased resource mobilization and support from partners, better education about schistosomiasis, and improved sanitation facilities. She called on the Director-General to endorse a programme of work encompassing those elements in order to eliminate schistosomiasis as rapidly as possible.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that the pharmaceutical industry had contributed actively to the control and elimination of neglected tropical diseases by increasing access to treatment through medicine-donation programmes. In the case of schistosomiasis, one member company of the Federation, Merck KGaA, which had been donating 25 million praziquantel tablets annually, had recently doubled that contribution, and would shortly announce a further increase. Yet, even greater quantities of praziquantel were needed in order for elimination targets to be attained over the next decade and, to that end, the Federation encouraged donors to increase their commitments.

The pharmaceutical industry was only one global partner among many. All stakeholders should be involved in schistosomiasis prevention and control efforts, which included improving sanitation facilities, increasing access to safe water, enhancing capacity building and preventive education, and strengthening health systems. The Federation also pledged to continue research and development in the area of neglected tropical diseases.

Dr NAKATANI (Assistant Director-General) thanked the members for Morocco and Somalia for sharing their experience in controlling schistosomiasis, the member for Sierra Leone for her recommendations, and the members for the United States and China for their amendments to the draft resolution. Replying to the question raised by the member for Estonia, he said that, were the draft resolution to be adopted, the Secretariat would report every three years on its implementation.

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

The donation of medicines was essential to schistosomiasis control, as were improved standards of hygiene. Moreover, as the representative of the United Kingdom had suggested, schistosomiasis control measures should be integrated into other disease control programmes.

Responding to the DIRECTOR-GENERAL's suggestion that the Board consider adopting the draft resolution, as amended, Dr DAULAIRE (United States of America) drew attention to the potentially contradictory nature of the amendment proposed by the member for China to subparagraph 3(1) and his own amendment to that same subparagraph.

The DIRECTOR-GENERAL asked the member for China if he would be willing to accept subparagraph 3(1) without the words "setting up a special programme".

Dr NIE Jiangang (China) agreed to that request.

Dr JESSE (Estonia) requested that subparagraph 3(2) of the draft resolution be amended to include the information that the Director-General would report every three years on progress in implementing the resolution.

The CHAIRMAN took it that the Board wished to take note of the report contained in document EB130/20 and to adopt the draft resolution on the elimination of schistosomiasis, as amended.

The Board took note of the report and adopted the resolution, as amended.¹

2. WHO REFORM: Item 5 of the Agenda (Documents EB130/5, EB130/5 Add.1 to Add.9)
(continued from the seventh meeting)

Dr GULLY (Canada), speaking in his capacity as chairman of the drafting group on WHO reform (programmes and priority setting), said that the draft decision drawn up by the drafting group would be distributed to the Board members as soon as possible. Under the decision, the Executive Board would: (1) define the scope of work for the Member State-driven process established to provide recommendations on programme and priority-setting methods to the Sixty-fifth World Health Assembly, (2) fix the objectives of the process and (3) set up a meeting at the end of February 2012 to provide Member States with the opportunity to give further consideration to the proposed categories, methodology, criteria and timeline for programmes and priority setting. The Board would also request the Secretariat to identify and provide, before the February meeting, materials that would facilitate discussion at the meeting, at which the participants would decide whether further work was needed before a report could be prepared and transmitted to the Sixty-fifth World Health Assembly.

(For adoption of the draft decision, see the summary record of the thirteenth meeting, section 2.)

The meeting rose at 17:30.

¹ Resolution EB130.R9.

ELEVENTH MEETING

Saturday, 21 January 2012, at 10:15

Chairman: Dr B.S. DANKOKO (Senegal)

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

Global mass gatherings: implications and opportunities for global health security: Item 6.8 of the Agenda (Document EB130/17) (continued from the ninth meeting)

The CHAIRMAN drew attention to a revised version of the draft decision on global mass gatherings proposed by the Islamic Republic of Iran, Libya, Morocco, Qatar, Saudi Arabia, Somalia, Syrian Arab Republic and Yemen, which read:

The Executive Board,

Having considered the report on global mass gatherings: implications and opportunities for global health security,¹

PP1 Recognizing that mass gatherings **have significant implications for public health beyond the acute public health events which may occur and require rapid detection and effective management;** ~~represent risks to health security, and have the potential to endanger the health of populations, raise levels of social anxiety and security alert, and cause economic disruption on a local, regional or global scale;~~

PP2 Recognizing that the planning and organization of mass gatherings is the responsibility of the Member States;

PP2-3 Building on the existing WHO resources to support the planning and conduct of mass gathering events;

PP3-4 Acknowledging the **challenges of some Member States in managing mass gatherings and the** expertise of the Kingdom of Saudi Arabia **which is managing** the largest annual recurring mass gathering event, attracting close to 10 million people from more than 180 countries across the globe,

1. Requests the Secretariat to **further develop and disseminate** multisectoral guidance on **planning, management, evaluation and monitoring of all types** of mass gathering events with specific emphasis on **sustainable** preventive measures including health education **and preparedness;** ~~taking into consideration the uniqueness of each gathering in terms of location, preparation, cultures and timing;~~

2. Decides that the Secretariat should, **where appropriate,** work closely with Member States that are planning and conducting mass gatherings, in order to **establish support** cooperation and communication between the concerned health authorities in each country, and ~~therefore contribute to the strengthening of functional capacities required under the International Health Regulations (2005)~~ **help Member States strengthening functional capacities to better utilize the International Health Regulations (2005) to this end;**

¹ Document EB130/17.

3. Encourages **the Secretariat to reach out to the participation of non-profit-making, nongovernmental and civil society organizations, including, as appropriate, the private sector in the development and implementation of health education related to mass gatherings;**
4. Requests the Secretariat to raise awareness on the health impact of mass gatherings **and support countries in developing, disseminating and evaluating effective communication strategies, including social media, around key public health messages.** ~~using a highly professional approach and state-of-the-art technologies that can be regularly monitored and evaluated.~~

Mr SAMRI (Morocco) proposed the insertion in the third line of paragraph 4 of the words “as appropriate” between “including” and “social media”.

The CHAIRMAN said that, hearing no objection, he took it that the Board wished to adopt the draft decision as amended.

The decision, as amended, was adopted.¹

Poliomyelitis: intensification of the global eradication initiative: Item 6.10 of the Agenda (Documents EB130/19 and EB130/19 Add.1) (continued from the tenth meeting, section 1)

The CHAIRMAN drew attention to a revised version of the draft resolution on poliomyelitis: intensification of the global eradication initiative, which read:

The Executive Board,
Having considered the report on poliomyelitis: intensification of the Global Polio Eradication Initiative,²

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

The Sixty-fifth World Health Assembly,
PP1 Having considered the report on poliomyelitis: intensification of the Global Polio Eradication Initiative;
PP2 Recalling resolution WHA61.1 on poliomyelitis: mechanism for management of potential risks to eradication, which, inter alia, requested the Director-General to develop a new strategy to reinvigorate the fight to eradicate poliovirus and to develop appropriate strategies for managing the long-term risks of reintroduction of poliovirus and re-emergence of poliomyelitis, including the eventual cessation of use of oral poliovirus vaccine in routine immunization programmes;
PP3 Recognizing the need to make rapidly available the necessary financial resources to eradicate the remaining circulating polioviruses and to minimize the risks of reintroduction of poliovirus and re-emergence of poliomyelitis after interruption of wild poliovirus transmission;
PP4 Noting the Independent Monitoring Board's recent finding that “polio simply will not be eradicated unless it receives a higher priority – in many of the polio-affected countries, and across the world” and its recommendation that the World Health Assembly “considers a resolution to declare the persistence of polio a global health emergency”;

¹ Decision EB130(3).

² Document EB130/19.

PP5 Noting the recent report of the Strategic Advisory Group of Experts on immunization that “states unequivocally that the risk of failure to finish global polio eradication constitutes a programmatic emergency of global proportions for public health and is not acceptable under any circumstances”;

PP6 Recognizing the need for Member States to engage all levels of political and civil society in order to ensure all children are vaccinated to eradicate poliomyelitis;

PP7 Noting that the technical feasibility of poliovirus eradication has been proved through the full application of new strategic approaches;

PP8 Noting that continuing poliovirus transmission anywhere will continue to pose a risk to poliomyelitis-free areas until such time as all poliovirus transmission is interrupted globally, **and that some countries, such as the Kingdom of Saudi Arabia, require poliovirus vaccination for travellers coming from polio-infected areas, including administration of an additional dose of vaccine upon arrival; [USA]**

1. DECLARES the completion of poliovirus eradication a programmatic emergency for global public health, requiring the full implementation of current and new eradication strategies, the institution of strong national oversight and accountability mechanisms for all areas infected with poliovirus, and the application of appropriate vaccination recommendations for all travellers to and from areas infected with poliovirus;¹

2. URGES Member States with poliovirus transmission to declare such transmission to be a “national public health emergency” **making poliovirus eradication a national priority programme, [JAPAN]** requiring the development and full implementation of emergency action plans, to be updated every six months, until such time as poliovirus transmission has been interrupted;

3. URGES all Member States:

(1) **to eliminate the unimmunized areas and [CHINA]** to maintain very high population immunity against polioviruses through routine immunization programmes and, where necessary, supplementary immunization activities;

(2) to maintain vigilance for poliovirus importations, and the emergence of circulating vaccine-derived polioviruses, by achieving and sustaining certification-standard surveillance **and regular risk assessment [CHINA]** for polioviruses;

(2bis) to review and, if necessary, align national guidelines and practice with WHO recommendations for the vaccination of travellers to and from poliovirus-infected areas; countries at particular risk of recurrent importation and spread of poliovirus may consider additional steps to promote vaccination; [USA]

(3) to urgently make available the financial resources required for the full and continued implementation through end-2013 of the necessary strategic approaches to interrupt wild poliovirus transmission globally, and to initiate planning for the financing to the end of 2018 of the polio endgame strategy;

(4) to engage in multilateral and bilateral cooperation, including exchanging epidemic information, laboratory monitoring data, and carrying out supplementary immunization activities simultaneously as appropriate; [CHINA]

¹ *International travel and health*. Geneva, World Health Organization, 2012 edition, in press.

- The associated financial and administrative implications for the Secretariat were as follows:

<p>1. Resolution: Poliomyelitis: intensification of the global eradication initiative</p>	
<p>2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)</p> <p>Strategic objective(s): 1</p>	<p>Organization-wide expected result(s): 1.2</p> <p>How would this resolution contribute to the achievement of the Organization-wide expected result(s)?</p> <p>It would support the interruption of circulation of wild poliovirus, and the minimization and management of long-term poliovirus risks.</p> <p>Does the programme budget already include the products or services requested in this resolution? (Yes/no)</p> <p>Yes, the products and services are included; however, as a result of delays against critical programme indicators in the biennium 2010–2011, additional activities are required in order to achieve the Organization-wide expected result mentioned above. In 2010–2011, the operating budget for poliomyelitis eradication (US\$ 909 million) was 99.8% funded through voluntary contributions earmarked for this purpose; approximately 92% of this budget is reflected under the Special programmes and collaborative arrangements budget segment, and approximately 8% reflected under the Base programmes segment. The operating budget for poliomyelitis eradication represents approximately 2% of the Base programmes segment and approximately 50% of the Special programmes and collaborative arrangements segment. Of note, the Base programmes budget segment for poliomyelitis eradication is also funded through earmarked voluntary contributions.</p>
<p>3. Estimated cost and staffing implications in relation to the Programme budget</p> <p>(a) Total cost</p> <p>Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).</p> <p>(i) 6 years (covering the period 2013–2018)</p>	

<p>(ii) Total: US\$ 1896 million (staff: US\$ 658 million; activities: US\$ 1238 million) projected to be funded through earmarked voluntary contributions.</p> <p>(b) Cost for the biennium 2012–2013</p> <p>Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000).</p> <p>Total: US\$ 935 million (staff: US\$ 281 million; activities: US\$ 654 million); projected to be funded through earmarked voluntary contributions.</p> <p>Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.</p> <p>8% of total costs incurred at headquarters level, 6% at regional level and 86% at country level.</p> <p>Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)</p> <p>No. US\$ 441 million are in the approved Programme budget 2012–2013, mainly under the Special programmes and collaborative arrangements budget segment; this figure is projected to be funded through earmarked voluntary contributions.</p> <p>If “no”, indicate how much is not included.</p> <p>US\$ 494 million. The budget increase would be under the Special programmes and collaborative arrangements segment, and is projected to be funded through earmarked voluntary contributions.</p> <p>(c) Staffing implications</p> <p>Could the resolution be implemented by existing staff? (Yes/no)</p> <p>Yes.</p> <p>If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.</p>	<p>4. Funding</p> <p>Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)</p> <p>No. US\$ 339 million is confirmed or projected.</p> <p>If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).</p> <p>US\$ 596 million; source(s) of funds: earmarked voluntary contributions from WHO Member States, multilateral organizations (including European Commission and development banks), private sector (including Bill & Melinda Gates Foundation and Rotary International).</p>
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Ms WISEMAN (Canada) asked whether the words “to eliminate the unimmunized areas” in subparagraph 3(1) meant a renewal of efforts to reach unimmunized areas. She also enquired whether the words “including the establishment of a special polio programme within the Organization” in subparagraph 4(1) referred to a new programme or to the strengthening of the existing one.

Dr TAKEI (Japan) proposed, in the interests of clarity, replacing the words “including the establishment of a special polio programme within the Organization” in subparagraph 4(1) with the words “including the enhancement of the existing Global Polio Eradication Initiative”.

Dr NIE Jiangang (China) said that the aim of the proposed amendment to subparagraph 3(1) was to enhance immunization coverage, especially in countries with limited coverage.

Ms SY (Senegal) requested a postponement of further consideration of the draft resolution as consultations were still under way within the African group, in particular on the proposed amendment to the eighth preambular paragraph.

Dr DAULAIRE (United States of America) said that he would withdraw the proposed amendment to the eighth preambular paragraph in the interests of an early adoption of the resolution.

Ms SY (Senegal) thanked the member for the United States for his flexibility and said that in that case she was prepared to adopt the draft resolution.

Dr BIRINTANYA (Burundi) said that the African group also had reservations about the second part of subparagraph 3(2*bis*) referring to countries at particular risk of recurrent importation.

Dr PRADHAN (India), referring to subparagraph 4(3*bis*), proposed that “to coordinate the relevant partners” should be amended to read “to coordinate with all relevant partners”.

Mrs BAMIDELE (Nigeria) thanked the member for the United States of America for withdrawing his proposed amendment. With regard to subparagraph 3(2*bis*), as the action proposed in the second part was a matter for national governments, the paragraph should end at “areas”.

Dr DAULAIRE (United States of America) said that he had no objection to that proposal.

The CHAIRMAN said that, in the absence of any further objection, he would take it that the Board wished to adopt the draft resolution as amended.

The resolution, as amended, was adopted.¹

Social determinants of health: outcome of the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, October 2011): Item 6.6 of the Agenda (Document EB130/15) (continued from the fourth meeting)

The CHAIRMAN drew attention to a revised version of the draft resolution on the outcome of the World Conference on Social Determinants of Health proposed by Brazil, Chile and Ecuador, which read:

The Executive Board,
Having considered the report on the World Conference on Social Determinants of Health, held in Rio de Janeiro, Brazil, 19–21 October 2011,²

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

The Sixty-fifth World Health Assembly,
PP1 Having considered the report on the World Conference on Social Determinants of Health, held in Rio de Janeiro, Brazil, 19–21 October 2011;
PP2 Reiterating our determination to take action on social determinants of health as collectively agreed by the World Health Assembly and reflected in resolution WHA62.14 (reducing health inequities through action on the social determinants of health), which notes the three overarching recommendations of the Commission on Social Determinants of Health: to improve daily living conditions; to tackle the inequitable distribution of power, money and resources; and to measure and understand the problem and assess the impact of action;

¹ Resolution EB130.R10.

² Document EB130/15.

PP3 Recognizing the need to do more to accelerate progress in addressing the unequal distribution of health resources as well as conditions damaging to health at all levels;

PP4 Recognizing the need to safeguard health of the populations regardless of global economic downturns;

PP5 Further acknowledging that health equity is a shared goal and responsibility and requires the engagement of all sectors of government, of all segments of society, and of all members of the international community, in an “all for equity” and “health for all” global actions;

PP6 Recognizing the benefits of universal health coverage in enhancing health equity and reducing impoverishment;

PP7 Reaffirming the political will to make health equity a national, regional and global goal and to address current challenges, such as eradicating hunger and poverty, ensuring food and nutritional security, access to affordable, safe, efficacious and quality medicines as well as to safe drinking-water and sanitation, employment and decent work and social protection, protecting environments and delivering equitable economic growth through resolute action on social determinants of health across all sectors and at all levels;

PP8 Welcoming the discussions and results of the World Conference on Social Determinants of Health held in Rio de Janeiro, Brazil, from 19 to 21 October 2011,

1. ENDORSES the Rio Political Declaration on Social Determinants of Health adopted by the World Conference on Social Determinants of Health, including as a key input to the work of Member States¹ and WHO;

2. URGES Member States:¹

(1) to implement the pledges made in the Rio Political Declaration with regard to (i) better governance for health and development, (ii) promote participation in policy-making and implementation, (iii) further reorient the health sector towards reducing health inequities, (iv) strengthen global governance and collaboration, and (v) monitor progress and increase accountability;

(2) to develop and support policies, strategies, programmes and action plans, which address social determinants of health, with clearly defined goals, activities and accountability mechanisms and with resources for their implementation;

(3) to support the further development of the health in all policies approach as a way to promote health equity;

(4) to build capacities among policy-makers, managers, and programme workers in health and other sectors to facilitate work on social determinants of health;

(5) to give due consideration to social determinants of health as part of the deliberations on sustainable development in particular in the United Nations Conference on Sustainable Development (Rio+20) and in other United Nations deliberations with relevance to health;

3. CALLS UPON the international community to support the implementation of pledges made in the Rio Political Declaration for action on social determinants of health, including through:

(1) supporting the leading role of the World Health Organization in global health governance, and in promoting alignment in policies, plans and activities on social determinants of health with its partner United Nations agencies, development banks and other key international organizations, including in joint

¹ Including, where applicable, regional economic integration organizations.

- advocacy, and in facilitating access to the provision of financial and technical assistance to countries and regions in particular, developing countries;
- (2) strengthening international cooperation with a view to promoting health equity in all countries, through facilitating transfer on mutually agreed terms of expertise, technologies and scientific data in the field of social determinants of health, as well as exchange of good practices for managing intersectoral policy development;
- (3) facilitating access to financial resources;
4. URGES those developed countries which have pledged to achieve the target of 0.7% of the gross national product for official development assistance by 2015 and those developed countries that have not yet done so, to make additional concrete efforts to fulfil their commitments in this regard. We also urge developing countries to build on progress achieved in ensuring that official development assistance is used effectively to help achieve development goals and targets;
5. REQUESTS the Director-General:
- (1) to duly consider social determinants of health in the assessment of global needs for health, including in the reform process and future WHO work;
- (2) to provide support to Member States in implementing the Rio Political Declaration through approaches such as “Health in All Policies” to address social determinants of health;
- (3) to work closely with other United Nations agencies in advocacy, research, capacity-building and direct technical assistance to Member States for work on social determinants of health;
- (4) to continue to convey and advocate the importance of integrating social determinants of health perspectives into upcoming United Nations and other high-level meetings related to health and/or social development;
- (5) to report to the Sixty-sixth and Sixty-eighth World Health Assemblies, through the Executive Board, on progress in implementing this resolution and the Rio Political Declaration.

The associated financial and administrative implications for the Secretariat, revised in line with the amended draft resolution, were as follows:

<p>1. Resolution: Outcome of the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, 19–21 October 2011)</p>
<p>2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)</p> <p>Strategic objective(s): 7 and 10 Organization-wide expected result(s): 7.1, 7.2, 7.3 and 10.5</p> <p>How would this resolution contribute to the achievement of the Organization-wide expected result(s)?</p> <p>The resolution would contribute to the achievement of the Organization-wide expected results mentioned above by requesting the Secretariat to scale up action on the social determinants of health, as identified in the Rio Political Declaration on Social Determinants of Health (2011).</p> <p>Does the programme budget already include the products or services requested in this resolution? (Yes/no)</p> <p>No</p>

<p>3. Estimated cost and staffing implications in relation to the Programme budget</p> <p>(a) Total cost Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000). (i) 6 years (covering the period 2012–2017) (ii) Total: US\$ 127 million (staff: US\$ 83 million; activities: US\$ 44 million)</p> <p>(b) Cost for the biennium 2012–2013 Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000). Total: US\$ 42 million (staff: US\$ 28 million; activities: US\$ 14 million) Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant. Headquarters: US\$ 16 million; regional offices: US\$ 10 million; country offices: US\$ 16 million Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no) No If “no”, indicate how much is not included. US\$ 8.3 million</p> <p>(c) Staffing implications Could the resolution be implemented by existing staff? (Yes/no) No If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant. In order to implement the resolution, six staff at grade P.4 and six at grade G.4 would be required at the country and regional levels, and one staff member at grade P.4 would be needed at headquarters.</p>
<p>4. Funding</p> <p>Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no) No If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds). US\$ 29 million; source(s) of funds: voluntary contributions from countries, private donors and multilateral organizations.</p>

Dr JESSE (Estonia), speaking on behalf of the European Union and its Member States, referring to the revised financial and administrative implications for the Secretariat, asked why the estimated cost appeared to have increased from US\$ 94 million to US\$ 127 million. The funding shortfall for the current biennium had also increased from US\$ 21.4 million to US\$ 29 million.

Ms ESCOREL DE MORAES (Brazil)¹ recalled that the Board had agreed that the word “global” should be inserted between “of” and “economic downturns” in the fourth preambular paragraph; the draft resolution should be amended accordingly.

She, too, would appreciate an explanation of the increased cost estimates.

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

Dr LARSEN (Norway), Dr NIE Jiangang (China), Dr AGUILAR (Ecuador), Ms SY (Senegal) and Mr SAMRI (Morocco) endorsed the amendment proposed by the representative of Brazil.

Dr KIENY (Assistant Director-General) explained that the higher figure in the revised report on the financial and administrative implications of the draft resolution represented the total cost of the Secretariat's work on social determinants of health, which included the cost of implementing the draft resolution: US\$ 8 million. The Secretariat would revise the report to reflect only the cost of implementing the draft resolution.

Dr JESSE (Estonia) acknowledged the explanation and requested that, in future, explanations of any such changes should be included in the relevant financial and administrative report.

The CHAIRMAN took it that the Board wished to adopt the resolution as amended.

The draft resolution, as amended, was adopted.¹

Draft global vaccine action plan: update: Item 6.12 of the Agenda (Document EB130/21)

The CHAIRMAN drew attention to a draft resolution on World Immunization Week, proposed by Barbados, which read:

The Executive Board,
Having considered the report on draft global vaccine action plan: update,²

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

The Sixty-fifth World Health Assembly,

PP1 Recalling resolutions WHA58.15 and WHA61.15 on global immunization strategy and the commitment to use the next decade 2011–2020 to achieve immunization goals and milestones in vaccine research and development;

PP2 Recognizing the importance of immunization as one of the most cost-effective interventions in public health;

PP3 Acknowledging the significant achievements of the Expanded Programme on Immunization at the global level, including the eradication of smallpox, major advances towards eradicating poliomyelitis, eliminating measles and rubella, and the control of other vaccine-preventable diseases, such as diphtheria and tetanus;

PP4 Noting the contribution of successful immunization programmes towards significant reductions in childhood mortality and improvements in maternal health, and thereby towards the attainment of Millennium Development Goals 4 (Reduce child mortality) and 5 (Improve maternal health), and towards cancer prevention;

PP5 Recognizing that initiatives such as regional vaccination weeks have contributed towards promoting immunization, advancing equity in the use of vaccines and universal access to vaccination services, and enabling cooperation on cross-border immunization activities;

PP6 Recognizing that the initiative of vaccination weeks, a growing global movement which was first introduced in the Americas in 2003, is scheduled to be observed simultaneously in WHO's six regions in April 2012, with the participation of more than 180 Member States, territories and areas;

¹ Resolution EB130.R11.

² Document EB130/21.

PP8 Concerned that, despite all the achievements of immunization initiatives, many challenges remain, including maintaining immunization as a fundamental aspect of primary health care, administering vaccines to all vulnerable populations regardless of their location, protecting national immunization programmes against the growing threat of misinformation on vaccines and immunization, and ensuring that national programmes are considered a financial priority for Member States,

1. REQUESTS Member States to designate the last week of April as World Immunization Week;
2. REQUESTS the Director-General:
 - (1) to support the annual implementation of World Immunization Week as the overarching framework for all regional initiatives that are dedicated to promoting the importance of vaccination across the life course and working to assure the universal right of individuals of all ages and in all countries to receive this essential preventive health service;
 - (2) to provide support to Member States in mobilizing the resources necessary to sustain World Immunization Week, and to encourage civil society organizations and other stakeholders to support the initiative.

<p>1. Resolution: World Immunization Week</p>	
<p>2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)</p> <p>Strategic objective(s): 1</p> <p>How would this resolution contribute to the achievement of the Organization-wide expected result(s)?</p> <p>Immunization Weeks help to: (i) raise global and local awareness of the benefits of vaccination; (ii) increase the population’s acceptance of, and demand for, immunization services; (iii) enhance political commitment; (iv) provide an additional opportunity to deliver vaccines to people, and, consequently, contribute to improving vaccine coverage.</p> <p>Does the programme budget already include the products or services requested in this resolution? (Yes/no)</p> <p>Yes</p>	<p>Organization-wide expected result(s): 1.1</p>
<p>3. Estimated cost and staffing implications in relation to the Programme budget</p> <p>(a) Total cost</p> <p>Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).</p> <p>(i) Implementation would be on a continuing basis, subject to review by the governing bodies.</p> <p>(ii) Total additional cost: US\$ 150 000 per annum (staff US\$ 30 000; activities: US\$ 120 000).</p> <p>Note: All WHO regions have adopted their own resolutions on Regional Immunization Weeks; four regions have been implementing Immunization Weeks for a number of years, with the African and South-East Asia regions joining them in 2012. Consequently, the cost of Regional Immunization Weeks has already been planned for and funded, and the increase in cost due to</p>	

the introduction of the World Immunization Week would be minimal and would simply reflect some additional staff time at the global level needed for coordination, additional media and communication materials, and a small coordination meeting.

(b) Cost for the biennium 2012–2013

Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000)

Total additional cost: US\$ 300 000 (staff US\$ 60 000; activities: US\$ 240 000)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant

Headquarters

Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

Yes

If “no”, indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

Yes

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

Yes

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ n/a; source(s) of funds: n/a.

The CHAIRMAN also drew attention to a draft resolution entitled “Towards the eradication of measles” proposed by Ecuador on behalf of the Union of South American Nations (UNASUR), which read:

The Executive Board,
Having considered the draft global vaccine action plan: update,¹

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

The Sixty-fifth World Health Assembly,
PP1 Considering resolution WHA56.20 on reducing global measles mortality and stressing the importance of achieving the goal of reducing deaths due to measles by half by 2005, compared with the 1999 level;
PP2 Attaching priority to the need for Member States to endeavour to achieve Millennium Development Goal 4, namely to reduce by two thirds, between 1990 and 2015, the under-five mortality rate;

¹ Document EB130/21.

PP3 Considering resolution WHA58.15, which adopted the Global Immunization Vision and Strategy to strengthen immunization programmes between 2006 and 2015 and also resolution WHA61.15, on the global immunization strategy, which, *inter alia*, established the target of reducing measles mortality by 90% by 2010,¹ and urged Member States to review national strategy and programme performance in order to achieve the goal;

PP4 Considering that five regions of WHO, at the level of their respective Regional Committees, have set themselves the objective of eliminating measles: in 1994 the Region of the Americas set itself the objective of eliminating measles by 2000; in 1997, the Eastern Mediterranean Region committed itself to achieve this goal by 2010; in 1998 the European Region committed itself to eradication by 2010; in 2003, the Western Pacific Region pledged to do so by 2012; and lastly, in 2009, the African Region pledged to eliminate measles by 2020. Significant progress has been made to date, and the Region of the Americas successfully interrupted endemic transmission of the measles virus in 2002 and the rubella virus in 2009. Considering that, in June 2009, the International Task Force for Disease Eradication concluded that measles eradication is technically possible, using tools that are currently available, from the point of view of biological, operational and programmatic feasibility, vaccine supply and cost-effectiveness;²

PP5 Considering the recent outbreaks of measles imported into the Region of the Americas, cases in Africa and Europe, and the persistently high number of measles deaths in India, in addition to the cost of controlling measles outbreaks for countries that have successfully interrupted transmission;

1. URGES Member States:

- (1) to establish a time frame for the eradication of measles, including the component of eliminating rubella and congenital rubella syndrome (CRS), given that technically and operationally this will not change national plans and represents an excellent opportunity to avoid thousands of serious birth defects, in addition to the family, community and institutional burden of CRS;
- (2) to develop and implement a global strategy to eradicate measles and rubella within the specified time frame. Due consideration should be taken of the lessons learnt in the Americas to eliminate these diseases, the high impact of which was demonstrated by scientific evidence;
- (3) urges Member States currently developing activities to eradicate poliomyelitis to include measles and rubella immunization in their activities;
- (4) to collaborate technically and politically in activities to eradicate measles;
- (5) to redouble efforts to expedite achievement of the targets of the Global Immunization Vision and Strategy by 2015 by expanding immunization coverage at all levels, and strengthening integrated epidemiological surveillance of measles and rubella;
- (6) to request the Review Committee of the International Health Regulations to revise Article 31 on special provisions relating to travellers (Chapter III), paragraph 1(c), Annexes 6 and 7, to include diseases targeted for elimination and/or eradication among those for which international travellers must be immunized, and also the effective development of international surveillance and control strategies;

¹ In relation to the rate in 2000.

² A63/18, Global eradication of measles, WHO Secretariat, 2010.

- (1) to require the Strategic Advisory Group of Experts on Immunization to undertake a comprehensive study in conjunction with the International Task Force for Disease Eradication with a view to submitting a draft global strategy on the eradication of measles and rubella and a corresponding plan of action to Member States. This should be accompanied by a planning schedule and a cost analysis of the implementation of a global strategy;
- (2) to keep the Sixty-sixth World Health Assembly informed, through the Executive Board, of progress towards implementation of this resolution;
- (3) to monitor annual progress towards the development and implementation of the global strategy for the eradication of measles.

<p>1. Resolution: Towards the eradication of measles</p>	
<p>2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)</p>	
<p>Strategic objective(s): 1</p>	<p>Organization-wide expected result(s): 1.1</p>
<p>How would this resolution contribute to the achievement of the Organization-wide expected result(s)?</p>	
<p>Implementation of the resolution would support the interruption of measles virus transmission by encouraging increased equitable access to measles-containing vaccine. It would also reduce the burden of rubella and congenital rubella syndrome through the increased use of combined measles- and rubella-containing vaccines.</p>	
<p>Does the programme budget already include the products or services requested in this resolution? (Yes/no)</p>	
<p>Yes</p>	
<p>3. Estimated cost and staffing implications in relation to the Programme budget</p>	
<p>(a) Total cost</p>	
<p>Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).</p>	
<p>(i) 14 years (covering the period 2012–2025)¹</p>	
<p>(ii) Total: US\$ 2369 million (staff: US\$ 1133 million; activities: US\$ 1236 million)²</p>	
<p>(b) Cost for the biennium 2012–2013</p>	
<p>Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000)</p>	
<p>Total: US\$ 536 million (staff US\$ 252 million; activities: US\$ 284 million)</p>	
<p>Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant</p>	
<p>Share of total cost: headquarters – 6%; regional level – 8%; country level – 86%</p>	
<p>Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)</p>	
<p>No</p>	

² US\$ 640 million of the cost of bundled vaccines is not included above (paid by national governments or UNICEF).

<p>If “no”, indicate how much is not included.</p> <p>US\$ 356 million</p> <p>(c) Staffing implications</p> <p>Could the resolution be implemented by existing staff? (Yes/no)</p> <p>No</p> <p>If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.</p> <p>At headquarters, 10 additional staff members would be required (including medical and technical officers and staff in the areas of programme management and finance, communications and administration). In the regions, 3 additional staff members would be needed per region, together with 6 additional staff in intercountry support teams in the African Region. At country level, based on the Organization’s experience with activities for the eradication of poliomyelitis, some 2500 national and local staff would be needed. Staff with various skills profiles would be required, including drivers and administrative personnel. Some of the staff concerned would be gradually transitioning from work on poliomyelitis eradication.</p>
<p>4. Funding</p> <p>Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)</p> <p>No</p> <p>If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).</p> <p>US\$ 356 million; source(s) of funds: voluntary contributions from various donors, including Member States, international organizations and foundations (including the United Nations Foundation and the American Red Cross, multilateral organizations, the private sector (including the Bill & Melinda Gates Foundation).</p>

The CHAIRMAN further drew attention to a draft decision entitled “Towards the eradication of measles” proposed by Ecuador on behalf of the Union of South American Nations (UNASUR), which read:

The Executive Board,

Taking note of the recent widespread outbreaks of measles in several WHO regions over the past two years, which have had a devastating impact on the lives of many young children and which further compromise progress towards achieving Millennium Development Goal 4;

Considering that in addition to the existing global approved immunization strategies, five of the six WHO Regions have established target dates for the elimination of measles, however, measles outbreaks continue to pose serious challenges to achieve these targets,

1. REQUESTS the Secretariat to emphasize that measles remains a serious threat to childhood health globally in the upcoming Global Vaccine Action Plan of the Decades of Vaccines, to be adopted by the Sixty-fifth World Health Assembly in May 2012;
2. DECIDES to include ambitious immunization coverage targets as well as measles elimination goals in the upcoming Global Vaccine Action Plan;
3. CALLS upon the Member States to commit to their responsibilities, as stated in the existing regional measles elimination targets and 2015 global measles mortality reduction goals, in order to prevent similar devastating outbreaks of measles in the future.

Dr ST. JOHN (Barbados), introducing the draft resolution on World Immunization Week, pointed out that immunization was one of the most cost-effective public health interventions.

Vaccination Week in the Americas had been launched in 2003. In Barbados it had afforded the opportunity to expand vaccination coverage, to train or retrain staff in cold-chain management, introduce new vaccines and conduct catch-up campaigns. Immunization weeks had been launched in the European Region in 2005, in the Eastern Mediterranean Region in 2010 and in the African and Western Pacific Regions in 2011. The Regional Committee for South-East Asia had adopted resolution SEA/RC64/R3 in 2011 urging Member States to organize an annual immunization week in 2012. The financial and administrative implications of the draft resolution showed that the costs for the Secretariat arising from the introduction of a world immunization week would be minimal. She noted that Bahamas, Brazil, Canada, Guyana, Jamaica, Mexico, Suriname and the United States of America were cosponsors of the draft resolution, and proposed an amendment to subparagraph 2(1), namely that the word “right” after “universal” should be replaced by “access”.

Ms WISEMAN (Canada) expressed support for both draft resolutions and the draft decision. In preparing a programme for eliminating measles, advantage should be taken of resources and networks made available as a result of the poliomyelitis eradication initiative. She asked for information on any consultations on the draft global vaccine action plan to be conducted before the Sixty-fifth World Health Assembly.

Mr DÍAZ ANAIZ (Chile), welcoming the report on the draft global vaccine action plan, said that his Government was firmly committed, both politically and financially, to implementing its national immunization plan. With sound management and improved quality, infrastructure and logistical arrangements, it should be possible to introduce or replace vaccines in line with evolving epidemiological requirements; in 2011, the pneumococcal conjugate vaccine had been introduced. His Government strongly favoured integrated public health programmes; those, in turn, depended on open and transparent communication with the public in order to counter misleading messages emanating from those opposed to vaccines and to foster public trust in immunization. He supported the draft resolution on World Immunization Week.

Dr JESSE (Estonia), speaking on behalf of the European Union and its Member States, welcomed the report's emphasis on the commitment of governments to immunization as a priority and on the integration of immunization programmes within national health systems. The Secretariat should play a clear role in both the drafting and the implementation of the action plan. Its normative and technical support would be crucial in the Decade of Vaccines (2011–2020).

The advisability of introducing new vaccines, especially in low-income countries, had to be weighed against other health interventions in terms of health benefits and cost-effectiveness. The public health benefits of vaccination could be undermined by increasingly negative attitudes towards vaccines, as witnessed in Europe during the recent outbreak of measles, and the Secretariat's work in that regard was welcome. She agreed on the need, noted in the report, for ongoing dialogue between suppliers and buyers in order to ensure the supply of high-quality vaccines and supported the idea of establishing a “vaccine access forum”, which could help to generate estimates of demand for vaccines. She also supported the establishment of an accountability framework for monitoring and evaluating progress. The European Union would examine ways of supporting a future research and development agenda.

A world immunization week could be a useful means of promoting the benefits of vaccines. Although it might have been better to incorporate that concept into the draft vaccine action plan, she would join the apparent consensus on the draft resolution. She strongly supported the draft decision concerning measles and the inclusion of elimination goals in the draft action plan.

Dr NIE Jiangang (China) encouraged the Secretariat to make the final version of the action plan available for Member States' review before the Sixty-fifth World Health Assembly. The action plan should emphasize the benefits of health education and promotion in enhancing individual and community understanding of, and demand for, immunization. It should also highlight the importance of risk communication in order to address public misunderstandings about the side effects of vaccines.

In order to integrate immunization programmes into broader health systems, immunization services had to be provided in an equitable way, and synergies between immunization and other health programmes needed to be identified. Strategies should be developed and funding sought for immunization programmes on the basis of disease burden, vaccine supply and prices, and the needs of individuals and communities. Intergovernmental donations and financing facilities should be used to support initiatives in areas with low rates of vaccination coverage and to reduce coverage gaps between countries and regions. Disease surveillance, post-market evaluation of vaccines, monitoring of adverse events, and communication with vaccine suppliers, the public, the media and relevant stakeholders should also be emphasized, as should technology transfer to enable developing countries to produce affordable, high-quality vaccines. Strategies should be devised to promote the introduction of new vaccines. He supported the draft resolution on World Immunization Week.

Dr DAULAIRE (United States of America) expressed appreciation of the integration of all aspects of immunization, from research to political commitment, in the draft global vaccine action plan and encouraged other Member States to support it. Most unvaccinated children lived in low-income and middle-income countries, but recent large outbreaks of vaccine-preventable diseases in high-income countries highlighted the need for action to re-establish and increase the demand for vaccination in those countries as well. He also encouraged Member States to support resource mobilization for vaccines. In many low-resource countries, the provision of high-quality services was an issue of development as much as disease control, hence the need to improve the quality and performance of their routine immunization programmes as an integral part of functioning health systems based on primary health care principles. As the report referred several times to access to vaccines but paid insufficient attention to their use, he recommended that it use the term “access and use” instead of “access”.

Who would undertake the actions in the draft global vaccine action plan and how would they be coordinated? Were the proposals in paragraphs 16 to 18 of the report to be noted or endorsed? What were the objectives and goals of the proposed vaccine access forum, and what value would it add, especially as other bodies dedicated to enhancing vaccine access existed?

He supported the draft resolution designating a world immunization week, as amended by the member for Barbados, and welcomed the intended flexibility for Member States and regions to tailor their participation. The event should be treated in a way that boosted coverage and strengthened the routine immunization system.

He endorsed the revised draft decision aimed at increasing efforts to increase measles vaccination coverage, particularly in view of recent outbreaks partly caused by diminished coverage. He could not, however, accept the use of the word eradication in the title; elimination would more accurately describe the desired objective.

Dr TAKEI (Japan) affirmed that the global vaccine action plan should contribute towards improving global public health and achieving the health-related Millennium Development Goals and the objectives of the United Nations General Assembly special session on children. However, the relationship between the draft global action plan and the Expanded Programme on Immunization needed to be reassessed in order to avoid duplication, especially in the field.

He supported the principles laid down in the draft resolution on a world immunization week, but stressed the need for flexibility in its implementation. For example, the week mentioned in paragraph 1 coincided with a national holiday period in Japan. He therefore proposed that in the first paragraph the words “where appropriate” be inserted between “April” and “as”.

He welcomed the draft decision on measles, in particular the emphasis it placed on controlling the disease in order to achieve Millennium Development Goal 4. Japan had been striving to eradicate measles domestically and was committed to international immunization programmes.

Dr AGUILAR (Ecuador), speaking on behalf of the Union of South American Nations, said that following the recommendation by the Board to streamline the agenda and informal consultations with Member States, it had been decided to withdraw the draft resolution entitled “Towards the eradication

of measles” in favour of the draft decision which would result in the inclusion of targets and goals in the global vaccine action plan. He emphasized the need for Member States’ commitment; achievement of those objectives should prevent outbreaks of measles – the recent outbreak in Ecuador had occurred after a period of 15 years during which transmission had been interrupted. In response to the member for the United States of America, he said that the word eradication had been a mistake and that the correct term was elimination.

Mr PRADHAN (India) commended the report and its emphasis on the need to raise awareness among communities and to reach underserved and marginalized children and on strong national commitments to immunization. India had designated 2012 as the year of intensified routine vaccination with the aim of improving coverage and reaching all children, particularly in remote areas and urban slums. An Internet system had been introduced for tracking and delivering immunization services to every child and identifying children who had been missed; the database already contained information on nearly 10 million children. Health workers were provided with lists of children due for vaccination. A second dose of measles vaccine had been administered to more than 40 million children as part of a catch-up campaign. The aim was to achieve elimination within three years.

Coverage with hepatitis B vaccine had been extended nationwide and a pentavalent vaccine containing the hepatitis B antigen had been introduced in two states with a good community response. He stressed vaccine security in countries, ensuring timely availability of vaccines at affordable prices in order to sustain immunization programmes, and strengthening and coordinating research and development programmes.

He supported the draft resolution on a world immunization week as amended by the member for Japan.

Mr MANCHA MOCTEZUMA (Mexico) supported the draft resolution on a world immunization week. Such an event should not involve vaccination campaigns, as the seasonal nature of outbreaks around the world made it difficult for everybody to conduct vaccinations on the same date; such an approach would be contrary to accepted technical practice. Rather, the objective should be to conduct health-promotion and awareness-raising activities aimed at the general public. A world immunization week would provide an opportunity to convey a consistent and clear message to the public about the importance of vaccination – a public health intervention that, in his country at least, was deeply rooted and had produced significant results.

As long as the measles virus was still circulating, the term “elimination” was more appropriate than “eradication”. Thus, the draft resolution should perhaps refer instead to the global elimination of measles as the objective for Member States.

Dr BELO (Timor-Leste) endorsed the draft resolution on a world immunization week and the report on the draft global vaccine action plan. Despite the progress made in reducing the morbidity and mortality associated with vaccine-preventable diseases since the launch of the Global Immunization Vision and Strategy 2006–2015, routine immunization coverage in most developing countries remained low owing to limited health-system delivery and financial resources; hence the importance of the adoption of the global vaccine action plan by the Sixty-fifth World Health Assembly. The report should be revised to give priority to developing countries with low immunization rates and where outbreaks were frequent, and to provide information on immunization coverage, financial shortfalls, geographical locations and resource constraints. She urged the Secretariat to provide technical support to Member States in preparing multiyear action plans and in facilitating global partnerships in order to secure international funding for developing countries with the greatest need.

Dr DE ASSUNÇÃO SAÍDE (Mozambique) welcomed the report. His country had successfully applied to the GAVI Alliance for support to introduce pneumococcal vaccine in 2012 and planned soon to introduce other vaccines such as those against rotavirus and human papillomavirus infections. His Government was committed to improving community involvement in efforts to extend access to

immunization programmes to hard-to-reach populations through more effective communication. He supported the draft resolution on a world immunization week.

Ms BRANCHI (France) supported the request by the member for the United States for more information on the proposals in paragraphs 16 to 18 of the report. She also asked about WHO's relationship with other partners, such as the GAVI Alliance.

Dr SHEKU DAOH (Sierra Leone), speaking on behalf of the Member States of the African Region, said that the report contained encouraging information on progress towards the elimination of some vaccine-preventable diseases. However, despite research worldwide, successful vaccines had still not been developed against HIV/AIDS, tuberculosis or malaria. He therefore urged WHO to continue to provide support to scientists and institutions engaged in research aimed at eliminating the major diseases affecting Africa, and to coordinate such research. Vaccination coverage rates in most African countries could be improved through the strengthening of health systems and other socioeconomic aspects. In order to maintain the progress made so far, countries and communities had to assume ownership of their vaccine programmes.

In December 2011, the Regional Office for Africa had coordinated a stakeholder consultation in Namibia, at which consensus had been reached on, *inter alia*, increasing Member States' ownership of, and financial input into, vaccination programmes, and enhancing regional advocacy for immunization through regional vaccination weeks. He therefore strongly supported the six broad strategies outlined in the draft action plan, in particular, that all countries and governments should commit themselves to immunization as a priority. Member States in the Region needed to increase their domestic funding in order to strengthen and sustain vaccination programmes, and the global community should give priority to the principle of equitable access to vaccines.

Dr LARSEN (Norway) asked about the consequences of replacing the word eradication with elimination and of substituting a draft decision for the draft resolution on measles in terms of the financial and administrative implications for the Secretariat.

Dr DAHL-REGIS (Bahamas),¹ observing that vaccination against measles was one of the most cost-effective public health interventions, urged Member States to strengthen their resolve to eliminate the disease by the target date of 2015. She fully endorsed the draft global vaccine action plan and supported the draft resolution on a world immunization week, as amended by the member for Japan.

Dr ATTAYA LIMWATTANAYINGYONG (Thailand)¹ welcomed the report on the draft global vaccine action plan and the strategic directions developed in consultation with stakeholders. She recalled the request to the Director-General in resolution WHA58.15 on the global immunization strategy to mobilize resources for promoting affordable and available new vaccines. That aspect should be reflected in the action plan in terms of generation of evidence, ranging from the burden of vaccine-preventable diseases and cost-effectiveness of vaccines to the impact on health budgets and health system capacity, as well as consideration of the ethical dimensions of equal access of all children, and ensuring that policy decisions to introduce new vaccines were evidence-based. She requested the Director-General to support efforts to promote vaccine affordability, and drew attention to the importance of the expansion of vaccine-production capacities in developing countries, public-private partnerships, financing initiatives and regional pooled procurement. In order to achieve sustainable long-term financing and the supply of high-quality vaccines, additional emphasis should be given to promoting international and regional cooperation in vaccine development, production and procurement, particularly among developing countries, and to devising global mechanisms for funding research and development of vaccines.

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

She expressed concerns about the required actions set out in the report on raising awareness and increasing demand for vaccination. Without appropriate preparative measures, raising awareness could be a double-edged sword: it could promote greater public acceptance, but, in the absence of evidence of disease burden or cost-effectiveness and without sustainable financing or guaranteed supply, it could create demand that could not be met or inappropriate pressures to introduce vaccines. Thailand wished to take an active role in the consultations on finalizing the global vaccine action plan.

She recognized the potential benefits of a world immunization week and welcomed the draft resolution. Member States must be able to use such an occasion to increase their vaccination coverage rates, and care should be taken to ensure that it was not used for the marketing of products that were not part of national immunization programmes. The focus of any global immunization week should be on basic immunization.

Mr NTA (Medicus Mundi International – International Organisation of Cooperation in Health Care), speaking at the invitation of the CHAIRMAN and on behalf of the People's Health Movement, welcomed the progress in developing the draft global vaccine action plan and the international efforts to promote the right to immunization. He expressed concern that WHO would have a limited role in setting immunization policies: as one of several parties working on the Decade of Vaccines, it might be prevented from taking leadership in global public health and in independently guiding the establishment of fair and effective vaccine policies. With regard to the proposed vaccine access forum, Member States should consider carefully how conflicts of interest would be dealt with, as the forum could include stakeholders with commercial interests. The report made no reference to evidence and data on the impact of the introduction of vaccines with new antigens on reducing mortality and decreasing the incidence of vaccine-preventable diseases. The introduction of new vaccines should be subject to detailed, country-specific assessments of needs and health impact, as well as cost-benefit analyses. Immunization programmes should not be seen to be substitutes for a broader range of public health measures, such as access to primary health care services, health education and the availability of safe drinking-water and sanitation. Member States should ensure that the Secretariat could contribute to ensuring safe access to affordable vaccines in a sustainable manner by facilitating local production at regional or country level depending on economies of scale and technology transfer.

Ms DIETTERICH (The Save the Children Fund), speaking at the invitation of the CHAIRMAN and also on behalf of the 230 organizations comprising the civil society constituency of the GAVI Alliance, commended the process adopted by the Decade of Vaccines Collaboration Secretariat that had given civil society the opportunity to engage in all consultations, and she urged the Director-General to ensure the continued engagement of civil society in the implementation of the global vaccine action plan following the dissolution of the Collaboration Secretariat. Immunization was a crucial component of integrated, essential health-care packages. Universal coverage could be achieved only with demand- and supply-side efforts, and the global vaccine action plan must seek to ensure universality, equity, quality, accountability and sustainability. Inequities within countries hampered progress towards the achievement of the Millennium Development Goals, and targeted strategies must be used to meet the needs of unreached populations within countries. A robust accountability framework sympathetic to the principles of aid effectiveness was necessary for the implementation of the global vaccine action plan. All Member States should ensure that the principles and objectives of the action plan were reflected in domestic health and immunization strategies, and she called for the active involvement of government, parliament and civil society to ensure that the implications of the action plan were fully understood. Given the relevance of recommendations of the Commission on Information and Accountability for Women's and Children's Health, WHO must play a central role in the development and implementation of the global vaccine action plan.

Dr BUSTREO (Assistant Director-General), thanking speakers for their valuable comments, said that the suggestions made had been carefully noted. With regard to concerns expressed, she said that the aim of a vaccine access forum would be to facilitate alignment of demand and supply in order to avoid shortages in supply; the concept was still under discussion and the Secretariat would provide

further clarification in due course. The Sixty-fourth World Health Assembly had noted the aims of the global vaccine action plan; that plan would capture the vision and actions necessary to achieve ambitious goals for vaccine delivery, quality, research, and public and political support. Intensive consultations with all stakeholders were being held at the regional level so as to maximize the inputs. The consultations would culminate in a discussion of the Strategic Advisory Group of Experts on immunization to be held in mid-February 2012. The WHO Secretariat and Decade of Vaccines Collaboration Secretariat would revise the draft action plan in the light of those discussions, and a briefing would be held in Geneva in March for missions with a view to obtaining further input from Member States. The aim was to share with all Member States a vaccine action plan that would include measures for monitoring and evaluating the progress made and for accountability, and define the responsibilities of the different actors. The process of collaboration with UNICEF and other partners had been enriching, and she acknowledged the significant inputs provided, in particular from the Decade of Vaccine Collaboration and the GAVI Alliance secretariats.

With regard to terminology, she said that eradication was used to refer to a targeted and specific effort to ensure the disappearance of the measles virus. The costings for the draft resolution covered what had already been agreed by the Health Assembly, namely the regional plan for elimination; costings were not provided for the specific effort to ensure that measles virus would disappear from the world. As such an undertaking would require further discussion and decision, the progress envisaged was progressive elimination of cases and transmission of the virus. The final push to make the virus disappear might require further discussion in the light of progress made with respect to poliomyelitis eradication.

She said that she was ready to provide further clarification and looked forward to receiving further input on the draft global vaccine action plan, the implementation of which would help to promote the achievement of the Millennium Development Goals, in particular Goal 4 (Reduce child mortality).

Responding to a request for clarification from Mrs REITENBACH (Germany), she confirmed that the financial and administrative implications for the Secretariat of the draft resolution on measles did not apply to the draft decision. The decision had no financial implications as the targets would be included in the global vaccine action plan.

Ms SY (Senegal) requested that the words “, in collaboration with all stakeholders,” be inserted after “Member States” in paragraph 3 of the draft decision.

The CHAIRMAN took it that the Board was prepared to adopt the draft resolution on World Immunization Week.

The resolution, as amended, was adopted.¹

The CHAIRMAN further took it that the Board was prepared to adopt the draft decision entitled “Towards the elimination of measles”.

The decision, as amended, was adopted.²

¹ Resolution EB130.R12.

² Decision EB130(4).

Substandard/spurious/falsely-labelled/falsified/counterfeit medical products: report of the Working Group of Member States: Item 6.13 of the Agenda (Documents EB130/22 and EB130/22 Add.1)

The CHAIRMAN drew attention to the draft resolution contained in Appendix 1 to document EB130/22. The financial and administrative implications of the draft resolution for the Secretariat were set out in document EB130/22 Add.1.

Mr PRASAD (India) said that access to quality, safe, efficacious and affordable medical products continued to present a formidable challenge to developing and least developed countries. Constraints, including high prices, weak drug regulatory authorities and capacity, were exacerbated by efforts to promote deliberate confusion between intellectual property and quality issues. He welcomed the unanimous support for WHO's fundamental role in measures to ensure the availability of quality, safe, efficacious and affordable medicines, but expressed concern about the lack of sufficient funding for WHO's work in that area, which included strengthening national health surveillance systems and drug regulatory authorities, and promoting access to quality medicines. India supported international cooperation to promote access to affordable, quality, safe and efficacious medical products. The proposed new Member State mechanism should promote effective collaboration between Member States and the Secretariat to that end, drawing on expert advice as appropriate. Any output from the mechanism relating to policies and recommendations would have to be endorsed through the governing bodies of WHO.

If it was to pursue its global public health mandate with undivided attention, WHO should sever any remaining links with the International Medical Products Anti-Counterfeiting Taskforce, which had a predominant agenda on intellectual property rights. Discussions on the enforcement of those rights should remain outside the work on the quality, safety and efficacy of medicines.

India attached the highest importance to ensuring access to affordable, high-quality, safe and efficacious medicines. As one of the largest exporters of generic medicines, it had taken measures to enhance tracking and tracing, including use of a two-dimensional barcode for the export of pharmaceutical products.

Dr SILBERSCHMIDT (Switzerland), speaking on behalf of the Member States of the WHO European Region, commended the Chair of the Working Group and welcomed the Group's successful outcome. The proposed new Member State mechanism should improve international cooperation among Member States, and the European Region supported the draft resolution as it stood.

WHO had a fundamental role to play in ensuring the availability of quality, safe, efficacious and affordable medical products. Sufficient resources must be provided from unearmarked sources, such as the regular budget, to enable WHO to continue its efforts and ensure that the new Member State mechanism could function properly once approved by the Health Assembly.

Dr DAULAIRE (United States of America) acknowledged Member States' constructive participation in the Working Group and commended the able leadership of its Chair. He supported the draft resolution. His Government was fully committed to the success of the proposed new Member State mechanism. It also recognized the sensitivities about the role of the International Medical Products Anti-Counterfeiting Taskforce, and would transfer its support from that entity to the new Member State mechanism as soon as the latter was established.

He expressed shock that in some parts of the world some 30% to 50% of the medicines used to treat serious diseases were counterfeit or substandard. Member States had a common mission to ensure the safety and efficacy of medicines and secure the increasingly complex global supply chain. Better surveillance and data were necessary, particularly since the pharmaceutical industry had moved much of its manufacturing operations into the international arena, and opportunistic crimes, such as counterfeiting, adulteration, diversion and cargo theft, were flourishing. The supply chain, which had become more complex, was only as strong as its weakest link. The proliferation of additional handlers, suppliers and middlemen created new entry points for contaminated, adulterated and counterfeit

products into that chain. Threats to the integrity of medicines and the security of the supply chain must be met through approaches that included strengthening national regulatory systems and cross-border collaboration. WHO was well-positioned to tackle the complexities and linkages associated with substandard, spurious, falsely-labelled, falsified and counterfeit medical products. Risk-based and multisectoral approaches and sound scientific evidence were essential tools to protect the public from adulterated drugs.

Dr JESSE (Estonia) speaking on behalf of the Member States of the European Union, said that the acceding State Croatia, the candidate countries the former Yugoslav Republic of Macedonia, Montenegro and Iceland, the countries of the Stabilisation and Association Process and potential candidates, Albania, Bosnia and Herzegovina, Serbia, as well as Ukraine, Armenia and Georgia aligned themselves with her statement. She thanked the members of the Working Group for their constructive efforts to overcome the deadlock on the controversial issue under discussion. It was to be hoped that the proposed new Member State mechanism, which would provide a platform for coordinated multisectoral cooperation to help to prevent falsified medicines from undermining the credibility of health systems, would be approved by the Board and the Health Assembly and established without delay. The European Union strongly supported WHO's fundamental role in ensuring the safety, quality and efficacy of medical products and promoting access to affordable, quality, safe and efficacious medicines. Recalling various initiatives, she said that promoting access to safe and high-quality medicines remained a long-standing and high priority in the European Union's support to health in developing countries. The prevention and control of falsified medical products also continued to be a high priority for the European Union; work must be focused on public health and led by WHO. The Secretariat should secure, in a transparent manner, the necessary financial means for work against substandard, spurious, falsely-labelled, falsified and counterfeit medical products within the approved Programme budget 2012–2013.

Mr DÍAZ ANAIZ (Chile) said that his country had a strong regulatory framework to prevent the manufacture, import, possession, distribution and transfer of any falsified, adulterated, contaminated and altered pharmaceutical products. Establishments handling pharmaceutical products were linked through a well-defined and monitored network that covered the only official channels from manufacture or import to delivery to the end-user. Imported pharmaceutical products were subject to quality control before distribution and marketing. At the international level, Chile had established a focal point for the exchange of information and coordination with other members of the Ibero-American Medicines Authorities. It had also designated a focal point for the Pan-American Network for Drug Regulatory Harmonization, which had yet to operate fully, and had taken part in Asia-Pacific Economic Cooperation forums on counterfeit products. He welcomed WHO's work against counterfeit and substandard medicines and medical products, as it provided tools for protecting public health, and he called for more forums for participation in initiatives for public health and for the development of projects and strategies aimed at countries like his.

Speaking on behalf of the Union of South American Nations, he proposed that the first meeting of the new Member State mechanism be hosted by Argentina, and requested that the representative of Argentina be given the floor.

Having been given the floor by the CHAIRMAN, Mr CAVALERI (Argentina)¹ said that his Government was offering to host the first meeting of the proposed new Member State mechanism, provisionally to be held over three days in October 2012. It would cover the cost of the event, and provide interpretation in English, French and Spanish. Argentina would be honoured to welcome the Director-General to that meeting and would collaborate with the Secretariat on its organization,

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

including the programming and agenda, accepting that adjustments could be made to suit the needs of Member States. A formal letter about the proposal would be sent shortly to the Director-General.

Ms JIN Guoying (China) endorsed the report of the Working Group and commended the continuous efforts to prevent the counterfeiting of medical products. Her Government attached high priority to ensuring safe medicines, and had taken appropriate steps, including the establishment of a legal framework, setting up an anticounterfeiting mechanism among 13 agencies, and enhancing monitoring and inspections. At the international level, China had established a mechanism for the timely exchange of information. Rigorous regulation of the supply chain at the national level and communication and collaboration among Member States were essential to prevent the counterfeiting of medical products. China would continue to work closely with the Secretariat and other Member States and intensify efforts to ensure the safety of medical products.

In view of differing national conditions and legal frameworks, Member States should be allowed to participate in the proposed new Member State mechanism on a voluntary basis. Accordingly, the words “on a voluntary basis” should be added at the beginning of subparagraph 6(1) of the draft resolution.

Ms WISEMAN (Canada) welcomed the report of the Working Group and supported the draft resolution recommending the establishment of a new Member State mechanism for international collaboration among Member States. Substandard, spurious, falsely-labelled, falsified, counterfeit medical products posed a serious risk to human health, and the international community must continue to make progress in developing coordinated multisectoral approaches in order to combat such medical products. All relevant stakeholders must be involved in the work, and every effort must be made to strengthen the capacity of national regulatory authorities and systems.

Mr TOSCANO VELASCO (Mexico) said that his country attached great importance to the matter under discussion. It had designed several policies to limit the proliferation of substandard, spurious, falsely-labelled, falsified and counterfeit medical products, and, since 2005, all medical products had to be re-registered with the national health authority every five years. Collaboration between national agencies on intellectual property, customs and crime was necessary, as were appropriate legislation and the monitoring of waste medical products. The pharmaceutical market was indeed becoming increasingly globalized; tracing products was becoming more complex, with the number of spurious, falsely-labelled and counterfeit medical products increasing as a result. It was thus important that the proposed new Member State mechanism be set up as soon as possible. The mechanism should open communication channels with industry with a view to facilitating joint action.

He supported the Secretariat’s activities, but urged the Secretariat to establish a subcommittee of experts as soon as possible in order to establish a definition of such products.

There was an increasing amount of advertising in the mass media for products that were not medicines but which were reputed to have curative properties. Such products could constitute a threat to health, and he called on Member States to redouble their efforts to restrict them before it was too late. He asked for further clarification of Argentina’s intention to cover the costs of the first meeting of the new Member State mechanism.

Dr AZODOH (Nigeria), speaking on behalf of the Member States of the African Region, commended the report of the Working Group. Despite the many strategies deployed by countries to authenticate the quality of products, counterfeit medical products were still entering markets. She encouraged the Secretariat to ensure that every possible step was taken to ensure access to and availability of quality, safe and affordable medical products, including strengthening existing programmes. Countries in the Region had instituted several approaches, including the use of new tools and innovative technological applications. She encouraged WHO to take every necessary step, including work on securing the supply chain, local production, capacity building and multisectoral collaboration, in order to ensure access to and availability of affordable, good-quality and safe medical products. The Secretariat should strengthen its existing programmes in the area. She supported the

proposal to establish a new intercountry mechanism, which should include Member States, the private sector and nongovernmental organizations under WHO's coordination. She would also welcome the establishment of a subcommittee of the Expert Committee on Specifications for Pharmaceutical Preparations to develop a definition of substandard, spurious, falsely-labelled, falsified and counterfeit medical products.

Dr ST. JOHN (Barbados) supported the draft resolution and welcomed Argentina's offer to host the first meeting of the proposed new Member State mechanism. The Secretariat should continue to provide support to drug regulatory authorities in preventing the entry of substandard products through licensing and in removing counterfeit drugs from the market through strengthened pharmacovigilance programmes. Barbados and other countries in the Caribbean would require further support in order to advance the pharmacovigilance activities begun in 2006. WHO's programme on the prequalification of medicines should be expanded, and the Secretariat should continue to provide support to countries in the monitoring of good manufacturing practices. Her country had benefited from the WHO partnership with the Commission of the European Communities on pharmaceutical policies (EC/ACP/WHO); it was to be hoped that the renewed partnership would begin shortly.

Dr TAKEI (Japan) welcomed the efforts of the Working Group. Japan supported the ongoing efforts to prevent substandard, spurious, falsely-labelled, falsified and counterfeit medicines and to ensure improved access to and the quality of medical products, in line with WHO's strategic objective 11. His Government's concerns about such products were not limited to safety and quality but included issues concerning the violation of trademarks and design rights. He highlighted the importance of support and cooperation involving government agencies, international organizations and other stakeholders such as the private sector, while recognizing the importance of transparency and the need to avoid conflicts of interest. Japan's technical support to improve the quality and safety of medicines for diseases prevailing in developing countries took into consideration the measures to prevent substandard, spurious, falsely-labelled, falsified and counterfeit medicines.

Dr BELO (Timor-Leste) welcomed the report of the Working Group and supported the draft resolution, which reaffirmed the role of WHO in ensuring the quality and safety of medical products.

Mr SAMRI (Morocco) commended the able leadership of the Chair of the Working Group and welcomed its report. He thanked the Government of Argentina for offering to host the first meeting of the proposed new Member State mechanism, and in particular to cover the costs of that event, which would facilitate the participation of Member States.

Dr LARSEN (Norway) thanked the Government of Argentina for the kind offer to host the first meeting of the proposed new Member State mechanism and suggested that a preparatory meeting be held in Geneva.

As the Member State process was voluntary in nature, the amendment proposed by the member for China was superfluous. Furthermore, the draft resolution was the result of delicate negotiations, which should not be reopened.

The meeting rose at 13:05.

TWELFTH MEETING

Saturday, 21 January 2012, at 14:30

Chairman: Dr B.S. DANKOKO (Senegal)

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

Substandard/spurious/falsely-labelled/falsified/counterfeit medical products: report of the Working Group of Member States: Item 6.13 of the Agenda (Documents EB130/22 and EB130/22 Add.1) (continued)

Dr REN Minghui (China), recalling his proposal at the previous meeting to add the words “on a voluntary basis” to the beginning of subparagraph 6(1) of the draft resolution, said that the amendment was in line with the content of Appendix 2 of document EB130/22.

Dr AZODOH (Nigeria), speaking on behalf of the Member States of the African Region, endorsed the draft resolution and, in particular, the recommendation to establish a Member State mechanism for international collaboration regarding substandard/spurious/falsely-labelled/falsified/counterfeit medical products. Was the offer by the Government of Argentina to host the first meeting of the proposed new Member State mechanism, which she supported in principle, in conformity with the proposed terms of reference?

Mr NEVES SILVA (Brazil)¹ welcomed the offer of the Government of Argentina. In its technical work, the proposed mechanism would be more effective if it focused on identifying the behaviours and actions to be prevented, which would provide an objective approach to the problem, rather than seeking concepts to define potentially irregular products.

The relationship between WHO and the International Medical Products Anti-Counterfeiting Taskforce was the one issue still dividing the Member States and, if left unresolved, might threaten the unity of the new Member State mechanism. Member States should be prepared to take a decision on the matter at the Sixty-fifth World Health Assembly.

Efficient prevention of substandard, spurious, falsely-labelled, falsified and counterfeit medical products could only be achieved by combating the root cause of the problem: unequal access to essential medicines. Trade in falsified medicines could not thrive where high-quality, affordable medicines were available to all.

Mrs DABRE (Burkina Faso)¹ said that the scourge of substandard, spurious, falsely-labelled, falsified and counterfeit medical products affected all individuals, regardless of their social status. Burkina Faso, a poor country at the crossroads of several trading routes, was not spared from the problem, and falsified medicines could be found widely. The organized illegal sale of such products was an ever-increasing challenge to the state of law, good governance and the right to health, adversely affecting efforts to attain the Millennium Development Goals.

Substandard, spurious, falsely-labelled, falsified and counterfeit medical products could be eliminated through cooperation between rich and poor countries. In recent years, various declarations and resolutions at the international and regional levels had called on States to put a stop to trafficking in falsified medicines, and the Cotonou Declaration on Fake Medicines (2009) made recommendations

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

to that end. The Ouagadougou Round Table on Fake Medicines in West Africa (Ouagadougou, 27–29 September 2011) had led to the formulation of a subregional strategy for joint action against spurious medical products and the establishment of a platform for coordination with technical and financial partners and the private sector.

Mr AGHAZADEH KHOEI (Islamic Republic of Iran)¹ welcomed the report of the Working Group and its recommendation to establish a new Member State mechanism to tackle the problem from a public health perspective. The insufficiency of funding for the Organization's work on the quality, safety and efficacy of medicines was a concern, made even more troubling by the expectation of Member States that the Secretariat should continue to play an active role in strengthening national health surveillance systems and drug regulatory authorities, as well as promoting access to medicines. The proposed mechanism should considerably increase collaboration between Member States and the Secretariat, and should serve as the sole official international mechanism for the prevention and control of substandard, spurious, falsely-labelled, falsified and counterfeit medical products.

Mr KAZI (Bangladesh)¹ said that the Working Group's recommendations should further strengthen the Organization's efforts to ensure the availability of and access to good quality, safe and effective medicines. The nine objectives proposed for the Member State mechanism offered a sound basis for revitalizing WHO's efforts to stop the spread of falsified medicines. Discussion of the definitions of such products should be conducted by the Member State mechanism, in a constructive and inclusive manner.

It was regrettable that the Working Group had not made recommendations on the Organization's relationship with the International Medical Products Anti-Counterfeiting Taskforce. Once the Member State mechanism had been established, WHO would have legitimate grounds for disengaging from that entity, thereby correcting the imbalance that had given rise to the establishment of the Working Group in the first place.

He thanked the representative of Argentina for his Government's offer to host the first meeting of the proposed Member State mechanism, and encouraged the Secretariat to provide support to least developed countries for travel costs.

The Secretariat should continue its efforts to enhance the capacity of countries, in particular least developed countries, to regulate access to quality, safe, efficient and affordable medical products.

Mr CAVALERI (Argentina)¹ affirmed that his Government would cover the cost of the first meeting of the Member State mechanism, in accordance with the usual standards applicable to a meeting of that type organized by a Member State in cooperation with WHO. Further details would be provided before the next Health Assembly.

Dr CHUTIMA AKALEEPHAN (Thailand)¹ endorsed the views of the members for India and Bangladesh and expressed particular concern about WHO's continuing relationship with the International Medical Products Anti-Counterfeiting Taskforce. She asked the Director-General to monitor closely the progress of the proposed new Member State mechanism, which she supported, in order to ensure that it produced timely results.

Ms GAL (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN and on behalf of the members of the World Health Professions Alliance, agreed on the need to strengthen national capacities in regulatory oversight and quality control but, because national law was applicable only in the country promulgating it, international law had to pick up where national law left off. She proposed adding an additional objective for the proposed Member State mechanism: establishment of an expert group to consider the feasibility of a public health treaty to

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

combat substandard, spurious, falsely-labelled, falsified and counterfeit medicines, similar to the WHO Framework Convention on Tobacco Control. She proposed also the insertion in the draft resolution of a new subparagraph 7(3) requesting the Director-General to report on the findings of the proposed expert group.

The emergence of media such as the Internet through which substandard, spurious, falsely-labelled, falsified and counterfeit medications might be traded called for additional expertise, and she asked Member States to ensure that the new mechanism was open to civil society, with the appropriate safeguards against conflict of interest.

Mr MWANGI (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, said that, because the subject of the agenda item called for immediate action, he welcomed the draft resolution, which reaffirmed WHO's fundamental role in ensuring the quality, safety and efficacy of medical products. A global, multistakeholder approach was essential to stop the proliferation of falsified products, which meant that the proposed new Member State mechanism should be open to stakeholders with the relevant expertise as well as patients.

Ms WANIS (Churches' Action for Health), speaking at the invitation of the CHAIRMAN and also on behalf of the People's Health Movement and the Third World Network, said that efforts to reduce the price of medicines and build regulatory capacities were urgently needed. If patients' needs were met promptly through regular channels, criminal activities would be less attractive. Enforcement agencies were unlikely to deal with issues of quality in the absence of adequate regulatory support. Some developed countries were promoting enforcement of intellectual property rights as a solution but that simply tended to create barriers to access rather than improving quality. A few months earlier some 50 nongovernmental organizations had called on WHO to disengage from the International Medical Products Anti-Counterfeiting Taskforce, which was in practice an initiative for enforcing intellectual property rights and lacked legitimacy. Once established, the Member State mechanism could tackle relevant issues in a more credible and inclusive manner. The Secretariat should revitalize its medicines programme which had had to abandon technical support to countries because of lack of funding.

Dr JESSE (Estonia) asked the Legal Counsel whether there was any precedent for the amendment proposed by the member for China to paragraph 6 of the draft resolution, and whether it would change the overall meaning of the paragraph.

The Working Group had agreed that the default venue for any meeting should be Geneva. Would holding the first meeting of the proposed Member State mechanism in Argentina be in line with the wishes of the Group?

Ms WISEMAN (Canada) observed that the voluntary nature of paragraph 6 was already implied by the word "URGES" and the amendment proposed by the member for China was consequently unnecessary.

Mr MCIFF (United States of America) also requested clarification about the amendment proposed by the member for China, and urged the Board to be flexible in its consideration of the draft resolution.

He agreed with the proposal made by the member for Norway in the previous meeting that, once the Member State mechanism had been endorsed by the Health Assembly, an organizational meeting could be held in Geneva before the first session was held in Argentina. Holding the meeting outside Geneva was in line with the proposed terms of reference for the Member State mechanism.

Dr REN Minghui (China), explaining his proposed amendment, said that, as participation in the Member State mechanism was to be open-ended, insertion of the words "on a voluntary basis" at the beginning of paragraph 6(1) only underscored the nature of the process.

Mr BURCI (Legal Counsel) said that he was unaware of any precedent for the wording “on a voluntary basis”, but reminded Member States that they were in the process of establishing an entirely new mechanism. Nevertheless, since any paragraph beginning with the word “URGES” did not imply a binding commitment, the amendment proposed by the member for China would only emphasize the existing meaning.

Dr ETIENNE (Assistant Director-General) thanked participants for their continuing commitment to ensuring access to safe, quality and efficacious medical products, and the Working Group for its guidance on the way to deal with a significant public health problem. Several speakers had pointed to the need to increase the funding allocated to the Secretariat’s work in that area. However, much of the work on essential medical products related to norms and standard setting, which was regarded as one of the Organization’s core tasks, and for which it was difficult to obtain extrabudgetary resources. The appropriation for essential medicines and pharmaceutical policies had remained constant over the past three bienniums. The terms of reference of the new Member State mechanism would need to be clarified, in order to enable accurate forecasts of the cost of an annual meeting and other working groups to be made and to determine the amount that would not be covered by the regular budget.

The CHAIRMAN took it that the Executive Board wished to adopt the resolution, as amended.

The resolution, as amended, was adopted.¹

Consultative expert working group on research and development: financing and coordination:
Item 6.14 of the Agenda (Document EB130/23)

Mrs SY (Senegal), speaking on behalf of the Member States of the African Region, recalled the Consultative Expert Working Group’s regional consultation with the African Region (Abidjan, Côte d’Ivoire, 27 August 2011) to review approaches to financing research and development and consider ways of implementing them in the Region. Eight main recommendations had been agreed: end data exclusivity; establish a patent pool, with the full knowledge of African manufacturers and their provision with the capacity to access its services; create open sources with a view to coordinating and improving access to health research results and opportunities of interest to the Region; study existing international funds and projects scheduled for implementation in the Region; create grants and build capacities of developing country organizations to apply for such grants; institute awards for innovative research and development; give high priority in the Region to procurement agreements; and promote regulatory harmonization not just at the international level, but at the regional and subregional levels.

Research and development at the national level were essential. Member States in the Region would consequently be regularly reminded of their commitments, in particular, to allocate to health research 5% of the budget for projects financed by health sector development partners and at least 2% of the overall budget of the health ministry.

Dr NIE Jiangang (China) noted that the Working Group had successfully concluded its mandate in a timely and transparent manner. Looking forward to reading the final report, he asked why reports were missing from two regions, and whether those regional consultations had already been held.

Dr LARSEN (Norway) said that he looked forward to the final report in April 2012 and asked, in view of the complex nature of the subject, that the Secretariat organize an informal meeting to

¹ Resolution EB130.R13.

enable Member States to prepare adequately for a substantive discussion of the subject at the Sixty-fifth World Health Assembly.

Professor PRASAD (India) welcomed the transparency with which the Working Group had fulfilled its mandate, avoiding conflict of interest. He looked forward to the final report. He also welcomed the recommendation to develop a legally binding global convention on research and development for Type II and Type III diseases and the specific needs of developing countries relating to Type I diseases. The principles underlying such a convention, which included de-linkage, open knowledge, competition, enhanced access and strengthening of innovation capacity in developing countries, warranted consideration. Any such agreement should call for increased investment and the transparent redistribution of resources.

The WTO's Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) in 1994 had required major producing countries, such as India, to begin granting patents. The subsequent Doha Declaration on the TRIPS Agreement and Public Health, in 2001, had clarified that patents should not prevent access to affordable medicines, outlining several safeguards that countries could use in that regard, including compulsory licences and patent laws that prioritized public health. However, newer medicines for HIV, malaria and tuberculosis, that were needed because of resistance and side effects, were increasingly being patented in developing countries, meaning they would not be produced as affordable generic medicines.

His Government was committed to increasing funding for the health sector, making it a priority for financing in the next five-year planning cycle from 2012. Better research focus, facilitated by sustainable financing and increased global coordination, would guarantee better health coverage and access to affordable medicines.

Mr DÍAZ ANAIZ (Chile) said that his country's National Health Strategy 2011–2020 defined a results-based strategy framework for health research, with identified strategic objectives. It set defined priorities, promoted targeted research, provided for periodical evaluation of existing research capacity, and encouraged information transfer to facilitate decision making. In 2004, the National Fund for Health-related Research and Development had been established to finance research, supported by the Ministry of Health and the National Commission for Research, Science and Technology. The national health system had a private component, which had to be taken into account when developing strategies to strengthen research. He looked forward to receiving the final report of the Working Group.

Mr KOLKER (United States of America) said that he awaited the Working Group's final report before commenting on specific recommendations. He welcomed the progress made by WHO on the financing and coordination of research and development and the various international partnerships established to increase access to medicines and vaccines. His country had good public and private sector investment in health research. He supported the realistic proposals to finance research and development in those diseases that had not had major research investments, irrespective of the Working Group's final decision. He welcomed the decision to create a patent pool (WIPO Re:Search) administered by the United Nations to encourage research into neglected tropical diseases and to promote innovation on new medications, vaccines and diagnostics for those diseases as well as for malaria and tuberculosis.

Ms WISEMAN (Canada) welcomed the fact that Working Group's work had included review of submissions from the general public and that there had been comprehensive regional consultations. She too awaited the final report, and supported the proposal of the member for Norway to hold an informal meeting before the Health Assembly.

Dr SILBERSCHMIDT (Switzerland) likewise awaited the final report, but from the information provided so far, he considered that all the recommendations would merit thorough examination by Member States. He supported the proposal by the member for Norway to hold an informal briefing for Member States, but warned that there might be insufficient time for a detailed review of the final

report before the Sixty-fifth World Health Assembly. Consequently, it might be necessary to design a one-year process to enable Member States to prepare a decision on the Working Group's conclusions that would include an answer to the question of whether it would be appropriate to start negotiations on an international convention. He requested the Secretariat to draft a procedural resolution or decision to take note of the report, request the Director-General to hold informal consultations with Member States, and postpone substantive discussion of the report to the Sixty-sixth World Health Assembly, thereby ensuring that all recommendations were given equal consideration, instead of forcing Member States to make rushed decisions.

Dr TAKEI (Japan) said that the Working Group had received some interesting recommendations; for example, WHO should use existing structures, such as the Advisory Committee on Health Research and similar regional committees, to advise governments. WHO should also expand its information sharing and its monitoring and evaluation function, including the Global Health Observatory. However, other recommendations needed further study in order to determine targeted and feasible future steps for enhancing research and development for Type II and Type III diseases.

Dr NASHER (Yemen), speaking on behalf of the Member States of the Eastern Mediterranean Region, expressed appreciation for the publication of the Working Group's documents on the WHO web site, and said that, following regional consultations, he approved the working group's report. The Region would support a continuation of the work of the Working Group, either through meetings or electronically, as constant global political, social, economic and epidemiological changes meant research and development activities must evolve, including the development of public-private partnerships. It was to be hoped that its final report would emphasize issues relating to trade-related and other aspects of intellectual property. He asked the Director-General to continue to provide support to Member States in drawing up appropriate public health plans, taking into account the links between health development, research and development and intellectual property that were required to improve health for all.

Dr JESSE (Estonia) agreed with the proposal by the member for Norway to hold an informal meeting on the Working Group's report to facilitate Member States' preparations for the Health Assembly. She also supported what she had understood to be a proposal by the member for Switzerland to hold discussions on the Group's recommendations at the regional committees.

Dr SILBERSCHMIDT (Switzerland) explained that the reference to regional committees had been in his original statement. He would support any process that involved either regional or informal consultations. The aim of his proposal was to ensure that Member States had sufficient time to consider which of the Working Group's recommendations merited decision and follow-up; the regional committees offered a further opportunity to consult between the Health Assembly and the subsequent session of the Board in January.

Mrs ESCOREL DE MORAES (Brazil)¹ noted that 2000 million people, most of them living in poverty in developing countries, were still deprived of access to essential medicines. The benefits of human progress should be available to all. The global strategy on public health, innovation and intellectual property, adopted in resolution WHA61.21, aimed at developing innovative products, mechanisms and solutions and improving access to medicines. The Consultative Expert Working Group had been established to stimulate and assess innovative ideas, and, based on its preliminary reports, it had fulfilled its mandate in a transparent and productive manner, including evaluating proposals to remove the link between research and development and the price of medicines. All proposals that best met the criteria for evaluation would undoubtedly be considered by Member States,

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

so as to promote access to medicines and fill gaps in knowledge and technology between countries. She welcomed the several proposals to hold a briefing on the Group's final report before the Health Assembly.

She said that she understood the reason for the proposal by the member for Switzerland, but it was not for the Board to change any mandate that had been decided by the Health Assembly. The Working Group's final report should therefore be presented to the Sixty-fifth World Health Assembly, which could decide how to proceed. She did not favour discussing the recommendations in the regional committees.

Mr ROSALES LOZADA (Plurinational State of Bolivia)¹ welcomed the transparent and inclusive manner in which the Working Group had fulfilled its mandate, which contrasted with the way of working of the former Expert Working Group on Research and Development Financing. When the current consultative process had begun, his Government had submitted five proposals for seeking new sources of funding and innovative mechanisms to stimulate research and development in areas related to diseases particularly affecting developing countries and that did not satisfy the market criteria that usually guided research and development undertaken by the pharmaceutical industry. The primary goal had been to remove the link between research and development and the price of medicines. It was important to ensure that medicines and health care were accessible to all, especially the poor and not only those who could pay.

He supported the proposal made by the member for Norway to hold a briefing on the Group's final report, which would enable Member States to make informed decisions during the Sixty-fifth World Health Assembly. He also agreed with the comments made by the representative of Brazil that the Board should not amend a mandate given by the Health Assembly.

Dr AGUILAR (Ecuador) supported the comments made by the representatives of Brazil and Bolivia.

Dr SILBERSCHMIDT (Switzerland) said that his intention had been to ensure constructive discussions, but that he understood that some Member States preferred not to change decisions made by the Health Assembly. As a result, informal consultations would be essential to agree on a Member State-driven process, with representatives from all regions, to ensure that discussions at the Health Assembly were as productive as possible.

Mr LOVE (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN, said that he expected the Working Group to recommend a start to intergovernmental negotiations on a binding research and development convention that would meet the need for sustainable sources of finance. Such a convention should also encompass elements of WHO's global strategy on public health, innovation and intellectual property, including de-linking product prices and research and development and transfer of technology. He backed the suggestion to hold a briefing on the final report of the Working Group and any proposal for a research and development convention before the Sixty-fifth World Health Assembly.

Dr KIENY (Assistant Director-General) thanked speakers for their comments. She recalled the Consultative Expert Working Group's transparent conduct of its work, and noted that a consensus had been reached on all the recommendations to be made to the Health Assembly. She would arrange for a briefing and informal consultations to be held before the next Health Assembly on the final report, the recommendations contained therein and their implications. Referring to the comments made by the member for Japan, she said that the reasons behind all the recommendations would be explained in the report.

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

Responding to the request for clarification from the member for China about the two regional consultations that had not been held, she said that members of the Working Group from the Eastern Mediterranean Region had been unable to schedule a meeting. Within the European Region, a consultation had been held during the 7th European Congress on Tropical Medicine and International Health (Barcelona, Spain, 3–6 October 2011), which had enabled Working Group members from that Region to discuss the proposals and submit comments.

The CHAIRMAN took it that the Executive Board wished to take note of the report.

The Board noted the report.

WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies: Item 6.15 of the Agenda (Document EB130/24)

The CHAIRMAN, recalling that it was the anniversary of the two major earthquakes of January and February 2010 in Haiti and Chile, respectively, pointed out that, although the latter had been of a greater magnitude than the former, the number of fatalities had been far lower, owing, in part, to better disaster preparedness. In the wake of those emergencies, WHO and the humanitarian relief community had developed new models to improve the speed and coordination of response activities. He drew attention to a draft resolution proposed by Finland on behalf of the 27 Member States of the European Union, Japan, Norway and the United States of America, which read:

The Executive Board,

PP1 Recognizing that humanitarian emergencies result in avoidable loss of life and human suffering, weaken the ability of health systems to deliver essential life-saving health services, produce setbacks for health development and hinder the achievement of the Millennium Development Goals;

PP1bis Reaffirming the principles of neutrality, humanity, impartiality and independence in the provision of humanitarian assistance, and reaffirming the need for all actors engaged in the provision of humanitarian assistance in situations of complex humanitarian emergencies and natural disasters to promote and fully respect these principles;

PP2 Recalling Article 2(d) of the Constitution of the World Health Organization on the mandate of WHO in emergencies, and resolutions WHA58.1 on health action in relation to crises and disasters and WHA59.22 on emergency preparedness and response;¹

PP3 Recalling United Nations General Assembly resolution 46/182 on the strengthening of the coordination of humanitarian emergency assistance of the United Nations, confirming the central and unique role for the United Nations in providing leadership and coordinating the efforts of the international community to support countries affected by humanitarian emergencies, establishing the Inter-Agency Standing Committee, chaired by the Emergency Relief Coordinator, supported by the United Nations Office for the Coordination of Humanitarian Affairs;

PP4 Recalling the humanitarian response review in 2005, led by the Emergency Relief Coordinator and by the Principals of the Inter-Agency Standing Committee aiming at improving urgency, timeliness, accountability, leadership and surge capacity, and recommending the strengthening of humanitarian leadership, the improvement of humanitarian financing mechanisms and the introduction of the cluster system as a means of sectoral coordination;

PP5 Taking note of the Inter-Agency Standing Committee Principals' Reform Agenda 2011–2012 to improve the international humanitarian response by strengthening leadership,

¹ Resolutions WHA34.26, WHA46.6, WHA48.2, WHA58.1, WHA59.22 and WHA64.10 reiterate WHO's role in emergencies.

coordination, accountability, building global capacity for preparedness and increasing advocacy and communications;

PP6 Recognizing United Nations General Assembly Resolution 60/124 and WHO's subsequent commitment to supporting the Inter-Agency Standing Committee transformative humanitarian agenda and contributing to the implementation of the Principals' priority actions designed to strengthen international humanitarian response to affected populations;

PP7 Recognizing also that it is the national authority that has the primary responsibility to take care of victims of natural disasters and other emergencies occurring on its territory, and that the affected State has the primary role in the initiation, organization, coordination, and implementation of humanitarian assistance within its territory;

PP8 Taking note of the 2011 Inter-Agency Standing Committee guidance note on working with national authorities, that clusters should support and/or complement existing national coordination mechanisms for response and preparedness and where appropriate, government, or other appropriate national counterparts should be actively encouraged to co-chair cluster meetings with the Cluster Lead Agency;

PP9 Recalling resolution WHA64.10 on strengthening national health emergency and disaster management capacities and resilience of health systems, that urges Member States, inter alia, to strengthen all-hazards health emergency and disaster risk-management programmes;

PP10 Reaffirming that countries are responsible 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;

PP11 Recognizing the comparative advantage of WHO through its presence in, and its relationship with Member States, and through its capacity to provide independent expertise from a wide range of health-related disciplines, its history of providing the evidence-based advice necessary for prioritizing effective health interventions, and that the Organization is in a unique position to support health ministries and partners as the global health cluster lead agency in the coordination of preparing for, responding to and recovering from humanitarian emergencies;

PP12 Recalling WHO's reform agenda and the 2011 Report by the Director-General on Reforms for a Healthy Future,¹ which led to the creation of a new WHO cluster, Polio, Emergencies and Country Collaboration, aimed at supporting regional and country offices to improve outcomes and increase WHO's effectiveness at the country level, by redefining its commitment to emergency work and placing the cluster on a more sustainable budgetary footing;

PP13 Welcoming the 2011 reform transforming the WHO cluster Health Action in Crisis into the Emergency Risk Management and Humanitarian Response department as a means of implementing these reforms, ensuring that the Organization becomes faster, more effective and more predictable in delivering higher quality response in health, and that the Organization holds itself accountable for its performance;

PP14 Recalling resolutions WHA46.39 on health and medical services in times of armed conflict; WHA55.13 on protection of medical missions during armed conflict; and the United Nations General Assembly resolution 65/132 on safety and security of humanitarian personnel and protection of United Nations personnel, considers that there is a need of systematic data collection on attacks or lack of respect for patients and/or health workers, facilities and transports in complex humanitarian emergencies,

1. CALLS ON Member States and donors:

- (1) to allocate resources for the health sector activities during humanitarian emergencies through United Nations Consolidated Appeal Process and Flash Appeals,

¹ Document A64/4.

and for strengthening the Organization's institutional capacity to exercise its role as the Global Health Cluster Lead Agency and to assume health cluster lead in the field;

(2) to encourage all humanitarian partners, including nongovernmental organizations, to participate actively in the health cluster coordination and ensure that their humanitarian interventions are carried out in accordance with the plans, standards and guidelines agreed through the consultative process within the health cluster, and to underscore the importance of the cluster level accountability;

(3) to strengthen the national level risk management, health emergency preparedness and contingency planning processes and disaster management units in the health ministry, as outlined in resolution WHA64.10, and as part of the national preparedness planning, with the Office for the Coordination of Humanitarian Affairs where appropriate, identify in advance the best way to ensure that the coordination between the international humanitarian partners and existing national coordination mechanisms will take place in a complementary manner to guarantee an effective and well-coordinated humanitarian response;

(4) to build the capacity of national authorities at all levels in managing the recovery process in synergy with the longer-term health system strengthening and reform strategies, as appropriate, in collaboration with WHO and the health cluster, keeping also in mind the 2011 Inter-Agency Standing Committee guidance note on working with national authorities;

(5) to cooperate with WHO and other relevant stakeholders in developing the collection of data on attacks on, or lack of respect for, patients and/or health workers' facilities and transport in complex humanitarian emergencies;

2. CALLS ON the Director-General:

(1) to have in place the necessary WHO policies, guidelines, adequate management structures and processes, required for effective and successful humanitarian action at the country level, as well as the organizational capacity and resources to best fulfil its role as the Global Health Cluster Lead Agency, in accordance with agreements made by the Inter-Agency Standing Committee Principals; and assume a role as Health Cluster Lead Agency in the field;

(2) to strengthen WHO's surge capacity, including standby arrangements with Global Health Cluster partners, to ensure that WHO has qualified humanitarian personnel to be mobilized at short notice when required;

(3) to ensure that in humanitarian crises WHO provides Member States and humanitarian partners with predictable support by coordinating rapid assessment and analysis of humanitarian needs, as part of the coordinated Inter-Agency Standing Committee response, building an evidence-based strategy and action plan, monitoring the health situation and health sector response, identifying gaps, mobilizing resources and performing the necessary advocacy for humanitarian health action;

(4) to define the core commitments, core functions and performance standards of the Organization in humanitarian emergencies, including its role as the Global Health Cluster Lead Agency and as Health Cluster Lead Agency in the field, and to ensure full engagement of country, regional and global levels of the Organization to their implementation according to established benchmarks, keeping in mind the ongoing work on the Inter-Agency Standing Committee transformative humanitarian agenda;

(5) to provide a faster, more effective and more predictable humanitarian response by operationalizing the Emergency Response Framework, with the performance benchmarks in line with the humanitarian reform, and to ensure the accountability of its performance against those standards;

(6) to establish necessary mechanisms to mobilize WHO's technical expertise across all disciplines and levels, for the provision of necessary guidance and support to Member States, and partners of the health cluster in humanitarian crises;

- The financial and administrative implications of the resolution for the Secretariat were as follows:

¹ The figures given do not include the additional resources that would be mobilized for specific emergencies.

(b) Cost for the biennium 2012–2013

Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000).

Total: US\$ 72.0 million (staff: US\$ 57.6 million; activities: US\$ 14.4 million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

This resolution would be implemented across the Organization. WHO's country-level efforts would be supported by the relevant regional offices and by headquarters (US\$ 32 million at headquarters; US\$ 13.5 million in the regional offices; and US\$ 26.5 million in key country offices, with a focus on high-risk countries in the African and Eastern Mediterranean regions).¹

Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

Yes

If “no”, indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

The total number of core staff would be similar to that of the biennium 2010–2011; however, the staff concerned would have different skill sets and there would be a different geographic distribution of posts, following the downsizing at headquarters in 2011 and the anticipated increase in staffing at the regional and country levels. At the country office level it is envisaged that the current complement of 35 core staff in the professional and higher categories would double to 70, with an emphasis on countries in the African and Eastern Mediterranean regions. Staff increases would also be required at the regional office level to ensure that the necessary competencies were present for overseeing and for fulfilling a backstopping role for the country offices. At the regional office level, it is likely that the current complement of 24 core professional staff would need to increase to 36, with an emphasis on the regional offices for Africa and the Eastern Mediterranean. Headquarters would require no additional staff as the relevant department was restructured and significantly downsized in 2011.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

No

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ 44 million; source(s) of funds: assessed contributions, voluntary contributions and programme monitoring and reporting funds. Response and recovery activities would be funded by any funding for outbreak and crisis response received against the consolidated and flash appeals for specific emergencies.

Dr JESSE (Estonia), speaking on behalf of the European Union and its Member States, said that the acceding State Croatia, the candidate countries the former Yugoslav Republic of Macedonia, Montenegro and Iceland, the countries of the Stabilisation and Association Process and potential candidates Bosnia and Herzegovina and Serbia, as well as Ukraine, aligned themselves with her statement. Recalling the Organization's constitutional mandate to provide assistance in humanitarian emergencies, she said that its extensive expertise in health issues put it in a unique position to act as the lead agency of the United Nations Global Health Cluster. In view of the recent changes in WHO's humanitarian activities as part of the reform process, the challenge was to ensure fulfilment of its

mandate in line with the fundamental principles of humanitarian assistance and the cluster approach while strengthening its response in the field.

Four main areas needed attention. First, the European Union approved a strong focus on linking risk management, preparedness, response and coordinated needs assessment, but sought more information on the Organization's core commitments, functions, performance standards, and roles and responsibilities. Secondly, WHO's surge capacity relied on the response capacity of regional offices, which depended on qualified personnel and clear protocols and procedures. WHO needed to coordinate better the many humanitarian actors in the field and to improve its internal coordination. Thirdly, collaboration with the United Nations Office for the Coordination of Humanitarian Affairs and other partners was essential and she welcomed WHO's support for the transformative agenda of the Inter-Agency Standing Committee. However, she sought more details about WHO's role within the United Nations humanitarian response system. Fourthly, she encouraged WHO to ensure the rapid deployment of experienced health cluster coordinators and to strengthen its capacity for leadership and coordination for major field operations. The worrying trend of humanitarian crises followed by health crises could be averted by proactive planning and effective preparedness and response. As for the challenge of financing, the European Union would continue to support WHO in its efforts to fulfil its mandate and called upon other Member States and donors to increase the predictability and flexibility of their funding of WHO's humanitarian action. The report to the Sixty-fifth World Health Assembly should provide more detail about the results of putting the new emergency response framework into operation.

The draft resolution sought to reaffirm WHO's constitutional mandate as the provider of essential life-saving health services in humanitarian emergencies and its role as the health cluster lead, and to provide guidance for implementing the new working methods introduced since the creation of its new department of emergency risk management and humanitarian response. It further called on Member States and donors to support and cooperate with WHO and its partners in humanitarian activities, and to take action to improve national capacities for preparedness and emergency response.

Several amendments had been proposed since the draft resolution had been tabled. First, the customary introductory text should be inserted, reading:

“Having considered the report on WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies,

RECOMMENDS to the Sixty-fifth World Health Assembly the adoption of the following resolution:”.

In the third preambular paragraph, the phrase “and the guiding principles thereon,” should be inserted after “emergency assistance of the United Nations,”; and the abbreviation “i.a.” should be inserted after “establishing.”. The word “Recalling” at the beginning of the fourth preambular paragraph should be replaced by “Taking note of”. The words “cluster system” on the last line of the fourth preambular paragraph should be replaced by “cluster”. In the sixth preambular paragraph, the words “taking note of” should be inserted after “60/124 and”. The words “Recognizing also” at the beginning of the seventh preambular paragraph should be replaced by “Reaffirming”. The word “also” should be inserted after “Reaffirming” at the beginning of the tenth preambular paragraph”. In the twelfth preambular paragraph, the words “taking note of” should be inserted after “reform agenda and”.

A footnote should be added to the introductory phrase of paragraph 1, reading: “Including, where applicable, regional economic integration organizations.” She clarified that in subparagraph 1(1), reference to “the Organization” meant WHO. Subparagraph 1(2) should be replaced by new text, reading: “to ensure that humanitarian activities are carried out in consultation with the country concerned for an efficient response to the humanitarian needs, and to encourage all humanitarian partners, including nongovernmental organizations, to actively participate in the health cluster coordination;”. In subparagraph 1(3), the wording following “outlined in resolution WHA64.10 and” should continue “in this context, as part of ...”.

Subparagraph 1(4) should end at “WHO and the health cluster”. Subparagraph 1(5) should be deleted.

In subparagraph 2(1), the words “to best fulfil its role” should be replaced by “enable itself to discharge its function”. In subparagraph 2(2), the word “developing” should be inserted after “including”. In subparagraph 2(3), the beginning of the third line should be amended to read: “needs, including as a part of the coordinated”. The word “and” at the beginning of the third line of subparagraph 2(6) should be replaced by “as well as”. The words “to address pre-existing inequities” at the end of subparagraph 2(7) should be deleted.

Dr NIE Jiangang (China) commended WHO’s response to the increasing number of disasters and emergencies. After the two major earthquakes that had struck the country in 2008 and 2010, his Government had put into operation a rapid response programme that included mechanisms for transferring the injured to well-equipped emergency medical services and disease prevention. He expressed appreciation of WHO’s support in providing medical resources, equipment and technology.

The Organization should step up its efforts to meet the needs of disaster-struck regions through the provision of medical supplies and training for support staff; to provide support to Member States in improving the preparedness of health services; and to play a greater role in providing technical advice, information, and the surveillance and control of communicable diseases. WHO should also help to evaluate and recommend measures to strengthen local capacities to respond to emergencies, and continue to promote the safe hospitals programme. Annual meetings should be convened for sharing national health sector information and experience in responding to humanitarian emergencies.

He asked the Secretariat to produce a clean copy of the draft resolution as amended by the member for Estonia.

Dr ST. JOHN (Barbados) supported the draft resolution and endorsed the observation in the report that WHO needed to become faster, more effective and more predictable in delivering high-quality action in response to humanitarian emergencies, with clear benchmarks for measuring performance. Health workers in the Caribbean subregion had received training to become health cluster coordinators in 2011, and mechanisms had to be established to enable their rapid deployment when needed.

Dr DE ASSUNÇÃO SAÍDE (Mozambique), speaking on behalf of the Member States of the African Region, said that his Region was beset by an increasing number of crises and natural disasters, resulting in death and disease, the destruction of health facilities, disruption of services and economic losses. Since the United Nations’ introduction of the cluster approach in 2006, WHO, in collaboration with health ministries and health-cluster partners, had significantly improved the coordination and management of health action in Africa owing, inter alia, to the training of health cluster coordinators. The multiplicity of humanitarian actors with different working methods and mandates, however, together with the lack of a common framework, led to weak intercluster information-sharing and planning, which in turn undermined cooperation with host governments and the participation of domestic nongovernmental organizations. Effective coordination was further undermined by a lack of coherence among donors, which resulted in duplication, and inadequate funding had resulted in the closure of health clusters in some countries that were still in crisis. Meanwhile, although health clusters were meant to be temporary structures, they currently had no clear strategies for ending their work or instituting other arrangements. He supported the draft resolution.

Mr KOLKER (United States of America) supported WHO’s efforts to enhance its role as the health cluster lead in humanitarian emergencies. Given the possible doubts among its partners as to whether WHO could fulfil the role at a time of major restructuring, the draft resolution’s reaffirmation of its commitment to that work was opportune. He urged the Secretariat to harmonize the preparedness functions of headquarters and regional and country offices, and to work with partners on defining roles.

The draft resolution brought together several aspects, including the crucial issue of the safety of health workers in emergencies and conflicts. Such situations called for the deployment of individuals with a wide range of expertise, and WHO must work with partners and governments to ensure their protection in the often heroic discharge of their duties, as well as to inform the world of any threats to, or violations of, their security.

Dr TAKEI (Japan) said that the draft resolution would serve to enhance WHO's coordination of stakeholders in humanitarian emergencies. His Government would share with WHO and other international partners its experience in disaster preparedness, reconstruction and monitoring the health effects of radiation in the wake of the earthquake and tsunami that had struck Japan in 2011. It had implemented the Hyogo Framework for Action 2005-2015, drawn up guidelines and enacted legislation. His country was supporting disaster preparedness initiatives through official development aid.

Dr LARSEN (Norway) said that Norway was a strong supporter of the various initiatives to improve the effectiveness of the United Nations humanitarian response system, and that it fully endorsed the transformative agenda promoted by the United Emergency Relief Coordinator. WHO had, in many cases, successfully fulfilled its role as health cluster lead in humanitarian emergencies. He called for adequate resources at every level of the Secretariat, including headquarters where the critical staffing situation was a cause for concern; he requested the Director-General to elaborate the underlying rationale.

He welcomed the emergency response framework that would enable WHO to respond more rapidly and effectively to sudden disasters, and its benchmarks would help to hold the Organization accountable for its performance. Close collaboration with national stakeholders and national capacity building were crucial to the prevention of humanitarian crises.

He joined the member for the United States of America in stressing the importance of highlighting the plight of health workers in conflict zones.

Professor PRASAD (India) noted the observation in the report that WHO's effectiveness as the health cluster lead was undermined by a lack of technically competent and rapidly deployable staff, inadequate data collection and underfunding. It was encouraging that WHO's efforts had doubled the amount of funding received through the Consolidated Appeals Process between 2006 and 2010, but funding still seriously constrained the Organization and many developing countries. The South-East Asia Regional Emergency Fund should be further strengthened with clear standards, operating procedures and assessment. Meanwhile, he urged WHO to recognize its role in responding to humanitarian emergencies within the Inter-Agency Standing Committee. He further stressed the need to enhance community resilience and response in health emergencies, as well as the importance of a primary health care approach, especially in the first 24 hours, an aspect that the report had failed to mention.

Ms WISEMAN (Canada) said that Canada strongly supported the Inter-Agency Standing Committee-led reforms to strengthen humanitarian response through improved coordination, leadership, accountability, preparedness and advocacy. Committee members, including WHO, should support the United Nations Office for the Coordination of Humanitarian Affairs in spearheading those efforts. The Secretariat should inform Member States of what they could do to help, and WHO should work closely with the relevant health actors, including the International Federation of Red Cross and Red Crescent Societies and nongovernmental organizations in the field.

Mr DÍAZ ANAIZ (Chile) expressed appreciation for the Secretariat's support for Member States in national risk-management capacity-building and in responding to the health needs of affected communities in humanitarian emergencies, including the recent disasters that had struck his country. Its work at regional level was also valued. The new focus on improving emergency care could enable WHO to provide a humanitarian response in the most efficient manner possible. WHO had a key role

to play in inter-agency action under the leadership of the United Nations Office for the Coordination of Humanitarian Affairs. Resources, coordination and technical and operational capacities were essential in the face of humanitarian emergencies, but above all there was a need for solidarity – an ethical challenge. Chile wished to cosponsor the draft resolution.

Dr KESKINKILIÇ (Turkey)¹ welcomed the draft resolution but said that it could be improved. Options could be explored to use the existing capacities and expertise of Member States, for example, by making available a WHO-certified list of those States with such capabilities and developing a mechanism for their mobilization in the event of emergencies. It would avoid having to make other arrangements and, hence, help to improve the speed of WHO's response and enhance its leadership role. Agreeing to a proposal by Dr JESSE (Estonia) for further elaboration of the proposal before the next Health Assembly at which it could be discussed further, he expressed his support for the draft resolution.

Ms COHEN (Australia)¹ hailed the Secretariat's creation of the Polio, emergencies and country collaboration cluster as a significant step towards ensuring WHO's provision of more effective and efficient support for humanitarian health action. Putting the emergency response framework with its performance benchmarks for measuring progress into practice would be another. She welcomed WHO's efforts to strengthen its country-level response capabilities, which should include increased surge capacity, continued work on risk reduction and preparedness, and supporting the development of evidence-based strategies and plans. Particular emphasis must be placed on empowering countries and regions through capacity building, which was essential for emergency risk reduction. She further welcomed WHO's commitment to working with the United Nations Office for the Coordination of Humanitarian Affairs and other partners. Swift implementation of the priority actions in the transformative agenda of the Inter-Agency Standing Committee was crucial to strengthening the international humanitarian response.

Miss CADGE (United Kingdom of Great Britain and Northern Ireland)¹ said that her Government firmly supported WHO's vital role as the health cluster lead in humanitarian emergencies, and acknowledged the hard work and dedication of the WHO staff members working in difficult and dangerous circumstances. The Secretariat's reform of the relevant cluster, especially the focus on linking risk management, preparedness and humanitarian response, was a positive step to improving performance. In fulfilling its lead agency role, WHO must position itself, and ensure that its response functions were adequately resourced, to meet the needs of an increasingly complex humanitarian environment. Demonstrable results at the global and country levels would be crucial to securing donor support and she supported the move to mainstream global cluster-coordination costs into the regular programme budgets. Those costs should be reflected in the Proposed programme budget 2014–2015.

She welcomed WHO's commitment to working with the United Nations Office for the Coordination of Humanitarian Affairs and other partners, and urged the Organization to continue playing a key role in advancing the transformative agenda of the Inter-Agency Standing Committee and in the dialogue led by the United Nations Emergency Relief Coordinator.

Mr KAZI (Bangladesh)¹ welcomed the report but expressed concern at the general lack of resources, the shortage of trained staff capable of being rapidly deployed in the field, and the poor coordination of humanitarian actors. WHO urgently needed to improve its surge capacity, with flexible associated resources. Its emergency response framework and overall reforms must take full account of the need to promote inclusive, community-based, approaches that ensure the participation of affected populations in health-sector responses. Preparedness was the key. He supported a stronger

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

role for WHO as the health cluster lead in humanitarian emergencies, but it should not displace national governments from the driving seat. Member States were looking for needs-based technical assistance and support in keeping with their own emergency risk reduction and management strategies, especially. The draft resolution was a positive step in that direction.

Dr EL OAKLEY (Libya)¹ thanked the Secretariat and other Member States for their support during his country's recent conflict. The Organization's assistance had been impeccable, but the lengthy procurement process had made it difficult at times to purchase medicines, and should be rendered more responsive. He supported the draft resolution.

Dr ATTAYA LIMWATTANAYINGYONG (Thailand)¹ expressed her Government's gratitude for the assistance and support received from around the world in the wake of the recent severe flooding in Thailand. She acknowledged the value of the recently-established South-East Asia Regional Emergency Fund and the coordinating work of the WHO country office. Nevertheless, a painful and costly lesson had been learnt: pre-crisis preparedness was more important than post-crisis aid. In that regard, WHO could provide technical support in improving information systems, knowledge-sharing and disaster management. It could strengthen its role as the health cluster lead by ensuring that assistance responded to demand rather than being donor-driven; dialogue between providers of assistance and affected countries was crucial to effectiveness of aid.

The draft resolution was relevant and timely, but it lacked clarity in terms of the definition and scope of humanitarian emergencies and the mechanisms for harmonizing collaboration and coordination between WHO and other relevant actors. She considered the Secretariat's transformation of the Health action in crises cluster into the Emergency risk management and humanitarian response department as mere rebranding, and her Government wanted to see a clear redesign and restructuring in the process and definition of the new roles. The draft resolution did not adequately reflect how the new department would facilitate coordination between the various organizations and WHO's various units with the expertise required in humanitarian emergencies, in areas such as communicable diseases, hazardous chemicals, vaccine-preventable diseases and mental health.

Member States themselves also had to take responsibility for establishing and strengthening disaster management, through for instance surveillance, early-warning systems and crisis management, with technical support from WHO and coordination with relevant partners within and outside the health sector.

Mr RUBENSTEIN (The World Medical Association, Inc.), speaking at the invitation of the CHAIRMAN and on behalf of his own association as well as the International Council of Nurses; World Confederation for Physical Therapy; International Rehabilitation Council for Torture Victims; IntraHealth International; African Medical and Research Foundation; American Public Health Association; American College of Physicians; Center for Public Health and Human Rights at the Johns Hopkins Bloomberg School of Public Health; Doctors for Human Rights, UK; Human Rights Watch; Physicians for Human Rights; International Health Protection Initiative; and International Federation of Health and Human Rights Organisations, drew attention back to the pressing problem of violence against health workers and patients, which had been described as "one of the most crucial yet overlooked humanitarian issues of today".² The problem called for the urgent attention of the global health community and WHO, with its expertise in data collection, could play the limited yet essential leadership role outlined in subparagraph 2(8) of the draft resolution.

Dr AYLWARD (Assistant Director-General) thanked the various speakers for their guidance and comments. Progress had been made in implementing the cluster approach, but he acknowledged

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

² *Health care in danger*. Geneva, International Committee of the Red Cross, 2011.

the call for improvements in terms of predictability and the quality of the Secretariat's work, especially in coordination of the sectoral response. He assured the Board that the changes outlined in the report amounted to more than a rebranding operation; they represented a fundamental overhaul of the approach, structures and processes in managing the health and broader humanitarian response.

Responding to the request for more information on the Organization's core commitments and performance standards, he said that the WHO emergency response framework had been finalized. The details, which dealt with the points raised by the member for Estonia, would be published imminently on the WHO web site in appropriate languages, well in advance of the discussion on the issue at the Sixty-fifth World Health Assembly.

Regarding the matter of WHO's position on the broader humanitarian stage, the Organization did recognize the central role of the United Nations Office for the Coordination of Humanitarian Affairs in managing the humanitarian response, as well as the crucial position of health in response to humanitarian disasters and WHO's performance in assisting affected populations. It had been deeply engaged in, had endorsed, and would continue to adhere to the major reforms in the transformative agenda of the United Nations Inter-Agency Standing Committee in the areas of leadership, accountability, speed and cluster coordination, which formed the bedrock of the emergency response framework.

On the all-important issue of surge capacity for technical assistance and health-cluster coordination in humanitarian emergencies, he recognized the chronic problems in that area and that the Organization might not have been able to respond optimally. However, after careful examination of the opportunities and challenges, a four-pronged approach had been incorporated into the emergency response framework that would allow the issue to be addressed directly: immediately giving new purpose to country offices; the establishment of standby teams that would be ready for deployment within 72 hours, on which work had already begun; working with Global Health Cluster partners to ensure that they could be part of standby arrangements, with deployment of their teams within five days; and analysing ways of implementing standby arrangements with Member States, which activity was currently being done. The suggestion by the representative of Turkey in that regard would prove useful. The Secretariat was giving the matter full attention and its strategy should meet some of the demands. On the issue of a mechanism for rapidly using Member States' expertise, a draft policy on standby arrangements had been submitted to the Director-General and was expected to be launched before the Sixty-fifth World Health Assembly. He thanked Member States for their commitment to that as their support would be essential to WHO's surge capacity; details of the assistance WHO would need would be provided in the emergency response framework document.

He assured the Board that preparedness and readiness formed the foundation of the Organization's work in the humanitarian arena. Coordinated work within the Secretariat – similar to that which had led to the development of the emergency response framework – had been launched in order to develop a common operational framework for preparedness and readiness; that framework should be ready and embedded in the country cooperation strategies by the end of 2012. The priority, however, had been to finalize the response work first, as a matter of urgency, before moving on to preparedness and readiness.

The Secretariat considered that the temporary nature and lack of exit strategies for the health cluster was an extremely important issue that had not been fully addressed by the Inter-Agency Standing Committee in its transformative agenda. The matter had been identified as a key area in which WHO wanted to play a leading role with the Office for the Coordination of Humanitarian Affairs and which would be worked on in the coming year.

He assured the Board that the downsizing of departmental capacity at headquarters had not reduced the Organization's ability to respond to, and provide support in, humanitarian emergencies. Efficiency had been improved greatly by consolidating five former departments working in two separate continents on emergencies into one single department located in Geneva. Efficiencies had also been gained through coordination with the work of the Health security and environment cluster, aiming to combine their respective capacities into a single operational platform, as reflected in the emergency response framework. Furthermore, key technical functions had been moved back into the technical departments as part of a broader strategy to make the humanitarian response work an

Organization-wide activity rather than exclusive to one group. His cluster was also aligning its work with cluster partners in order to provide additional capacity; alongside the downsizing at headquarters there would be an overall increase in staffing in the regional and, in particular, country offices where the expected outcomes had to be achieved.

Procurement functions had been identified as crucial to the consultative reform process and their capacity would be maintained. Primary health care might not have appeared prominently in the report but it remained a core commitment, and more explicit information would be provided in future. WHO was fully committed to working with its core Global Health Cluster partners, with which it had recently initiated a dialogue about joint implementation of the new framework.

The leading role of national authorities was a central tenet of both the Inter-Agency Standing Committee's transformative agenda and WHO reform, and the Organization would make sure that its response was demand-driven. It fully recognized that disasters were set to increase in scale and frequency, as would the demands on Member States and the Secretariat for provision of assistance. The reform agenda recognized that and set out to ensure that the Organization was fit for that purpose.

The DIRECTOR-GENERAL recalled the Organization's constitutional duty to respond to humanitarian emergencies but noted that Member States were conveying mixed messages. Some called for WHO to intervene in the field, others for it to stick to its standard-setting mission. WHO's work in the humanitarian sector was vital yet its capacities were limited and its resources in short supply. As the report had shown, its programmes for humanitarian emergencies had received on average only about 40% of their funding requirement, yet Member States wanted the Secretariat to meet 100% of their expectations. That was quite a challenge.

At one stage, she had wanted to pull the Organization out of the humanitarian field but had been persuaded to change her mind after consulting widely with partners, especially the Principals of the Inter-Agency Standing Committee and colleagues at the International Committee of the Red Cross and in civil society. As a result, she had reaffirmed the Organization's commitment, which called for the reforms just outlined by the Assistant Director-General following deep consultations with all regional directors, leading to the new, unified, emergency response framework that was about to bring about some major changes in the ways in which the Organization responded, as the health cluster lead, to humanitarian emergencies. She had changed her mind because 2010 had been an extremely difficult year, not just for WHO but all humanitarian actors, in and outside the United Nations system. It had severely tested the entire humanitarian response sector; a test that, according to a Global Health Cluster review, it had failed. That, in turn, had led to the development of the transformative agenda of the Inter-Agency Standing Committee under the courageous leadership of the Emergency Relief Coordinator. WHO was a strong partner in that process, and would continue to lend its full support, because change in the humanitarian sector was crucial in order to meet the expectations of Member States.

Donors, too, needed to change. WHO, as the health cluster lead in response to the earthquake in Haiti in 2010, for instance, had been in charge of coordinating the work of 350 or more health-sector nongovernmental organizations. Some had been cooperative but others had flatly refused to recognize WHO as the coordinator; some had not even attended coordination meetings. Member States funding those agencies should hold them to account in the same way as they, quite rightly, held the Organization to account. Any body that was spending their money should be compelled to join in the collective effort so as to promote synergy in place of duplication and fragmentation.

Responding to the point made by the representative of Libya, she said that WHO had been happy to support his country in difficult times through the procurement of medical supplies. While keen to streamline procedures, however, she could not compromise a transparent bidding process, identifying reliable agencies on the ground and ensuring that none of the supplies were diverted. If that happened, WHO could be criticized for not delivering the supplies it had procured. Great caution was needed for transparency and accountability to be ensured.

As for the matter of the humanitarian space in which the Organization operated, it was a real challenge when staff were killed or kidnapped, and she appealed to countries to ensure the security of those staff and a neutral space where they could work. Health workers should not be targeted.

The CHAIRMAN, in the absence of any objection, took it that the Board wished to adopt the draft resolution, as amended by the member for Estonia.

The resolution, as amended, was adopted.¹

The meeting rose at 17:30.

¹ Resolution EB130.R14.

THIRTEENTH MEETING

Monday, 23 January 2012, 09:15

Chairman: Dr B.-I. LARSEN (Norway)

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

United Nations Conference on Sustainable Development Rio+20: Item 6.16 of the Agenda (Document EB130/36)

The CHAIRMAN drew attention to a draft decision on United Nations Conference on Sustainable Development (Rio+20) proposed by Brazil and Ecuador, which read:

The Executive Board,

Recalling Principle 1 of the Rio Declaration on Environment and Development (1992), which states “Human beings are at the centre of concerns for sustainable development. They are entitled to a healthy and productive life in harmony with nature”;

Acknowledging that economic, social and environmental objectives are mutually supportive;

Noting the two main themes of the United Nations Conference on Sustainable Development, namely the green economy in the context of sustainable development and poverty eradication and, the institutional framework for sustainable development;

Recalling the WHO World Conference on Social Determinants of Health and, particularly, the Rio Declaration;

Noting also the submissions by the WHO Secretariat to the United Nations Conference on Sustainable Development Bureau,

1. DECIDES to convene informal consultations among Member States to debate the contributions of WHO to the forthcoming deliberations of the United Nations Conference on Sustainable Development with a view to ensuring that health has an appropriate bearing on the Conference proceedings;

2. REQUESTS the Director-General to facilitate consultations among Member States and organize an informal meeting with Permanent Missions in Geneva for that purpose.

Dr AGUILAR (Ecuador) said that various countries of the Union of South American Nations, including Ecuador, were contributing to sustainable development with innovative proposals that were made from the point of view of theory and method but also grounded in operational experiences that had produced tangible results. That holistic logic underpinned the synergy of economic, social and environmental interventions that had a considerable impact on health and had inspired various experiments in Latin America. In Ecuador that approach had continued since 2007, and the President had assumed responsibility for development planning.

The draft decision would make it possible to establish a position to permit Member States and regions to give health due prominence in the United Nations Conference on Sustainable Development (Rio+20), due to be held in Rio de Janeiro, Brazil, 20–22 June 2012. He asked that the other sponsor be invited to introduce the draft decision.

Having been invited by the CHAIRMAN to take the floor, Mrs ESCOREL DE MORAES (Brazil) thanked the Board for deciding to include the item on its agenda and expressed appreciation to the Secretariat for preparing a report at short notice. The report stressed the strong links between health and sustainable development. The current global epidemiological, nutritional and demographic transitions necessitated synergistic interactions between the health sector and other sectors of government and society. Challenges such as ageing, the high incidence of noncommunicable diseases, urban violence and obesity were directly related to the social, economic and environmental aspects of development, underlining the need to incorporate health in deliberations on sustainable development.

The purpose of the draft decision was to engage Member States in the preparatory process for Rio+20 and provide an opportunity to determine how health matters could be properly reflected in the Conference. The proposed informal consultations would comprise a meeting with permanent missions in Geneva that would follow a technical briefing by the Secretariat on the content of the documents submitted to the Conference bureau and document EB130/36. The intent was a constructive dialogue, guided by the common objective of protecting the health of populations and promoting sustainable development. She urged the Board to adopt the draft decision, which should contribute to, not interfere with, the preparatory process under way at the United Nations in New York.

Dr DAULAIRE (United States of America), recognizing the important role of health in efforts to achieve sustainable development, welcomed the elaboration of a submission by WHO to the current negotiating process on the Rio+20 Conference. He did not object to the informal consultations proposed in the draft decision, but emphasized that they should comprise a one-off exchange of views and would not establish a process parallel to that under way at the United Nations in New York. He therefore proposed that paragraph 1 be amended by replacing the word “debate” with “discuss”, by replacing “contributions of” with “contribution submitted by”, and by replacing “has an appropriate bearing on” with “is appropriately considered in”. He further proposed that, in paragraph 2, “consultations” should be replaced by “discussions”. The proposed amendments had been discussed with the sponsors of the draft decision.

Dr JESSE (Estonia), speaking on behalf of the European Union and its Member States, said that the Conference offered a unique opportunity to accelerate and broaden the worldwide transition to a green economy that promoted sustainable development and contributed to poverty eradication; health was central to that debate. She therefore welcomed a submission from WHO to the preparatory process that would emphasize that many health risks could be prevented and health benefits enhanced by a more integrated approach to policy-making. Existing policies contributed to the burden of disease, particularly affecting disadvantaged groups. For example, inappropriate policies on energy and agriculture were exacerbating air pollution and encouraging production of unhealthy foods, respectively. Links between health, health inequalities and sustainable development had been highlighted by Member States in the Rio Political Declaration on Social Determinants of Health adopted at the World Conference on Social Determinants of Health in October 2011.

The proposed informal discussions would provide a useful opportunity to raise awareness of the importance of health for sustainable development among Member States and to contribute to WHO’s submission to Rio+20. They could also serve as a first step in shaping visions and goals for health in sustainable development beyond the Millennium Development Goal framework. They should not establish a process parallel to the current negotiations in New York, and she therefore proposed that the draft decision should be amended by adding the words “while fully respecting the ongoing negotiations in New York” at the end of paragraph 1. She supported the amendments proposed by the member for the United States of America.

Ms VIEITEZ MARTÍNEZ (Mexico) welcomed the increased commitment of Member States to improving human health as a contributor to sound development. However, data on maternal mortality indicated that the established goals would not be reached without fair and equitable social health protection; access must be provided to prevention, treatment and rehabilitation services. Universal health coverage was central to Mexico’s national health policy. She also advocated integrated

community policies and interventions designed to encourage physical activity and reduce harmful gas emissions, thereby reducing the risk of noncommunicable diseases and natural disasters due to climate change. Global governance to promote sustainable development should also take account of the effects on health of normative decisions. It was important to define the indicators to be included in the social determinants of health, such as universal health coverage as a development goal after 2015.

She supported the draft decision as amended by the member for the United States of America.

Dr SILBERSCHMIDT (Switzerland) said that health was an important component of Agenda 21 adopted at the first United Nations Conference on Environment and Development held in Rio de Janeiro in 1992 and which was part of the outcome of the World Summit on Sustainable Development held in Johannesburg in 2002. The lack of clear follow-up epitomized the difficulty the health sector faced in contributing to a broader process that it did not lead, even though health underpinned sustainable development.

The zero draft of the outcome document for Rio+20 hardly mentioned health, indicating perhaps inadequate input from Member States. Cautioning against overambition, he argued that health should be given at least as much importance as in Agenda 21 and the outcome of the World Summit on Sustainable Development. The following elements should be reflected in the Rio+20 outcome document: health as a contribution to, and indicator of, sustainable development; the importance of universal health coverage as part of social protection; the links between the social determinants of health and sustainable development; the environmental determinants of health, including the impact of climate change; the importance of sustainable development for the prevention and control of noncommunicable diseases; and the threat to sustainable development posed by rising prevalence rates of noncommunicable diseases.

The schedule for the negotiating process on the zero draft was tight: general comments on chapters 1 and 2 were due to be submitted by 23 January 2012 and comments on chapters 3–5 by 17 February. Would it be feasible to hold the proposed informal consultations immediately after the current Board session, namely in the same week or early the following week?

The outcome of the consultations should be submitted by Member States rather than WHO itself, and thus should not be seen as a parallel process to the negotiations under way but as a means of helping Member States to present coherent contributions. He supported the draft decision as amended.

Ms WISEMAN (Canada) said that, although significant progress had been made since the original conference in 1992, efforts must be reinvigorated in order to meet the many remaining and new challenges. Her Government would continue to engage in the preparations for the United Nations Conference on Sustainable Development (Rio+20). Canada's approach to sustainable development emphasized transparency and accountability in the integration of sustainability into government planning, principally through the Federal Sustainable Development Strategy. The contribution of improvements in health to the achievement of sustainable development was explicit in the strategy's goals for reducing health risks from environmental hazards through efforts to improve air and water quality and the management of resources, including water, and chemicals. Attention should be paid to the link between work on sustainable development and the attainment of the Millennium Development Goals.

She supported the draft decision as amended but proposed that, for the sake of consistency, paragraph 1 should also be amended by replacing "consultations" with "discussions". She endorsed the comments of the member for Switzerland about the timing of informal discussions.

Dr NAPAPHAN VIRIYAUTSAHAKUL (Thailand)¹ said that universal health coverage was a major social protection tool, which linked the social and economic pillars of sustainable development, and was central to poverty prevention and reduction. Universal health coverage should therefore be

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

given particular emphasis in the debate on sustainable development, together with the need to include health and the social determinants of health-in-all policies.

She supported efforts to raise the profile of health in the Rio+20 Conference. She therefore welcomed the draft decision. Although her country would participate in the proposed informal consultations, she shared the concern raised about their timing. Not all low-income and middle-income countries were in a position to have permanent missions in Geneva, and it was to be hoped that participation could be enhanced through electronic means, including webcasting of the consultations.

Dr DAULAIRE (United States of America) said that the proposed language for paragraph 1 should be further amended by replacing “informal discussions among Member States to discuss” by “informal discussions among Member States on”.

Mr LEFEBVRE (International Federation of Medical Students Associations), speaking at the invitation of the CHAIRMAN, commended WHO’s work on sustainable development, in particular on climate change and health, but drew attention to the current lack of opportunity for discussions on health in the Rio+20 agenda. Health, central to sustainable development, should be given priority. The international health community should enhance its input to the negotiating process for the Conference; Member States and the Secretariat should also do so by reporting on progress to the Sixty-fifth World Health Assembly and consider submission to the Health Assembly of a draft resolution that would provide a strong mandate for health sector engagement in Rio+20. WHO should also call for the inclusion of health as a thematic area of the Rio+20 process. Civil society should be involved in the WHO’s informal consultations.

The diverse social, environmental and economic determinants of health demanded the cross-sectoral integration of health indicators in policies on sustainable development. That process should be characterized by joint leadership within and between governments in formulating policies that embraced the opportunities provided by sustainable development. Civil society and governments must work together to realize health for all through sustainable development. He urged Member States and the Secretariat to develop and lead engagement on health throughout the process.

Ms EGGERMONT (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, said that the health sector should assume a more prominent role in the preparations for Rio+20 than was evident from the zero draft of the outcome document. Despite progress in the prevention and control of specific diseases, the current framework had failed to redress the growing inequalities between and within countries. The Rio+20 Conference provided an unprecedented opportunity to improve health by placing equity at the heart of sustainable development. Equity would do more for health than any new fund, alliance or partnership, and provided a basis for engagement with other sectors. She called on delegates to advocate forcefully for health and equity within their governments and to give the Secretariat a clear mandate to provide support to Member States in preparing for the Conference.

She expressed regret that the draft decision referred to health having a bearing on the Conference and not vice versa, as the Board had already acknowledged the importance of sustainable development for health in its discussions at the current session on the Millennium Development Goals, the social determinants of health, and noncommunicable diseases. As the Secretariat was reviewing its priority setting and looking at the era after the Millennium Development Goals, the Sixty-fifth World Health Assembly should consider the place of sustainable development in the future work of the Organization, given its contribution to improving health and equity.

The DIRECTOR-GENERAL, responding to comments, confirmed that the proposed informal discussions were intended to contribute to the official negotiations in New York and not to establish a parallel preparatory process. Contributions to the Conference’s preparatory process could be made in two ways: through individual national channels and through WHO. Informal discussions would have to take place before the 17 February deadline for the submission of comments on the zero draft of the outcome document to enable the Secretariat to consolidate the views of Member States. Of the three

pillars of sustainable development, the social pillar was the weakest, and Member States and the Secretariat would need to make skilful use of language to focus more attention on that pillar, which included health. Contributions should also be aligned with Agenda 21 and the outcome of the World Summit on Sustainable Development in 2002. Should the draft decision be adopted, Member States would be informed as soon as possible of the timing of the informal discussions.

The CHAIRMAN said that he took it that the Board wished to take note of the report and adopt the draft decision, as amended.

The Board took note of the report and adopted the decision, as amended.¹

2. **WHO REFORM:** Item 5 of the Agenda (Documents EB130/5 and EB130/5 Add.1 to Add.9) (continued from the tenth meeting, section 2)

Programmes and priority setting

The CHAIRMAN drew attention to a draft decision on WHO reform (programmes and priority setting) prepared by an informal drafting group, which read:

The Executive Board,
Having considered decision EBSS2(1),

1. DECIDES on the following scope of work and terms of reference for the Member State²-driven process established to provide recommendations on methods for programmes and priority setting for the consideration of the Sixty-fifth World Health Assembly in May 2012;

PP1 Scope of work: to make recommendations to the Sixty-fifth World Health Assembly on the categories, methodology, criteria and timeline for programmes and priority setting in order to serve as guidance for the development of the next and future general programmes of work, recognizing the important linkages to other elements of the WHO reform process;

PP2 The specific objectives of the process will be:

- (a) to review and consider proposals on priority setting contained in the background paper EB130/5 Add.1 taking as a basis for priority setting: country needs, the relevance of WHO for all countries, its specific comparative advantage and its leading role in global health;
- (b) to elaborate methodology, criteria and the timeline for the priority-setting process;
- (c) to consider possible ways of grouping WHO's work into categories, including but not limited to the seven categories contained in document EB130/5 Add.1, as proposed for the framework for the next general programme of work;
- (d) to identify additional analytical work by the Secretariat emerging from these discussions, which will contribute to the development of the next and future general programmes of work;

PP3 The process will be open to all Member States.² It will be chaired by Mr R. El Makkaoui, Chairman of the Executive Board. Any other officers deemed necessary will be determined by the Officers of the Executive Board;

PP4 A meeting will be held on 27 and 28 February 2012 at WHO headquarters to

¹ Decision EB130(5).

² And where applicable, regional economic integration organizations.

advance the work of the Member State¹-driven process, with any follow-up meetings or discussions, as necessary, to be agreed at that meeting in order to finalize the work before the Sixty-fifth World Health Assembly;

PP5 The Chairman of the Member State¹-driven process shall submit a report on the results of the process to the Sixty-fifth World Health Assembly;

2. REQUESTS the following support from the Secretariat, based on existing information:
 - (1) On the afternoon of 26 February, a presentation on current priority-setting practices and the strengths and weaknesses of those practices and the relationship between the country cooperation strategies, the general programme of work formulation process and the programme and budgeting process. Copies of the presentation will be circulated three days in advance of the presentation. Arrangements will be made for a web-based consultation for nongovernmental organizations in official relations with WHO to present their views according to the scope of work and for them to observe the presentation;
 - (2) No fewer than seven days in advance of the meeting on 27 and 28 February, the following documents will be provided:
 - (a) a three-page summary paper on the presentation described in subparagraph 2(1) above;
 - (b) mapping of the functions of the Organization (Article 2, WHO Constitution) in relation to the categories proposed in document EB130/5 Add.1, including cross-cutting global needs and areas of work;
 - (c) an analysis of country cooperation strategies that identifies the needs of countries in a way that allows a determination of what WHO should focus its work on and where WHO is best placed to add value;
 - (d) a road map and timelines for the preparation of the next general programme of work and the Programme budget 2014–2015;
 - (e) reference documents including, in particular, the following:
 - Eleventh General Programme of Work, 2006–2015;
 - Medium-term Strategic Plan 2008–2013 (amended);
 - Documents EB130/5 Add.1 and Add.2;
 - *World Health Statistics 2011* (which provides information on disease burden).

The CHAIRMAN said that, hearing no objection, he took it that the Board wished to adopt the draft decision.

The draft decision was adopted.²

Governance

The CHAIRMAN said that, as proposed after the Board's discussions earlier in the session, Member States were invited to submit comments on two of the governance reform proposals considered: the draft revised terms of reference for the Programme, Budget and Administration Committee; and proposals for increasing linkages between regional committees and the global governing bodies, and harmonization of the practices of regional committees. Comments should be submitted before 29 February 2012 through the password-protected web site that would be open to all Member States. (The Secretariat could separately provide further information to Member States that did not currently have access to the web site.) On the basis of the feedback received, the Secretariat

¹ And where applicable, regional economic integration organizations.

² Decision EB130(6).

would prepare revised proposals for submission to the Board at its 131st session, through its Programme, Budget and Administration Committee.

On the basis of the Board's discussions at the current session, the Secretariat would revise the proposed options for the schedule of governing body meetings, incorporating the proposals for a revised schedule for sessions of the regional committees, the Executive Board, the Programme, Budget and Administration Committee and the Health Assembly. It would also prepare a detailed analysis of the advantages and disadvantages, feasibility and costs of the options. The Secretariat would also investigate means of streamlining national reporting, and further elaborate the proposals for management of resolutions.

Further discussions would be required on WHO's engagement with other stakeholders, including nongovernmental organizations and industry, and the proposals to review and update the principles governing WHO's relations with nongovernmental organizations. Further work was also needed on comprehensive policy frameworks to guide interaction with the private for-profit sector and not-for-profit philanthropic organizations. Those discussions would be held during the Sixty-fifth World Health Assembly.

The Board had agreed on the importance of partnerships and the need for better management and greater oversight by the governing bodies, in particular the Board. Members of the Board had proposed a review of WHO's hosting arrangements, along with further efforts to harmonize work with hosted partnerships.

In the area of managerial reforms, the Secretariat would elaborate further the proposals for the predictable financing mechanism and the contingency fund, on the basis of the feedback from members at the current session, and submit them to the Board at its 131st session, through the Programme, Budget and Administration Committee.

Member States were invited to submit comments on the draft evaluation policy also through the password-protected web site open to all Member States before 29 February 2012. On the basis of the feedback received, the Secretariat would prepare a revised draft evaluation policy for submission to the Board at its 131st session, through the Programme, Budget and Administration Committee.

The Board had welcomed the offer of the External Auditor to carry out stage one of the independent evaluation of WHO, and expected that his report would be submitted to the Sixty-fifth World Health Assembly and would include a proposed road map for stage two. As discussed by the Board, the Secretariat would update the terms of reference for stage one of the independent evaluation on the basis of the written comments submitted by the Joint Inspection Unit of the United Nations system.

The Board had also welcomed the agreement of the Joint Inspection Unit to update its reports on decentralization within WHO and on management and administration in WHO.

The Secretariat would prepare a consolidated report covering all aspects of WHO reform for submission to the Sixty-fifth World Health Assembly. The Health Assembly would have the opportunity to review and discuss all of the proposals on reform. The report would cover the three areas of programmes and priorities, governance and managerial reforms, and incorporate the outcome of the Member State-driven process on priority setting, showing linkages and indicating areas where consensus had been reached, and those areas where further discussion was required. The report would include the elements of WHO reform agreed at the Board's special session in November 2011, and further elaboration of the proposals for which the Board had requested additional work. It would also include a draft implementation plan, with a budget and a monitoring framework, for consideration by the Health Assembly.

In line with the Board's desire to strengthen the oversight of the Programme, Budget and Administration Committee, which already had a crowded agenda for a one-day meeting, he proposed that the meeting of the Committee in May 2012 should be extended to three days, to enable it to consider the documents on WHO reform being presented to the Sixty-fifth World Health Assembly and the Board at its 131st session. The report of the Committee would be presented to the Health Assembly. He further proposed that the Board's 131st session should be extended to two days, to ensure adequate time to consider the reform proposals.

Dr SILBERSCHMIDT (Switzerland) proposed that a paper version of the useful summary provided by the Chairman, which he endorsed, should be circulated to Board members. He noted that the 29 February 2012 deadline for submitting comments through the web platform was just one day after the proposed meeting on priority setting. It was important to ensure coherence among reform proposals, and he therefore suggested that it would be more logical to set the deadline either one week before or one week after the priority-setting meeting. That would permit two options: either the comments could be taken into account during the priority-setting meeting or the outcome of the priority-setting meeting could be taken into account in preparing comments.

Dr REN Minghui (China) supported the proposal by the member for Switzerland that the Chairman's summary should be circulated to Board members.

Dr DAULAIRE (United States of America) agreed, suggesting that the summary should be circulated before the Board took any further decision on the item.

The DIRECTOR-GENERAL said that the Secretariat would prepare a document containing the Chairman's summary for circulation as soon as possible, to enable Board members to seek any clarification necessary.

In reply to a request for clarification from Dr REN Minghui (China), Mr BURCI (Legal Counsel) explained that it was customary for the Chairman to recapitulate the Board's discussions in summary form to confirm with the Board that his understanding was correct. That recapitulation would be reflected in the summary records. A formal draft decision on the matter was not required, although one could be requested.

Dr SILBERSCHMIDT (Switzerland) said that his previous intervention had been intended as an endorsement of what had been said by the Chairman. Any subsequent review of the written summary should be for clarification purposes only, with no reopening of substantive negotiations on the text.

The CHAIRMAN, indicating that he would be available for informal clarification of the text of his summary during the lunch break, said that he took it that the Board wished to suspend consideration of the item pending the circulation of his summary in writing.

It was so agreed.

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

3. STAFFING MATTERS: Item 8 of the Agenda (continued)

Statement by the representative of the WHO staff associations: Item 8.4 of the Agenda (Document EB130/INF.DOC./2)

Mr BELGHARBI (representative of the WHO staff associations), highlighting key issues from the statement contained in document EB130/INF.DOC./2, underlined the loyalty and dedication of staff members, which had allowed a dialogue between staff and management to continue despite staff cuts and other difficulties. The staff associations welcomed the belated efforts being made to reduce the budget deficit, including measures of protection against exchange-rate fluctuations; greater foresight on the part of certain managers in dealing with the financial situation could have reduced or averted the deficit and the consequent laying off of 700 staff members. By factoring in the staff who were due to retire every year, it should be possible to avoid further layoffs. The likely impact of staff cuts and retirement on the reform process needed to be assessed. It was stated in document

EB130/26 Add.1 that 16.2% of the workforce was due to retire within five years. In the professional and higher categories, the proportion was 22.2%; cumulatively 29% of such staff members were due to retire in 10 years. Hence, WHO could lose 40% of its senior technical experts, and, without a proper recruitment plan, find itself hard pressed in the future. There was a growing sense of injustice among staff members, which could adversely affect their relations with the Organization. The staff associations had therefore agreed on the need for a recruitment plan that took into account planned retirement and short-term departures, and for a revised staffing model that would ensure that the best staff were attracted and retained. It was also generally acknowledged that United Nations salaries were no longer competitive. The tendency to replace internationally recruited staff by national professional officers represented a direct violation of the WHO Manual's provisions, and, despite requests from the staff associations, no decision had yet been taken to stop that practice.

The Global Management System was slow, inflexible and not sufficiently user-friendly and, therefore, in need of re-evaluation.

With regard to the fair treatment of staff, there had been an increase in the number of appeals; currently more than 150 cases were pending, with an average waiting time of 18 months before a case report was finalized. The first step in the appeal process was the Office of Internal Oversight Services, but its independence, and, therefore, its suitability for the task, was in question. Managers needed to be better trained in managing staff, mobilizing resources and communicating in order to ensure consistent policies and approaches across programmes and regions.

In order to counteract the poor public image that the workforce believed WHO had acquired and which was affecting its ability to attract new sources of financial support, it might want to consider setting up two flagship, focused, time-limited health initiatives, along the lines of those that were currently performing well.

Dr SILBERSCHMIDT (Switzerland) said that the Board should maintain a dialogue with the WHO staff associations as staff members were the Organization's greatest asset. At the recent meeting of the Programme, Budget and Administration Committee, participants had expressed satisfaction that the information provided had indicated that the necessary staff reductions had been made at all staffing levels, with no bias towards lower levels. Board members should be clear that the cuts were the result of the financial situation and were not linked directly to the WHO reform process. He supported the view of the WHO staff associations that it was essential to respect the Staff Regulations when reduction measures were taken. However, the current reductions could not have been foreseen. The reform process should include consideration of improvements in the management's preparedness for dealing with such circumstances. In addition, full use should be made of the existing rules and regulations, for example the exchange-rate facility covered by Financial Regulation 4.4, in order to avoid situations of the kind that had arisen in 2011. Transparency should be increased and statistics on all categories of staff working for WHO should be made available in the future. Human resource management was a key pillar of reform and he therefore encouraged the Director-General, in consultation with the staff and the governing bodies, to take measures to ensure that staff had the appropriate mix of skills and, if necessary, to propose amendments to the relevant regulations for consideration by the competent bodies. The aim should be, once the downsizing made in 2011 and the reform process had taken effect, to ensure that WHO was operating once again at full strength with excellent and fully motivated staff.

Ms STIRØ (Norway) agreed that staff were the Organization's most valuable asset. A knowledge-based organization like WHO must always have the best expertise available. The recent downsizing had been the result of efforts to adjust expenditure to income, but it had nevertheless been difficult and painful for the staff. Such measures must be transparent, fair and just. Downsizing should also be based on a strategy that would allow WHO to continue to meet its objectives in its core areas of work, and she requested further information in that regard. If the criticisms of WHO's management made by the representative of the WHO staff associations reflected the attitudes of WHO staff, they were worrisome. Staff and management should continue to work to adjust the Organization to new financial realities and future reform, with both sides maintaining a professional, constructive and

flexible approach. The improvements in management proposed by the staff associations lay within the authority of the Director-General and the staff associations should use established channels to work jointly with management on those and other issues.

Dr DE ASSUNÇÃO SAÍDE (Mozambique), speaking on behalf of the Member States of the African Region, said that motivated and committed staff and strategic orientation were the keys to a successful WHO, and that, if WHO was widely recognized in the international arena for its achievements and its leadership in public health, that was mainly due to its competent, qualified staff. However, the financial crisis and the need for reform were affecting human resources in various ways. WHO, while adopting necessary reforms, should maintain its commitment to ensuring a better gender balance and to employing highly qualified specialists. WHO's management and the WHO staff associations should therefore continue efforts to improve dialogue at all levels and to ensure coordination of measures to produce a stronger Organization with better career development.

Staff reductions in priority programmes such as HIV/AIDS, tuberculosis, malaria, maternal health and health systems were of particular concern. The Secretariat should find ways to protect the staff of such programmes.

Ms WISEMAN (Canada) agreed that the staff were the most valuable asset of a knowledge-based organization like WHO and that it was vital for it to maintain technical capacity and the right mix of skills in order to fulfil its core mandate. Processes to facilitate succession planning were an essential component of human resources management. The different parties should listen to each other and demonstrate flexibility in order to strengthen WHO. The challenges inherent in the current staff changes were not confined to WHO; staff reductions were under way in many Member States with a view to aligning human resource models with government priorities. The Secretariat should maintain its current practice of open and transparent communication with staff, including regular meetings with staff representatives, and its proactive approach to staff management.

Dr DAULAIRE (United States of America) agreed that WHO's staff were crucial for its work. He appreciated the commitment of the staff to the Organization and acknowledged the recent uncertainties they had experienced. However, the Organization must be fit for purpose if it was to function, and indeed survive, in the 21st century. Management and staff must focus on how best to fulfil its core mission, consistent with its values and its resources. Transparent communication between management and the staff associations was essential, and efforts to reassign staff where possible, as recently reported to the Programme, Budget and Administration Committee, were to be commended. WHO must take cost-effectiveness measures, such as changes in travel allowances, at a time of resource constraints. WHO should review the use of national professional officers in the light of practices in other United Nations organizations, including those with similar service centres.

The DIRECTOR-GENERAL reaffirmed her view, as stated to the Programme, Budget and Administration Committee at its recent meeting, that the success of WHO depended on the talents, experience, commitment and dedication of its staff, many of whom worked long hours in the Organization's service. Cutting staff was a painful process that nobody wanted or enjoyed. However, the financial reality necessitated appropriate mechanisms to ensure that WHO lived within its means and did not incur financial liabilities that threatened the Organization's survival. One solution would be for Member States to increase their contributions. However, that was not feasible since, as the member for Canada had rightly said, many governments were going through similar exercises in staff reduction. As the responsible officer, she had therefore worked closely with the staff associations over the previous two years to develop fair, transparent and strategic mechanisms for staff reduction. Given that contributions were often earmarked to programmes, the simplest measure was to cut programmes that were not being funded. However, that was not a strategic approach and would not be good for the future of the Organization. She had therefore welcomed the agreement by the staff associations that a strategic mechanism was needed. That meant considering estimated income, likely expenditure and future direction for a particular programme over the coming few years to determine how many staff

would be required, rewriting the job descriptions for the programme, and then conducting a staff matching exercise in collaboration with the staff associations. The Secretariat had reported in detail on the process to the Programme, Budget and Administration Committee. The Organization had fulfilled its responsibilities as a manager. It had operated an open-door policy with the staff associations; it had taken measures to reassign staff members where possible, although proposals for the relocation of programmes and staff to areas that were less expensive than Geneva had largely been rejected, mainly for family reasons. The Secretariat had also offered outreach services to help staff to rewrite their curricula vitae. There were areas where management and the staff associations did not agree and management understood that staff that had lost their jobs were unhappy. However, as Director-General, she was responsible to the Member States for managing the staff to the best of her abilities with fairness, transparency and equity.

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

Human resources: annual report: Item 8.2 of the Agenda (Documents EB130/26 and EB130/26 Add.1)

Dr DE ASSUNÇÃO SAÍDE (Mozambique), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee and recalling the Committee's recent deliberations on the item (document EB130/4, paragraphs 34–40), said that the Committee had recommended that the Board should take note of the reports contained in documents EB130/26 and EB130/26 Add.1.

Dr TAKEI (Japan), stressing the importance of learning programmes and capacity building, said that staff members who had benefited from such measures should be assigned to posts where they could apply the expertise thus acquired. That measure would also be consistent with the rotation and mobility policy, which he supported. With respect to strategic human resources management, an issue at the core of reform, at least 30% of staff should originate from outside each recruiting region and their numbers should be increased over time with a view to expanding international diversity, effectiveness and transparency, as well as increasing the quality and impact of WHO's work.

Mrs REITENBACH (Germany) said that Organization-wide implementation of the human resources policy was hampered by WHO's staffing levels, which were considerably lower than in other organizations. The figures contained in the annual report did not provide a comprehensive and reliable picture of the current situation, as they were based on a limited definition of staff that excluded a substantial number of WHO's present workforce. The next annual report should therefore include information on the overall workforce in order to ensure the transparency needed for giving constructive guidance to the Secretariat in the area of human resources.

The overall efforts towards the goal of gender parity were perhaps inadequate in that some regions had made limited or negligible progress since the adoption of resolution WHA56.17 on gender balance some nine years earlier, whereas other international organizations operating in those same regions had moved much closer to parity. Insofar as Health Assembly resolutions applied to all regions, she asked how organizational alignment was enforced with respect to gender balance and what steps were envisaged in order to strengthen gender parity in the regions concerned.

Ms WISEMAN (Canada) expressed continued support for the Director-General's efforts to overcome the challenges posed by the misalignment between financing and sustainable staffing, in particular through the development of a revised workforce model integrated with planning and budgetary processes. She also encouraged the continuation of efforts to achieve gender parity with a view to ensuring progress across all regions and all levels of the Organization.

Ms ALTMAIER (Human Resources Management), responding to comments, said that substantial efforts had been made to increase e-learning in the interests of cost-effectiveness and efficiency, using a blended approach involving face-to-face learning, tutorials and a new e-learning

platform that would soon be fully operational. For the current biennium, a total of US\$ 14 million had been allocated to learning activities, which would be focused mainly on global programmes of the type described in the annual report. Given that the Organization's staff were indeed its greatest asset, she devoted a weekly minimum of five hours to dialogue with staff members in a joint effort to achieve constant improvements within the Organization. With respect to diversity, the mobility and rotation measures described in the report were part of the attempt to improve the current situation, particularly in regions where it was less than satisfactory.

Concerning non-staff contracts, coordination was under way with a view to providing a clearer and fuller picture by including information on special services agreements, agreements for performance of work and consultants in the next annual report. Progress in the area of gender parity was admittedly slow in some countries and regions and efforts for improvement were continuing. The workforce model would henceforth be based on cross-organizational planning, bearing in mind the need for a global recruitment process to ensure diversity and the need to link planning with strategic objectives on the basis of a high-performance culture.

The Board took note of the reports.

Report of the International Civil Service Commission: Item 8.3 of the Agenda (Document EB130/27)

The Board took note of the report.

Amendments to the Staff Regulations and Staff Rules: Item 8.5 of the Agenda (Documents EB130/28 and EB130/28 Add.1)

The CHAIRMAN drew attention to two draft resolutions contained in document EB130/28. The financial and administrative implications of the two draft resolutions, were they to be adopted, were contained in document EB130/28 Add.1. The Programme, Budget and Administration Committee had recommended that the Board adopt the two draft resolutions.¹

The Board adopted the two resolutions.²

4. MANAGEMENT MATTERS: Item 9 of the Agenda

Election of the Director-General of the World Health Organization: report of the Working Group: Item 9.1 of the Agenda (Document EB130/29 Corr.1)

The CHAIRMAN drew attention to the recommendation contained in paragraph 24 of the annexed report of the Working Group, namely that the Board should convene a follow-up session of the Working Group to explore discussed proposals further and to finalize its work before the Sixty-fifth World Health Assembly.

Dr JESSE (Estonia), speaking on behalf of the European Union and its Member States, said that the acceding State Croatia, the candidate countries Turkey, the former Yugoslav Republic of Macedonia, Montenegro and Iceland, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, and Serbia, as well as Ukraine, Georgia and Armenia aligned themselves with her statement. The deliberations of the Working Group had been

¹ See document EB130/4.

² Resolutions EB130.R15 and EB130.R16.

aimed at finding solutions for ensuring, in the shared interests of all, that WHO was led by the person best qualified for the post. The options considered had focused on the quality of candidates and equal opportunity of access to the position, with due regard for the principles of recruitment on the widest possible geographical basis and of gender balance.

To that end, the selection, nomination and election process must be fair and transparent, enabling candidates from all Member States to participate in an equitable manner. WHO's system for electing its Director-General, which had been identified by the Joint Inspection Unit as one of the best in the United Nations system, could be further improved by some of the options discussed by the Working Group, such as the fine-tuning of criteria, the establishment of a forum to audit the candidates and the proposal for a non-binding code of conduct. She looked forward to engaging in further work on the subject with a view to arriving at a universally acceptable solution to what was a complex issue.

Ms SY (Senegal), speaking on behalf of the Member States of the African Region, welcomed the conclusions of the Working Group and supported the recommendation that it should be enabled to continue its work in a follow-up session.

Mrs ESCOREL DE MORAES (Brazil)¹ said that the debate within the Working Group had enhanced understanding of the advantages and shortcomings of the current election process. Among the ideas considered for promoting the establishment of more inclusive, transparent and equitable rules and methods with a view to building trust among Member States, she favoured the creation of a candidates' forum and the adoption of a code of conduct. Given the positive results achieved thus far in the intergovernmental setting of the Working Group, she also supported the recommendation for a follow-up session to enable it to conclude its work before the Sixty-fifth World Health Assembly.

Bearing in mind the principle that merit should be the main criterion for election of the Director-General of WHO and that worthy candidates could be found in any part of the world, an adequate response to those Member States that had expressed discontent with the current process was imperative. Brazil had advocated a more inclusive and transparent process that ensured the same opportunities to all Member States and the representation of all regions in the post of Director-General. One way forward would be to introduce new procedural elements designed to achieve geographical diversity in the post, albeit without distancing WHO from United Nations practice. The Board should continue its functions of screening, interviewing and selecting candidates on the basis of pre-established criteria. The Health Assembly, however, should assume a more prominent role in the election process, which should fully engage all Member States in order to guarantee the greatest possible participation in that process and its transparency, inclusiveness and democratic nature.

The CHAIRMAN said that he took it that the Board wished to take note of the report and agreed to the recommendation that the Board convene a follow-up session of the Working Group before the Sixty-fifth World Health Assembly.

It was so agreed.

Membership of the Independent Expert Oversight Advisory Committee: Item 9.2 of the Agenda (Document EB130/30)

Dr DE ASSUNÇÃO SAÍDE (Mozambique), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, said that the Committee had discussed the action to be taken in the light of the expiry of the terms of office of two of the members of the Independent Expert Oversight Advisory Committee. The Programme, Budget and Administration Committee had

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

agreed to recommend to the Board that one of the two outgoing members be replaced and had stressed the importance of maintaining a robust roster for possible members of the Independent Expert Oversight Advisory Committee (document EB130/4, paragraphs 41–46).

Dr AZODOH (Nigeria), speaking on behalf of the Member States of the African Region and noting the Independent Expert Oversight Advisory Committee's advisory function, the qualifications for membership (document EB130/30, paragraph 2) and the stipulations in the terms of reference for the composition of the Committee, said that the concern for continuity would be met by the three remaining members whose terms were not due to expire. The two outgoing members should therefore be replaced by experts from Member States of the African and Eastern Mediterranean Regions, which were not currently represented on the Committee, in strict compliance with the terms of reference.

Dr AL-ADBULLA (Qatar), referring to the need to promote the representation of the Eastern Mediterranean Region, said that he was prepared to consider any proposal aimed at strengthening equitable representation on the Advisory Committee.

Ms WISEMAN (Canada), supported by Ms VIEITEZ MARTÍNEZ (Mexico), Dr JESSE (Estonia) and Mr KÜMMEL (Germany), endorsed the compromise solution of replacing one outgoing member and renewing the term of the second member, which would address the concern for continuity. She stressed the high quality of the work being done by the Independent Expert Oversight Advisory Committee and of its reporting to the Programme, Budget and Administration Committee.

Mr SAMRI (Morocco) said that any decision on the matter must take into account the fact that two regions were currently unrepresented in the membership of the Advisory Committee.

Ms BLACKWOOD (United States of America), agreeing with the remarks made by the member for Canada, pointed out that the renewal of the term of office of one or both of the outgoing members of the Advisory Committee would be in full compliance with its terms of reference.

Dr AZODOH (Nigeria), speaking on behalf of the Member States of the African Region, said that expansion of the membership to six would carry the risk of creating a gridlock in any voting procedure and that the retention of an odd number of members was therefore preferable. Consequently, and in the interests of both accommodating other regions and ensuring continuity, the solution she proposed after considered and in-depth discussion was that of enlarging the Committee membership to seven, with a two-yearly rotation of the chairmanship to another region.

Ms WISEMAN (Canada) said that, while she appreciated the approach advocated by the member for Nigeria, the current membership of five was more conducive to efficient management of the Advisory Committee's workload. She therefore urged support for the compromise solution recommended by the Programme, Budget and Administration Committee.

Ms SY (Senegal) suggested that consideration of the item be suspended and resumed at the next meeting following informal consultations among members.

The CHAIRMAN, hearing no objections, took it that the Board agreed.

It was so agreed.

(For adoption of a decision, see the summary record of the fourteenth meeting, section 3.)

Reports of committees of the Executive Board: Item 9.3 of the Agenda**Standing Committee on Nongovernmental Organizations** (Document EB130/31)

The CHAIRMAN drew attention to the draft resolution contained in paragraph 12 of document EB130/31.

The resolution was adopted.¹

The CHAIRMAN drew attention to the draft decision on the review of nongovernmental organizations in official relations with WHO, contained in paragraph 13 of document EB130/31.

The decision was adopted.²

Foundations and awards (Document EB130/32)**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 2012 to Dr Shaikha Salim Al Arrayed (Bahrain) for her significant contribution to public health in Bahrain, in particular the control of genetic diseases. The laureate will receive the equivalent of 2500 Swiss francs in United States dollars.³

Ihsan Doğramacı Family Health Foundation Prize

Decision: The Executive Board, having considered the report of the Ihsan Doğramacı Family Health Foundation Selection Panel, awarded the Ihsan Doğramacı Family Health Foundation Prize for 2012 to Dr Ayşe Akın (Turkey) for her long-standing career in the area of family health in Turkey. The laureate will receive US\$ 20 000.⁴

Sasakawa Health Prize

Decision: The Executive Board, having considered the report of the Sasakawa Health Prize Selection Panel, awarded the Sasakawa Health Prize for 2012 to the Syamsi Dhuha Foundation (Indonesia) for its work in improving the quality of life for people living with lupus and poor vision. The laureate, as an organization, will receive US\$ 40 000.⁵

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 2012 jointly to Dr Chen Bowen (China) for his important contribution to the establishment

¹ Resolution EB130.R17.

² Decision EB130(8).

³ Decision EB130(9).

⁴ Decision EB130(10).

⁵ Decision EB130(11).

of community health services in China and to the Renal Disease Control Program (Philippines), which takes charge of implementing the public health projects of the National Kidney Transplant Institute in the Philippines on the prevention and control of renal and related diseases. The laureates will each receive US\$ 20 000.¹

State of Kuwait Prize for Research in Health Promotion

Decision: The Executive Board, having considered the report of the State of Kuwait Prize for Research in Health Promotion Selection Panel, awarded the State of Kuwait Prize for Research in Health Promotion for 2012 to Dr Eltahir Medani Elshibly (Sudan) for his dedication to a wide range of family health issues, from breastfeeding promotion to HIV prevention and nutrition. The laureate will receive US\$ 20 000.²

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 2012 to the Pacific Leprosy Foundation based in New Zealand for its outstanding contribution to public health. The laureate will receive US\$ 100 000.³

5. MATTERS FOR INFORMATION: Item 10 of the Agenda

Reports of advisory bodies: Item 10.1 of the Agenda

Expert committees and study groups (Documents EB130/34 and EB130/34 Add.1)

Ms WISEMAN (Canada) emphasized her full appreciation of and support for the standard-setting recommendations contained in document EB130/34.

The Board took note of the reports.

Progress reports: Item 10.2 of the Agenda (Documents EB130/35, EB130/35 Add.1, EB130/35 Add.2 and EB130/35 Add.3)

Health systems and research

- A. Health system strengthening (resolutions WHA64.9, WHA64.8, WHA63.27, WHA62.12 and WHA60.27)**
- B. WHO's role and responsibilities in health research (resolution WHA63.21)**
- C. Global strategy and plan of action on public health, innovation and intellectual property (resolution WHA61.21)**

Dr JESSE (Estonia) said that the condensed progress report on health system strengthening (document EB130/35) could be further improved through the sharing of experiences for the benefit of other regions by including in paragraph 4 additional information on the activities of Member States in

¹ Decision EB130(12).

² Decision EB130(13).

³ Decision EB130(14).

the European Region, in particular the fulfilment of their commitments made in 2008 to strengthen health systems in a transparent and accountable manner, as reported to the Regional Committee for Europe in 2011. Actions undertaken in response to resolution WHA63.27 on strengthening the capacity of governments to constructively engage the private sector in providing essential health-care services should also be more strongly reflected.

Statistical and other references should be carefully checked for accuracy; those relating to women's and children's health cited in paragraph 11 did not, for example, correspond to those contained in paragraph 4 of document EB130/14.

Mr DE SANTIS (Switzerland) expressed appreciation of the considerable attention WHO was giving to improving aid effectiveness, particularly at the country level, by taking the lead on health within the United Nations system. He fully supported WHO's collaboration in the context of the International Health Partnership and related initiatives (IHP+). Equal access to affordable and good-quality primary health care, in particular for the poor and most vulnerable groups, remained at the core of Swiss health development policy. He called upon the Secretariat, at all levels of the Organization, to accelerate the implementation of all the resolutions on health system strengthening. He endorsed the emphasis placed on the four tracks identified in document EB130/35 (paragraphs 8–11), but noted that results at the global, regional and country levels were not described in the report. In order to enhance the culture of monitoring and evaluation within WHO, concrete results should be set against existing and measurable strategic objectives of the Medium-term strategic plan 2008–2013 and the programme budget. He welcomed the Director-General's strong commitment to priority setting and health system strengthening.

Ms SY (Senegal), speaking on behalf of the Member States of the African Region, said that weaknesses in health systems in the Region remained a matter of concern. A shortage of human and financial resources and inadequate laboratory, information and communication infrastructures made it impossible to provide universal access and respond to epidemics and disasters. However, significant progress had been made through the implementation of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa (2008). Moreover, at the sixty-first session of the Regional Committee for Africa (Yamoussoukro, 29 August–2 September 2011), Member States had agreed to take steps to increase financial resources and reduce wastage, by improving efficiency and accelerating the achievement of universal access. Workshops for the staff of country offices and WHO Representatives had been organized by the Regional Office between June and December 2011 in order to facilitate an exchange of views on plans, strategies and policies concerning national health. The main challenges facing the Region were: to maintain the current momentum; to organize coordinated, coherent and intersectoral action to ensure that all social determinants of health were included in government policies; and to ensure that Member States had the skills to measure the progress made in achieving long-term objectives and to implement collective measures in a timely manner. She welcomed the support provided by the international community, including through the International Health Partnership and related initiatives (IHP+), the Harmonization for Health in Africa initiative and the GAVI Alliance.

Ms WISEMAN (Canada), referring to the progress report on WHO's role and responsibilities in health research (document EB130/35), supported the updating of WHO's existing operational guidelines for ethics committees that reviewed biomedical research. It was important for WHO to have better oversight of the research of such committees and to streamline the review of multisite clinical trials. Her country would be pleased to share some of the results of its recent work on the development of standards for research ethics committees.

Dr BIRINTANYA (Burundi), speaking on behalf of the Member States of the African Region and referring to the progress report on the global strategy and plan of action on public health, innovation and intellectual property (document EB130/35), observed that less than 5% of the funds devoted to pharmaceutical research and development worldwide were used in relation to diseases that

disproportionately affected developing countries. Moreover, stringent national and international legislation on intellectual property rights continued to restrict access to affordable pharmaceutical products. However, the African Region welcomed the efforts made to improve the situation in recent years, including the adoption of the global strategy and plan of action, one basic element of which was the strengthening of research and development on traditional medicine. In order to accelerate the implementation of the global strategy and plan of action, future actions should be aimed at securing more sustained financing for research and development in respect of public health and diseases that disproportionately affected developing countries, and at improving access to effective health products for all populations.

Dr DE ASSUNÇÃO SAÍDE (Mozambique), speaking on behalf of the Member States of the African Region and referring to the progress report on WHO's role and responsibilities in health research (document EB130/35), outlined the basis for research activities in the Region, where priorities for research included health systems, communicable and noncommunicable diseases, and the resurgence of epidemics of poliomyelitis, measles and viral haemorrhagic fever. Support was being provided to help countries to strengthen health research systems, using the Evidence-Informed Policy Network, and the first policy briefs developed to facilitate better decision-making in the Region had been published.¹ Workshops involving the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases had been conducted in collaboration with other partners, including the Implementation Research Platform, in order to validate training modules to be used in implementation research training courses and workshops. Such action aimed at enhancing the capacity of in-country institutions and centres of excellence to conduct research on identifying problems in the implementation of projects and programmes, finding solutions, identifying best practices to overcome obstacles, and monitoring and evaluating disease control programmes. In addition, the terms of reference of the African Advisory Committee on Health Research and Development had been amended, and the membership of that Committee had been reconstituted to provide a broad base of stakeholders for consultations.

He drew attention to the primary challenges faced by the Region, which included the conduct of research by diverse stakeholders without the permission of the regional authorities; lack of understanding of basic requirements of health research systems; poor implementation of and compliance with existing research standards; and a shortage of staff.

Dr TAKEI (Japan) said that his country attached importance to health system strengthening. He had noted with satisfaction that the issue would remain a priority for the Director-General. Japan supported WHO's activities relating to universal coverage, health information, the health workforce, and health financing. Self-financing for health was indispensable in order to ensure the long-term sustainability of health systems. In order to improve overall health conditions at country level, health care and support must be delivered to vulnerable populations and hard-to-reach groups. He encouraged the Secretariat to step up work in the areas of implementation research and health policy research in the coming years.

His Government would continue to support health system strengthening and the related research agenda, including universal coverage and the strengthening of human resources, in close collaboration with other Member States, the Secretariat and global partners.

Ms CHARLES (United Kingdom of Great Britain and Northern Ireland)² said that WHO's work on health system strengthening was important for the achievement of universal coverage. Her Government was directly supporting that work, for instance through the secondment of a health financing expert to the Secretariat. The lack of information in the report on concrete results,

¹ *International Journal of Technology Assessment in Health Care*, 2010, volume 26.

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

particularly at country level, was disappointing. Future reports should focus on providing evidence of the strengthening of health systems and action taken by governments to harness the contributions of private service providers and increase the coverage of primary health care.

Mrs ESCOREL DE MORAES (Brazil)¹ said that health system strengthening should be a priority for WHO, and welcomed the Organization's efforts to implement the resolutions on that issue. Her country was fully committed to enhancing primary health care and to pursuing equity and social justice as major guiding principles for the achievement of health for all. National and regional regulatory authorities had an important role to play in ensuring the effective performance of health systems. The increasing challenges faced by national regulatory authorities as a result of the multiplication of manufacturers and suppliers could be addressed through enhanced capacity building and strengthened international cooperation. Programmes and activities within WHO, such as the International Conference of Drug Regulatory Authorities and the Prequalification of Medicines Programme had demonstrated the value of deepening international cooperation. Member States had a responsibility to continue to improve international cooperation between regulatory agencies, through exchange of information and confidence building, and she highlighted the important contribution that WHO and its regional offices could make to that endeavour. Brazil, for its part, would be organizing in May, in Geneva, an event aimed at enhancing understanding of current regional and global initiatives in the area of sanitary regulation and at exploring possibilities for engaging Member States, the Secretariat and the international community in a sustainable strategy of cooperation in sanitary regulation.

Turning to the progress report on the global strategy and plan of action on public health, innovation and intellectual property, she commended PAHO's work to build a regional platform for access and innovation in health technologies that could provide a model for other regions. Brazil was committed to implementing the global strategy and plan of action by 2015. She requested a clearer overview of the progress made with respect to the indicators.

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

The meeting rose at 12:45.

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

FOURTEENTH MEETING

Monday, 23 January 2012, 14:40

Chairman: Dr B.-I. LARSEN (Norway)

- 1. WHO REFORM:** Item 5 of the Agenda (Documents EB130/5 and EB130/5 Add.1–Add.9)
(continued from the thirteenth meeting, section 2)

The CHAIRMAN confirmed that his summary of the discussions at the previous meeting had been circulated in writing among the members of the Board. It was not a formal document, and was intended to aid understanding of his main points. He added several clarifications that resulted from informal consultations since the previous meeting.

In May 2012 the Sixty-fifth World Health Assembly would have the opportunity to review all elements of WHO reform in a consolidated document to be prepared by the Secretariat. He confirmed that written feedback from Member States to the Secretariat could cover any aspect of governance and managerial reforms. Following the comments by the member for Switzerland, he proposed that the closing date for submission of written feedback be advanced to Friday 17 February 2012, namely the week before the meeting on programmes and priority setting.

The Board welcomed the offer of the External Auditor to carry out stage one of the independent evaluation of WHO before the Sixty-fifth World Health Assembly, with the support of the Office of Internal Oversight Services. The Board mandated its Programme, Budget and Administration Committee to inform the Sixty-fifth World Health Assembly of the results of its discussions on reform at its meeting in May 2012, as there was no session of the Board for the Committee to report to before the Health Assembly. The Committee would also report formally to the Board as usual.

In order to allow the Secretariat sufficient time to prepare new documents, the Board agreed that the documents related to reform would be issued no later than three weeks before the session of the Programme, Budget and Administration Committee in May before the Health Assembly.

It was so decided.

- 2. MATTERS FOR INFORMATION:** Item 10 of the Agenda (continued)

Progress reports: Item 10.2 of the Agenda (Documents EB130/35 Add.1, EB130/35 Add.2 and EB130/35 Add.3) (continued from the thirteenth meeting, section 5)

Disease eradication, prevention and control

- D. Smallpox eradication: destruction of variola virus stocks (resolution WHA60.1)**
- E. Eradication of dracunculiasis (resolution WHA64.16)**
- F. Chagas disease: control and elimination (resolution WHA63.20)**
- G. Viral hepatitis (resolution WHA63.18)**
- H. Prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis (resolution WHA62.15)**
- I. Cholera: mechanisms for control and prevention (resolution WHA64.15)**
- J. Control of human African trypanosomiasis (resolution WHA57.2)**
- K. Global health sector strategy on HIV/AIDS, 2011–2015 (resolution WHA64.14)**
- L. Prevention and control of sexually transmitted infections: global strategy (resolution WHA59.19)**

The CHAIRMAN invited the Board to consider the nine progress reports relating to disease eradication, prevention and control, contained in documents EB130/35 Add.2 and EB130/35 Add.3.

Dr DAULAIRE (United States of America), referring to the progress report on viral hepatitis, applauded WHO's global efforts on control, in particular the establishment of its global hepatitis programme. He called for continued monitoring of progress and greater effort to keep track of Member States' activities, as WHO did not currently have a mechanism in place for routine collection of information on progress in hepatitis prevention and control. The survey conducted in 2010 by WHO in collaboration with the World Hepatitis Alliance had been an important step forward, and should form the basis for further work in that regard. He welcomed the inclusion of HIV/hepatitis coinfection on the agenda of the UNAIDS Programme Coordination Board meeting (due to be held in Geneva, June 2012), at which WHO should present Member States' experiences and recommend appropriate policies.

There was widespread frustration at the poor progress against multidrug-resistant tuberculosis; he noted with concern that the global case-detection rate for new incident cases was still at best only 10%. Member States needed to maintain a united approach and make progress on two fronts: improving access to diagnostic laboratory capacity and more-affordable and easily-available second-line medicines; and addressing the root causes of multidrug-resistant and extensively drug-resistant tuberculosis. More research was also needed into new, safe and effective treatment regimens for people for whom the available medicines were ineffective.

Ms WISEMAN (Canada) acknowledged the intensive efforts undertaken by PAHO and its United Nations and nongovernmental partners to implement strategies on the prevention and control of cholera, including improving access to safe drinking-water and sanitation, promoting hygienic practices and food safety, and providing high-quality care and treatment. She welcomed the launch of the Call to Action for Accelerating the Elimination of Cholera in Haiti and the Dominican Republic on 11 January 2012.

On the prevention and control of sexually transmitted infections, her country supported an age-appropriate, comprehensive and integrated approach to prevention. Canada had developed, pilot-tested and validated a set of indicators of sexual health for youth, which would be instrumental in prevention and control.

Dr DANKOKO (Senegal), speaking on behalf of the Member States of the African Region on the progress report on drug-resistant tuberculosis, said that the Region faced serious challenges in tuberculosis control, particularly poor diagnostic capacity for multidrug-resistant tuberculosis, inadequate health infrastructure and human resources, and a lack of isolation facilities in most health centres and at the community level. Although the Stop TB Strategy had been implemented in most countries, its targets were far from being reached at regional and national levels. The cure rate for smear-positive cases in the Region was 80%, which was below the global target. Moreover, there was a high prevalence of tuberculosis/HIV coinfection, particularly in eastern, southern and central Africa, which increased the probability of the spread of drug-resistant tuberculosis. People with multidrug-resistant or extensively drug-resistant tuberculosis did not receive adequate care, as medicines for those forms of the disease were not systematically funded by national health budgets. Even where second-line medicines were available, the long duration of treatment made it difficult to ensure patient compliance and monitoring. He welcomed the efforts of the Regional Office for Africa, particularly its establishment of a surveillance and monitoring system and the provision of support for Member States in the development and review of their national plans for the control of multidrug-resistant tuberculosis. He called upon Member States and the international community, particularly the Global Fund to Fight AIDS, Tuberculosis and Malaria, to increase their support.

Dr BAYE LUKONG (Cameroon), speaking on behalf of the Member States of the African Region on the progress report on viral hepatitis, recalled that hepatitis B virus infection was endemic in most African countries. Several steps had been taken, including the endorsement by the Task Force

on Immunization in Africa of strategies for the prevention and control of viral hepatitis, with regional targets for hepatitis B vaccination coverage and disease control; the marking of the first World Hepatitis Day; introduction of routine immunization with hepatitis B vaccine in 45 countries in the Region, with coverage with the third dose of vaccine reaching 76% at the end of 2010; and the use of auto-disable syringes in all countries to increase the safety of injection practices. Major challenges remaining included the availability of accurate data on the burden of viral hepatitis infection; low coverage rates for administration of the first dose of hepatitis B vaccine to neonates within 24 hours of birth; ensuring sustainable financing for vaccine procurement; ensuring safe injection practices and the use of screened blood for transfusions; and integration of strategies to prevent and control infection with hepatitis viruses. Most of those challenges could be met with stronger health systems.

Dr DE ASSUNÇÃO SAÍDE (Mozambique), speaking on behalf of the Member States of the African Region on the progress report on cholera, said that the Region accounted for more than 85% of the global cholera burden. Resolution AFR/RC57/R1 on the resurgence of cholera in the WHO African Region: current situation and way forward, adopted by the Regional Committee for Africa in 2007, urged Member States to mobilize resources for safe drinking-water and food supplies and environmental sanitation, increase the priority accorded to cholera prevention and control, and promote multisectoral coordination. The Regional Committee's decision (resolution AFR/RC61/R3) to establish an African Public Health Emergency Fund, which would provide additional resources for the investigation of and response to public health emergencies, was further proof of its commitment. The main challenges faced by the Region with regard to cholera control and prevention were an inadequate infrastructure for safe drinking-water supply, sanitation and solid waste management, weak early-warning systems for detection and notification of cases of cholera, limited national capacity for case management and infection prevention and control, weak coordination and cross-border collaboration among stakeholders, and inadequate resource mobilization and allocation.

Dr PHILLIPS (Barbados) said that many aspects of the Global health sector strategy on HIV/AIDS, 2011–2015 had already been incorporated into his country's national programme, which had recently undergone a mid-term evaluation by PAHO. Barbados had a low HIV/AIDS mortality rate, and HIV incidence had started to decline as a result of the introduction of antiretroviral medicines a decade earlier. The rate of mother-to-child transmission of HIV had been reduced to 0.7%. However, activities in the areas of information, education and communication and behavioural change communication had not yet had the desired impact on high-risk behaviour, although an antidiscrimination law had been adopted in 2008. Tuberculosis rates were also low.

Mr MANCHA MOCTEZUMA (Mexico), speaking on the report on drug-resistant tuberculosis, shared the concerns expressed by the member for the United States of America with regard to the availability of second- and third-line medicines. He advocated a return to earlier best practices such as directly-observed, short-course treatment (DOTS), which had given good results. In Mexico, tuberculosis was being dealt with in conjunction with other co-morbidities, in particular HIV/AIDS, and recently diabetes, in view of the higher risk due to the weakened immune system in people with that condition. For that reason he exhorted Member States to continue DOTS.

Turning to the progress report on Chagas disease, he expressed appreciation for the support provided by the Secretariat in arranging the donation of nifurtimox, which had made it possible to treat about 840 people with the disease each year in 2010 and 2011. He commended the work of the Drugs for Neglected Diseases initiative, in which Mexico was participating with a particular focus on the social determinants of health.

Dr SHEKU DAOH (Sierra Leone), speaking on behalf of the Member States of the African Region on the progress report on eradication of dracunculiasis, acknowledged the support of stakeholders in the continuing work. The disease remained endemic in only two countries in the Region, and seven countries were currently at the pre-certification stage. Poor access to safe

drinking-water and the potential for transmission between countries by nomadic groups were among the main obstacles to eradication.

In the area of sexually transmitted infections, the challenges included health system strengthening, the lack of data, inadequate funding and stigmatization. Member States needed to show renewed commitment in addressing those challenges and ensure proper use of existing funding.

Dr BIRINTANYA (Burundi), speaking on behalf of the Member States of the African Region on the progress report on human African trypanosomiasis, said that the disease remained a significant public health problem for the Region. Significant progress had been made in recent years, thanks to vigorous public-private partnerships and the use of effective combination therapies. The regional strategic plan on noncommunicable diseases was being updated to include strategies for accelerating projects related to human African trypanosomiasis. He cautioned that the successes achieved could reduce awareness of the disease and the priority placed on it compared with other public health problems. For disease-endemic countries, it was still a public health priority, and he called upon the international community to maintain its technical and financial support.

Dr AZODOH (Nigeria), speaking on behalf of the Member States of the African Region on the progress report on smallpox eradication, noted with concern the postponement of the proposed destruction of remaining variola virus stocks; that should take place immediately in order to preclude unauthorized use of the virus. She expressed concern also that stocks of variola virus might exist outside the WHO-authorized repositories and could be used to cause deliberate harm. Since the global eradication of smallpox, diagnostic and treatment skills had been lost in the Region. The WHO Advisory Committee on Variola Virus Research should have at least one member from the Region, but the report gave no indication of any efforts to implement resolution WHA60.1, which called for a review of the Committee's membership in the interests of equitable geographical distribution. She stressed the importance of information-sharing and technology-transfer activities for the strengthening of laboratory capacity in developing countries.

On the Global health sector strategy on HIV/AIDS, 2011–2015, she noted that consultations on improving the strategy were currently under way. However, the progress report did not adequately emphasize the issue of prevention of mother-to-child transmission of HIV, which was central to the control of HIV/AIDS in Africa. She also expressed concerns about sustainable financing, particularly as people with HIV/AIDS were living longer.

Dr TAKEI (Japan) welcomed WHO's efforts to control and eliminate Chagas disease. His Government had provided support to many Member States for measures to counter neglected tropical diseases. Experience had shown that a permanent monitoring system, systematic vector control and awareness-raising at the national level were effective measures. PAHO had commended Japan's activities to combat Chagas disease in Central and South America. He supported the approach of promoting Chagas disease as a mainstream priority at the global or regional level as part of policies to control neglected tropical diseases.

With regard to drug-resistant tuberculosis, it was important to promote the DOTS strategy in order to prevent the development of drug resistance and improve the diagnosis and treatment of multidrug-resistant tuberculosis. The DOTS strategy should be jointly implemented by the public and private sectors. It was also important to improve and expand the capacity of tuberculosis laboratories and develop new technologies. Prevalence surveys were an important way of acquiring information about the impact of the strategy, and Japan was providing relevant bilateral assistance to the countries in the Western Pacific Region.

Dr NASHER (Yemen), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that all low-income and middle-income countries in the Region had developed or were in the process of developing strategies related to HIV/AIDS, and programmes were in place for the free distribution of antiretroviral medicines. It was important to provide care for those who needed it most. There was a great deal of collaboration with international organizations in the Region.

The significant changes in countries in the Region over the previous year meant that health issues had been given less priority. It was hoped that stability would soon be restored and that health care would improve, particularly for people living with HIV/AIDS. Many countries in the Region relied on external aid; they were concerned that recent decisions by the Global Fund to Fight AIDS, Tuberculosis and Malaria might result in a withdrawal of aid and that they would be unable to bridge the resulting funding gap.

Dr JESSE (Estonia), referring to the progress report on the prevention and control of sexually transmitted infections, expressed concern that it did not describe progress made but focused instead on the activities undertaken. She requested that the report be expanded to include progress and results.

Dr NASHER (Yemen), speaking on behalf of the Member States of the Eastern Mediterranean Region on the progress report on dracunculiasis, said that they were committed to implementing resolution WHA64.16. Despite the fact that nearly all new cases were reported in South Sudan, awareness-raising in that country was particularly difficult as a result of constant population movements, issues that the Government of South Sudan was committed to addressing. Both Somalia and South Sudan required more funding to improve their surveillance and monitoring systems; in the case of Somalia, it was hoped that Kenya would continue to provide its vital and highly appreciated support.

Mr RUSH (United Kingdom of Great Britain and Northern Ireland),¹ welcoming the progress made towards eradicating dracunculiasis, recognized that challenges remained in countries where the disease remained endemic. The international community had a responsibility to ensure that support for eradication activities continued by making sure that the Carter Center and WHO had access to sufficient resources for interventions, surveillance and post-elimination surveillance. His Government had recently announced a five-fold increase in funding for neglected tropical diseases, amounting to £245 million in the period to 2015. Activities would focus on the eradication of dracunculiasis, the elimination of lymphatic filariasis and onchocerciasis, and the protection of millions of people against schistosomiasis.

Ms RAHMAN (Bangladesh)¹ said that it had been useful to learn that a consensus had been reached on the use of cholera vaccines reactively in outbreaks during large-scale humanitarian crises, in which it was difficult to deliver other interventions effectively. Noting the ongoing work to stockpile oral cholera vaccines, she urged that due attention must also be paid to the mobilization of funds for that activity. Behavioural change interventions, such as the promotion of hand-washing and point-of-use water treatment, were vital, particularly in resource-poor settings. Such measures were being tested in a large scale in an urban setting in Bangladesh, both with and without the concomitant use of oral cholera vaccines. That research required significant investment in terms of funding and improvements in the sanitation infrastructure.

As stated in resolution WHA64.15, it was important to revive the Global Task Force on Cholera Control, which had become moribund. She expressed concern that recent administrative measures would lead to the demise of the Task Force instead of its strengthening. She asked the Secretariat to report to the Sixty-fifth World Health Assembly on steps taken to implement the resolution, and sought the Director-General's personal intervention to ensure that sufficient human and other resources were allocated to the Global Task Force. It was also vital to ensure the alignment of cholera prevention and control activities between the Global Task Force, based at WHO headquarters, and the relevant regional offices.

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

Mr AGHAZADEH KHOEI (Islamic Republic of Iran)¹ noted with concern the report of the thirteenth meeting of the WHO Advisory Committee on Variola Virus Research. According to the major review carried out by WHO in 2010 and the report of the Advisory Group of Independent Experts to review the smallpox research programme, there was no compelling scientific reason to retain stocks of the variola virus or continue the WHO-authorized research programme. However, the report of the Advisory Committee showed that those conclusions had not been taken into consideration, and that the Committee continued to approve a wide range of projects using variola virus. Such actions were inconsistent with the global consensus on the destruction of the remaining stocks of the virus and the scientific conclusions of the Advisory Committee itself. By 2014 at the latest, the number of WHO-authorized research projects using the virus should be zero.

Ms WANIS (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN and also on behalf of the People's Health Movement and Third World Network, said that the WHO review of variola virus research had effectively concluded that the WHO-authorized research programme was coming to an end, implying that the scope and number of related research studies should be decreasing. However, the report of the thirteenth meeting of the Advisory Committee had shown, on the contrary, increasing numbers of projects using variola virus, even in areas where the Advisory Committee had previously concluded that its use was not necessary. Moreover, despite the recommendations of the Advisory Group of Independent Experts to review the smallpox research programme to move away from research on animals using live virus, the scientific subcommittee of the Advisory Committee had authorized more experiments in that area for 2012. WHO should begin to wind down its research using variola virus and increased attention should be paid to the operations of the Advisory Committee to ensure that it fulfilled its mandate and maintained its integrity. The need for further oversight of variola research had been underlined by a recent violation of WHO's regulations relating to genetic engineering of variola virus DNA.

Mr GORE (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, welcomed the establishment of a dedicated hepatitis team at WHO headquarters and the development of a comprehensive framework to prevent and control viral hepatitis at both a strategic, global level and an operational, national level. However, two major challenges remained. The first was the transformation of the framework into action at the national level, as many countries still had not begun to implement national strategies. Less than 50% of governments had marked the first World Hepatitis Day in 2011, despite their stated resolve to do so, expressed in resolution WHA63.18. Secondly, that resolution contained no provision for reporting on progress. He requested the Board to propose to the Health Assembly the ongoing monitoring of the progress made by Member States in the implementation of the strategy.

Other

- M. Reproductive health: strategy to accelerate progress towards attainment of international development goals and targets (resolution WHA57.12)**
- N. Advancing food safety initiatives (resolution WHA63.3)**
- O. Climate change and health (resolutions EB124.R5 and WHA61.19)**
- P. Partnerships (resolution WHA63.10)**

The CHAIRMAN invited the Board to consider the four remaining progress reports, relating to reproductive health, food safety, climate change and partnerships, contained in document EB130/35 Add.1.

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

Dr PHILLIPS (Barbados), speaking on the progress report on climate change and health, said that Barbados was affected by many of the factors cited by the Intergovernmental Panel on Climate Change in its assessment report. It was participating in a global climate change mitigation project, in which PAHO was also involved, and had defined terms of reference for consultants and established technical working groups.

Dr REN Minghui (China), commending WHO's work on climate change and health, encouraged the Secretariat to work with WMO and other partners on the establishment of the WMO Global Framework for Climate Services, which included health-related elements.

On the issue of partnerships and given the financial situation of WHO, the Secretariat should ensure that the Organization was reimbursed for expenses resulting from partnership activities, as requested in resolution WHA63.10.

Dr BAYE LUKONG (Cameroon), speaking on behalf of the Member States of the African Region on the progress report on food safety, said that the Region continued to face problems related to foodborne diseases, and cholera outbreaks were frequent in several countries. Sales of street food as sources of nourishment and income for the urban poor were on the increase. However, some progress had been recorded, including the drafting of an advocacy document on the food crisis in Africa and a related framework on strengthening nutrition and food safety actions at the country level, the strengthening of cross-sectoral collaboration through the establishment of multisectoral food safety and nutrition coordination teams, the development of regional capacity-building tools and guidelines, and the strengthening of risk communication through the promotion of the "Five keys to safer food" manual in schools, food establishments and health sectors.

Several challenges remained, notably: the global food crisis; the prevalence of foodborne diseases; the fragmented approach to food safety, given that programmes were often the responsibility of more than one ministry; and the lack of comprehensive policies promoting intersectoral cooperation and the shared responsibility of all stakeholders, including producers and consumers. In view of those challenges and the importance of the issue, she called for increased advocacy for additional resources to strengthen national food safety programmes by means of modernization of food inspection procedures and better enforcement of regulations.

Mrs BALAS (Germany), expressing appreciation for all the progress reports, said that Germany had funded a pilot initiative on protecting health from climate change in some countries in the European Region, in collaboration with the Regional Office for Europe. The results of those initiatives included the development of innovative ways of estimating the health effects of climate change and the capacity of health services to anticipate and mediate those effects; the strengthening of emergency health services to respond to extreme weather events due to climate change; the identification of key priorities, such as the need to strengthen early-warning and emergency services, early disease detection and greater investment into prevention in general; and ways to develop green health services through use of solar energy and increased energy efficiency in hospitals. The development of multisectoral, government-led committees and wide-ranging communication campaigns had been one particularly valuable result of the initiative. She acknowledged with appreciation the cooperation of the Regional Office for Europe in the initiative, particularly its technical support, and looked forward to the enlargement of the WHO European Centre for Environment and Health in Bonn, Germany.

Dr DANKOKO (Senegal), speaking on behalf of the Member States of the African Region on the progress report on climate change and health, welcomed the efforts of the Director-General to raise awareness of the need to adapt to climate change. Through the implementation of the Libreville Declaration on Health and Environment in Africa, financial and technical support had been provided to enable countries in the Region to evaluate their risks of, and vulnerability to, climate change. National reports were being drafted and priority actions were being agreed upon in each country. Those activities had already resulted in the African Ministers of Health and Environment Joint Statement on Climate Change and Health (Luanda, 2010). Moreover, the Framework for Public Health

Adaptation to Climate Change in the African Region had been approved by the Regional Committee for Africa (resolution AFR/RC61/R2) and by the Fourth Special Session of the African Ministerial Conference on the Environment (Bamako, 12–16 September 2011). Resolution AFR/RC61/R2 requested the Regional Director to establish a pan-African programme for public health adaptation to climate change.

The Region faced two major challenges in the adaptation of public health to climate change, namely producing, combining and analysing environmental and epidemiological data for a better understanding of the effects of climate change on health, particularly at the local level; and increasing the participation of health ministers in the global negotiations on climate change, particularly in the designation of national focal points for climate change and health in order to promote the inclusion of health-related elements in national projects on climate change funded by international foundations.

Dr AL HAJ HUSSEIN (Syrian Arab Republic), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that in most countries communicable diseases often resulted from contamination of food, which was a major challenge for the food sector and constituted a significant global health risk. Recent results had shown that water pollution had underlined the contribution of food contamination to the problem. Steps needed to be taken to decrease contamination, particularly that resulting from contact with animals. Despite the current economic situation and lack of stability in the Region, it was important to pay due attention to that important issue.

Dr DE ASSUNÇÃO SAÍDE (Mozambique), speaking on behalf of the Member States of the African Region on the progress report on partnerships, commented on the significantly greater number of health partnerships in recent years, with WHO providing technical leadership in many cases. Following the adoption of resolution WHA63.10, several studies had analysed partnership arrangements at the country level, which had resulted in the adoption in 2010 of WHO's Policy Framework on Engaging and Working with the Commercial Private Sector. A Partnership Strategy for the African Region had been published to provide policy advice and tools, and studies of current partnership and resource mobilization trends had been undertaken. However, despite those steps, development aid continued to be supplied in a fragmented manner at the country level, which led to high transaction costs for host governments. Ensuring the timely flow of information and communication between partners and the alignment of donor agendas with country priorities were key challenges that remained.

Speaking as the member for Mozambique on the report on climate change, he commended the collaboration between WHO and WMO, particularly in respect of the Global Framework for Climate Services. It was hoped that dialogue between the climate change and health communities would be broadened, particularly at the national level, in order to facilitate the development of climate services including health-related elements. Long-term planning must be informed by robust information that could be acted upon.

Dr DAULAIRE (United States of America) reiterated his country's strong commitment to reproductive health, technically, programmatically, and as it related to international assistance. Ensuring universal access to, and appropriate quality of, sexual and reproductive health care was critical to the attainment of Millennium Development Goals 4 and 5, and also contributed to Goal 6. The progress report on reproductive health highlighted the vital connection between improved reproductive health and development, and he noted the statement that there was a continuing unmet need for contraceptive services, particularly in sub-Saharan Africa, where the lack of such services affected about 25% of women. His Government was willing to work with countries with high unmet needs for family planning and other aspects of reproductive health in order to ensure that all women had effective access to those vital services.

Mr LUCIO (World Meteorological Organization) said that climate information was fundamental for planning, sustainable development and assisting in the development of appropriate strategies to adapt to climate variability and change. Despite the broad acknowledgement that climate

extremes caused loss of life, increased the disease burden and had a significant socioeconomic impact, climate services did not adequately meet current (let alone future) needs, despite significant advances in forecasting. For that reason, the Global Framework for Climate Services had been established in 2009, with the aim of bridging the gap between climate information produced by scientists and the practical needs of end-users. It would also strengthen the capacities of almost 70 countries that currently were unable to provide basic weather and climate services and enable them to develop country-specific climate services. Drafts of the implementation plan and governance mechanisms for the Framework, which were being elaborated by a team of experts from 36 countries, United Nations and international bodies and regional organizations, should be ready for consideration by the World Meteorological Congress at an extraordinary session to be held in October 2012.

The long-term success of the Framework depended on the engagement of all concerned parties and the creation of an environment in which they could all make their contribution. Consultations were being held with various stakeholders to discuss the production, availability, delivery and application of climate services in the four priority areas identified by the Framework, namely agriculture, water, health and disaster risk reduction, in order to ensure that the Framework reflected their aspirations. WHO should lead the development of the user interface platform for the Framework, which was a mechanism to enable interaction between climate service providers and the health community. WMO looked forward to continued collaboration with WHO on the Global Framework for Climate Services.

Ms RUGELINA (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN and also on behalf of Nord-Sud XXI and International-Lawyers.Org, said that the lack of emphasis on health issues in the discussions of the 17th Conference of the Parties to the United Nations Framework Convention on Climate Change in 2011 was a matter for concern. Although WHO had participated in the discussions at that meeting, its input had not led to the inclusion of any health issues in the main decision documents adopted at the conference. She encouraged the Secretariat to provide information about the results of its participation at the meeting.

She expressed the hope that the Director-General would address the 18th Conference of the Parties, to be held in December 2012, in order to highlight the significant, but insufficiently acknowledged, relationship between health and climate change. She welcomed WHO's contribution to the Intergovernmental Panel on Climate Change Special report on managing the risks of extreme events and disasters to advance climate change adaptation, and encouraged WHO to consider engaging with the recently created Green Climate Fund to ensure that adequate resources were made available for health-related activities.

The CHAIRMAN took it that the Board wished to take note of all the progress reports.

The Board noted the progress reports.

3. MANAGEMENT MATTERS: Item 9 of the Agenda (continued)

Membership of the Independent Expert Oversight Advisory Committee: Item 9.2 of the Agenda (Document EB130/30) (continued from the thirteenth meeting, section 4)

The CHAIRMAN, noting that no agreement had been reached on the membership of the Independent Expert Oversight Advisory Committee, recalled the four options before the Board: to renew the terms of office of the two members whose terms were due to expire and thus retain the same five members as at present; not to renew the terms of office of those two members and to replace them with other individuals; to renew the term of only one of those members – a compromise suggested by the Programme, Budget and Administration Committee following its own lengthy discussion on the matter (see document EB130/4); or to increase the overall membership of the Committee from five to seven individuals.

Dr BAYE LUKONG (Cameroon), speaking on behalf of the Member States of the African Region, reaffirmed the Region's position that the terms of reference of the Advisory Committee should be retained and respected, notwithstanding the recommendations of the Programme, Budget and Administration Committee. As such, she supported the second option proposed by the Director-General in document EB130/30: not to renew the terms of office of the two members, in line with the need to give due regard to geographical representation and gender balance. However, she could support the renewal of their terms, if instead the overall membership of the Committee were increased to seven people with the additional positions being allocated to the regions that had not been represented in the Committee. The position of Chairman should also rotate among the regions.

Dr DAULAIRE (United States of America) said that expanding the membership to seven people would not be in the best interests of the Committee and its need for robust processes. He respected the concerns of the Member States of the African and the Eastern Mediterranean regions. His Government was committed to ensuring the principle of appropriate representation at the technical level and would not contest the recommendation of the Programme, Budget and Administration Committee to renew the term of one member and replace the other, particularly in light of previous discussions on WHO reform, which had articulated the importance of respecting decisions taken by committees.

Ms CHEDEVILLE-MURRAY (France) said that she had favoured renewing the terms of the two members who had served on the Committee for only two years, but acknowledged with appreciation the constructive discussions in the Programme, Budget and Administration Committee the previous week. She was therefore willing to accept the recommendation in its report.

France's primary concern about the membership of the Independent Expert Oversight Advisory Committee was not of nationality but how its members could best serve WHO, and it was hoped that the Committee would continue to work in optimal conditions.

Dr DANKOKO (Senegal) observed that the Programme, Budget and Administration Committee had conveyed only a recommendation to the Board. The Board's resolution EB125.R1 establishing the Independent Expert Oversight Advisory Committee had set out explicitly its terms of reference, including its composition and the need for due regard to be given in the selection process to geographical representation and rotation. Replacement of the two members whose terms of office had come to an end was in line with those terms of reference, and he could thus accept the consensus reached by the Programme, Budget and Administration Committee. As the decision on that compromise was the prerogative of the Board, he reaffirmed the African Region's position.

Mr TOSCANO VELASCO (Mexico) agreed with other members who had argued for the maintenance of the membership of the Independent Expert Oversight Advisory Committee at five individuals. He asked the Legal Counsel whether it would be possible, given the continued lack of agreement among Board members on the issue, to take a decision by means of a vote rather than by consensus.

Mr BURCI (Legal Counsel) said that the Board was entitled to reach a decision by whatever means it chose, including a vote, but recommended that members strove to reach consensus, as that was the consistent practice of the Board.

The CHAIRMAN said that, instead of taking a vote, the Board could decide that further consultation on the item was needed and delay a final decision until its next session when consensus might be reached. The consequence of that would be, however, that the two members under discussion would continue in their roles until that time.

Dr JESSE (Estonia) supported the recommendation of the Programme, Budget and Administration Committee. The overarching principle for the Independent Expert Oversight Advisory Committee was that its members should serve as independent experts, in a personal and not national or

regional capacity, without any influence from governments or other bodies. The Programme, Budget and Administration Committee's recommendation clearly adhered to the provisions on terms of office approved in resolution EB125.R1 and the Board should be able to reach consensus on the issue at its current session.

Ms WISEMAN (Canada) agreed with others on using the recommendation of the Programme, Budget and Administration Committee as the basis for the Board's discussions and decision, especially as the suggested compromise had been the outcome of lengthy and difficult deliberations in that Committee.

An expansion of the membership of the Independent Expert Oversight Advisory Committee would not be appropriate, especially as the Joint Inspection Unit of the United Nations system had cited having five members in an oversight committee as one of the best practices for such committees throughout the United Nations system.

She encouraged all Board members to endorse the Programme, Budget and Administration Committee's recommendation.

Dr REN Minghui (China) said that, if consensus could not be reached and further discussions were set for the Board's next session, a decision would already have implicitly been taken on the issue by virtue of the fact that the two members' terms of office would terminate at the end of January but they would still serve in their roles at the Committee's meeting in February, effectively renewing their terms of office irrespective of a Board decision.

In light of that, the Board should decide that, if consensus could not be reached at its current session, those two members should be prohibited from participating at the Committee's next meeting, noting that the Committee would still be able to function, as three members constituted its quorum.

Mr SAMRI (Morocco) supported the proposal put forward by the member for China, as it was evident that more consultation was needed before the Board could take a decision. During the Programme, Budget and Administration Committee's discussions, Member States from the African and Eastern Mediterranean Regions had expressed their concerns and requested flexibility and understanding from the other regions. Unfortunately, the understanding shown had not been adequately reflected in the final recommendation transmitted to the Board.

He understood the desire of the member for the United States of America to maintain the membership of the Independent Expert Oversight Advisory Committee at five, and said that he would accept any decision, as long as the concerns expressed by the African and Eastern Mediterranean regions were also appropriately addressed.

Dr ST. JOHN (Barbados) requested clarification from the Legal Counsel on what other options were available if the Board could not reach a decision by consensus in the current meeting, in addition to the proposal by the member for China that the February meeting of the Independent Expert Oversight Advisory Committee take place with only three members.

Ms ESCOREL DE MORAES (Brazil)¹ said that the proposals put forward by the African Region were in line with the principle set out in the terms of reference of the Advisory Committee of giving due regard to geographical representation and gender balance and should therefore be viewed as a viable solution for the Board's decision.

She saw no difficulty with enlarging the membership to seven, as that was still a small number and would not greatly affect the Committee's processes. Six members could also be considered, with one coming from each Region. The Board should give due recognition to the fact that all regions could identify individuals with the necessary expertise and experience required to participate in the work of

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

the Advisory Committee and should address the concerns of the regions who, to date, felt that they had been underrepresented in that body.

Mr AGHAZADEH KHOEI (Islamic Republic of Iran)¹ noted that the Member States that had expressed concerns over the under-representation of certain regions in the Independent Expert Oversight Advisory Committee had not stipulated that one option regarding membership should be chosen above any other. The Board needed to find a way to address those concerns in whatever decision it took.

Mr USTINOV (Russian Federation)¹ agreed that the Board should follow the recommendation of the Programme, Budget and Administration Committee. Although it was a compromise, it adequately accommodated the need for individuals with suitable expertise and qualities to serve as members in the Independent Expert Oversight Advisory Committee.

Ms LANTERI (Monaco)¹ expressed surprise at the level to which the discussions of the Programme, Budget and Administration Committee were being repeated by the Board and said that it should follow the recommendation put forward by that Committee.

Fair geographical representation was an important guiding principle, but the very nature of the Advisory Committee meant that individual expertise was the most important condition of membership.

She disapproved of expanding the Committee to seven members, given that its terms of reference specified clearly that membership should comprise five individuals and the Board had no time available to modify those terms.

Mr AL-THANI (Qatar) agreed with the member for Morocco and the representatives of Brazil and the Islamic Republic of Iran that increasing the membership of the Advisory Committee to seven was a viable solution, as it was only a small difference in numbers and would not adversely affect the Committee's work but would in fact better distribute the responsibilities of members. Certain regions had been underrepresented in other high-profile positions within the Organization and the matter under discussion provided an opportunity for the Board to rectify that state of affairs and accommodate the interests and concerns of all Member States.

Dr AGUILAR (Ecuador) commented that regional sensitivities were coming into play on the issue and, although he respected the recommendation of the Programme, Budget and Administration Committee, that Committee had only 14 members and there were clear numerical limitations in its ability to reach a globally appropriate decision on the matter. It was important to remember that the Board had authority to take whatever decision it wished to, regardless of the discussions and recommendation of the Programme, Budget and Administration Committee.

He said that he understood the concerns of the African and the Eastern Mediterranean regions, which should be given due consideration by all Board members. It was important to be fully cognizant of what each region viewed as the most appropriate solution to the issue of membership.

Ms WISEMAN (Canada) argued against the Board postponing its decision on the item. Bearing that in mind, as well as the noted best practice of having five members on such oversight committees, she was willing to withdraw support from the recommendation of the Programme, Budget and Administration Committee in favour of the second option proposed by the Director-General in document EB130/30, and strongly endorsed by the Member States of the African Region, not to renew the terms of office of the two members, so as to give due regard to geographical representation.

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

Dr DAULAIRE (United States of America), Ms CHEDEVILLE-MURRAY (France), Mr DÍAZ ANAIZ (Chile), Dr ST. JOHN (Barbados), and Dr TAKEI (Japan) said that they would also follow Canada's lead and support the second option proposed by the Director-General.

Dr JESSE (Estonia) expressed regret at withdrawing support from the recommendation of the Programme, Budget and Administration Committee, but for the sake of consensus would support the option not to renew the terms of office of the two members and to replace them with other individuals, taking account of the principle of regional balance.

Responding to the representative of Brazil on why many Member States did not favour enlarging the membership of the Committee, she said that such an emphasis on regional representation and balance above all else would overly politicize a committee that was supposed to be independent of any other body, country or region and such an enlargement would thus be inappropriate.

Mr SAMRI (Morocco) thanked other Board members for their flexibility on the matter and for giving due consideration to the concerns expressed by the African and Eastern Mediterranean regions.

Dr BIRINTANYA (Burundi) endorsed the statement by the member for Morocco. The African Region's concern had always been the need to adhere to basic principles such as geographical representation and it was hoped that the consensus reached would promote even greater adherence to such principles in future.

Dr JESSE (Estonia) requested clarification from the Legal Counsel on what action the Board needed to take following its agreement on the second option, given that paragraph 11 of document EB130/30 stipulated that the Director-General would propose, later in the 130th session, names to the Board for consideration, but that the present meeting was the last of the current session.

Dr DANKOKO (Senegal) thanked both the member for Canada for supporting the second option, which had been strongly favoured by the African and Eastern Mediterranean regions, and all those who had followed Canada's lead.

In response to a request for clarification from Dr REN Minghui (China), Mr BURCI (Legal Counsel) said that the Board had reached consensus on the second option as presented in paragraph 9 of document EB130/30, namely not to renew the terms of office of the two members and to replace them with other individuals, giving due regard to geographical representation and gender balance.

Responding to the member for Estonia, he said that, although the Secretariat had been reviewing the list of possible new members for a week or so, it was not yet in a position to present a full range of names to the Board for consideration. It would continue to do the necessary work, including determining whether candidates were indeed available to take on that membership, before presenting a list to the Board in due course.

Ms WISEMAN (Canada) stressed the importance of appointing two candidates in accordance with the terms of reference and on the basis of their expertise and experience and the value that they could add to the Advisory Committee, while underscoring the need for the Committee to maintain its independence and for regional rotation to be taken into due consideration.

Dr SILBERSCHMIDT (Switzerland), after expressing support for the emerging consensus, requested clarification from the Legal Counsel on the process for confirming proposed candidates and whether the Board would have the option to delegate responsibility for confirming names to the Officers of the Executive Board, in view of the limited time available before the next meeting of the Committee and the desire for it to be working at full capacity with five members.

Dr MAKUBALO (South Africa)¹ reiterated that the concerns of the African Region, reinforced by other speakers, related to adherence to best practices and the terms of reference of the Committee, including that selection of candidates should give due regard to geographical representation. Those terms of reference had been approved by the Board. It was clear that candidates should be nominated on the basis of their individual expertise and capacity to fulfil the conditions of membership, and all Board members should acknowledge that such candidates existed in all regions. She thanked Board members for their flexibility and efforts to reach consensus.

Mr OSEI (Ghana)¹ also expressed appreciation for the reaching of consensus on such an important matter. The governing bodies should continue to embrace and promote a culture of inclusiveness, tolerance and equity, while taking into account regional and cultural sensitivities and interests.

The CHAIRMAN noted that consensus had been reached on the second option proposed by the Director-General in document EB130/30 (paragraph 9). In view of time constraints and the need for the Secretariat to produce a list of names, he asked the Board whether it would agree to delegate authority provisionally, until its next session, to the Officers of the Executive Board to approve the two new members of the Independent Expert Oversight Advisory Committee to be proposed by the Director-General, on the understanding that those nominations would have to be finally approved by the Board at its next session.

It was so decided.²

Ms WISEMAN (Canada) welcomed the decision but asked whether new members would be appointed in time to participate in the work of the Committee at its next meeting in February.

The CHAIRMAN confirmed that the intention of the decision was to confirm two new members before that meeting so that they were able to participate.

Dr REN Minghui (China) said that it had been his understanding that the two new members would not participate in that meeting, which would go ahead on the basis that the other three members would form a quorum.

The CHAIRMAN reiterated that, as long as the Secretariat was able to produce a list of potential candidates in time, the intention of the decision was for the Officers of the Board to confirm two new members as soon as possible so that they could participate in the meeting of the Committee in February.

Dr JESSE (Estonia) asked how many experts were currently on the roster, and what the likelihood was of two individuals being able to confirm that they were available to work at such short notice and could take on that membership on a pro bono basis for two to four years.

Dr JAMA (Assistant Director-General) said that the Director-General currently held a list of around 40 names and had also asked other organizations that had recently appointed experts to their own similar committees if they could share the names of their shortlisted candidates.

Dr JESSE (Estonia) said that, once the Board's Officers had confirmed the two new members, that information should be conveyed to the rest of the Board and other Member States immediately

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

² Decision EB130(15).

and not delayed until it appeared in the documentation for the May session of the Board and the Sixty-fifth World Health Assembly.

Mr AGHAZADEH KHOEI (Islamic Republic of Iran)¹ thanked the Board for its flexibility, which had allowed a consensus to be reached. He took it that all Member States would join him in thanking the two outgoing members of the Independent Expert Oversight Advisory Committee for their hard work in the past two years.

Provisional agenda of the Sixty-fifth World Health Assembly and date and place of the 131st session of the Executive Board: Item 9.4 of the Agenda (Document EB130/33)

The CHAIRMAN drew attention to document EB130/33 and the draft decision contained therein.

Mrs ROSE-ODUYEMI (Office of the Governing Bodies) said that there were two amendments to the draft provisional agenda of the Sixty-fifth World Health Assembly, namely to delete item 16.5, on scale of assessments for 2012–2013 and item 16.7, on amendments to the Financial Regulations and Financial Rules [if any]. There were no changes to report in either case.

The CHAIRMAN took it that the Board wished to approve the provisional agenda, contained in document EB130/33, as amended.

It was so decided.²

The CHAIRMAN proposed that the 131st session of the Executive Board, following the Sixty-fifth World Health Assembly, should be held at WHO headquarters in Geneva on 28 and 29 May 2012, lasting two days, in view of the discussions that had been held on WHO reform. He further proposed that the Programme, Budget and Administration Committee should meet for three days before the Sixty-fifth World Health Assembly, 16–18 May 2012.

It was so decided.³

The CHAIRMAN said that, in compliance with Rule 8 of the Rules of Procedure of the Executive Board, the Director-General would draw up the provisional agenda for the 131st session of the Board, which would be circulated to Member States and Associate Members within four weeks of the closure of the current session.

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

The DIRECTOR-GENERAL expressed her gratitude to all Board members for the remarkable way in which they had tackled the many items on the agenda, which had spanned some of the biggest challenges and opportunities in public health at the current time. The spirit of the session had been characterized by competence, collegiality and commitment, the last quality being especially evident in the lengthy and complex discussions and decisions on WHO reform. She deeply valued Members'

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

² Decision EB130(16).

³ Decision EB130(17).

unwavering commitment to WHO and their ability to take what were sometimes difficult decisions on what was important for the Organization and its future.

After the customary exchange of courtesies, the CHAIRMAN declared the 130th session of the Executive Board closed.

The meeting rose at 17:25.

LIST OF MEMBERS AND OTHER PARTICIPANTS

MEMBERS, ALTERNATES AND ADVISERS

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M. A. LAASSEL, Ministre, Mission permanente, Genève

M. A. SAMRI, Ministre, Mission permanente, Genève

M. A. BENMAMOUN, Chef, Division, Maladies transmissibles, Division, Epidémiologie et Lutte contre les Maladies, Rabat

Dr T. LAHLOU, Conseillère, Secrétariat général de la Santé, Ministère de la Santé, Rabat

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Alternates

Mrs S. ABGARIAN, Deputy Permanent Representative, Geneva

Mr G. KOCHARIAN, Counsellor, Permanent Mission, Geneva

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Alternate

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Alternates

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Mr YE MYINT AUNG, Deputy Permanent Representative, Geneva

Dr MIN THAN NYUNT, Deputy Director-General, Department of Health, Ministry of Health, Nay Pyi Taw

Dr KO KO NAING, Director, International Health Division, Ministry of Health, Nay Pyi Taw

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Dr I. KANA, Technical Assistant, Federal Ministry of Health, Abuja

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Mr G.O. ASAOLU, Minister, Permanent Mission, Geneva

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Ms B. STIRØ, Minister Counsellor, Permanent Mission, Geneva

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Mr B. SKOTHEIM, Adviser, Norwegian Directorate of Health, Oslo

Mr C.B. ELIASSEN, Intern, Permanent Mission, Geneva

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