



WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD

132ND SESSION

GENEVA, 21–29 JANUARY 2013

**SUMMARY RECORDS
LIST OF PARTICIPANTS**

GENEVA
2013

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 132nd session of the Executive Board was held at WHO headquarters, Geneva, from 21 to 29 January 2013. 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 issued in document EB132/2013/REC/1.

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¹ As adopted by the Board at its first meeting (21 January 2013).

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- M. Progress in the rational use of medicines (resolution WHA60.16)
- N. Health policy and systems research strategy¹

16. Closure of the session

¹ See document EB132/1(annotated) for the recommendation by the Officers of the Executive Board to accept, as a progress report, the proposal to inform the Board about "Health policy and systems research strategy".

LIST OF DOCUMENTS

EB132/1 Rev.1	Agenda ¹
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EB132/2	Report by the Director-General to the Executive Board at its 132nd session
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¹ See page ix.

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EB132/7 and EB132/7 Corr.1	Draft action plan for the prevention and control of noncommunicable diseases 2013–2020
EB132/8	Draft comprehensive mental health action plan 2013–2020
EB132/9	Draft action plan for the prevention of avoidable blindness and visual impairment 2014–2019. Universal eye health: a global action plan 2014–2019
EB132/10	Disability
EB132/10 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly
EB132/11	Monitoring the achievement of the health-related Millennium Development Goals
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EB132/13	Follow-up actions to recommendations of the high-level commissions convened to advance women's and children's health
EB132/14	Social determinants of health
EB132/15 and EB132/15 Add.1	Implementation of the International Health Regulations (2005)
EB132/16	Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits. Pandemic Influenza Preparedness Framework 2013 biennial report
EB132/17	Poliomyelitis: intensification of the global eradication initiative
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EB132/28	Scale of assessments 2014–2015
EB132/28 Add.1	Scale of assessments for 2014–2015. Foreign exchange risk management
EB132/29, EB132/29 Add.1 and EB132/29 Add.2	Follow-up of the report of the Working Group on the Election of the Director-General of the World Health Organization
EB132/29 Add.3	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly
EB132/30	Evaluation: update and proposed workplan for 2013
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EB132/36	Provisional agenda for the Sixty-sixth World Health Assembly
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EB132/INF./4	Proposed programme budget 2014–2015
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EB132/DIV./2	Preliminary daily timetable
EB132/DIV./3	Decisions and list of resolutions
EB132/DIV./4	List of documents

COMMITTEES¹

1. Programme, Budget and Administration Committee²

Mr Jamal Thabet Nasher (Yemen, Chairman), Dr Joy St. John (Barbados, member ex officio), Dr Dirk Cuypers (Belgium), Dr Martina Baye Lukong (Cameroon), Dr Ren Minghui (China), Mr Liow Tiong Lai (Malaysia), Dr Ahmed Jamsheed Mohamed (Maldives), Mr Rodrigo Reina (Mexico), Dr Mouzinho Osvaldo de Assunção Saide (Mozambique), Mr Abdulla Al-Qahtani (Qatar), Dr Boubacar Samba Dankoko (Senegal, member ex officio), Mr Pascal Strupler (Switzerland), Dr Madelena Sarmento P. da Costa (Timor-Leste) and Dr Nils Daulaire (United States of America).

Second Extraordinary Meeting, 6 and 7 December 2012:

Mr Jamal Thabet Nasher (Yemen, Chairman), Dr Joy St. John (Barbados, member ex officio), Dr Dirk Cuypers (Belgium, Vice-Chairman), Dr Martina Baye Lukong (Cameroon), Dr Ren Minghui (China), Dr Chong Chee Kheong (alternate to Dr Liow Tiong Lai, Malaysia), Dr Ahmed Jamsheed Mohamed (Maldives), Mr Juan José Gómez Camacho (alternate to Mr Rodrigo Reina, Mexico), Dr Mouzinho Osvaldo de Assunção Saide (Mozambique), Dr M. Al-Thani (alternate to Mr Abdulla Al-Qahtani, Qatar), Mrs M. Peneveyre (alternate to Mr Pascal Strupler, Switzerland), Dr Madelena Sarmento P. Da Costa (Timor-Leste) and Mr Jim Kolker (alternate to Dr Nils Daulaire, United States of America).

Seventeenth meeting, 17 and 18 January 2013:

Mr Jamal Thabet Nasher (Yemen, Chairman), Dr Joy St. John (Barbados, member ex officio), Dr Dirk Cuypers (Belgium, Vice-Chairman), Dr Martina Baye Lukong (Cameroon), Dr Ren Minghui (China), Mr Mazlan Muhammad (alternate to Dr Liow Tiong Lai, Malaysia), Dr Ahmed Jamsheed Mohamed (Maldives), Mr Juan José Gómez Camacho (alternate to Mr Rodrigo Reina, Mexico), Dr Mouzinho Osvaldo de Assunção Saide (Mozambique), Dr Saleh Ali Al-Marri (alternate to Mr Abdulla Al-Qahtani, Qatar), Mrs Muriel Peneveyre (alternate to Mr Pascal Strupler, Switzerland), Dr Madelena Sarmento P. Da Costa (Timor-Leste) and Dr Nils Daulaire (United States of America).

2. Standing Committee on Nongovernmental Organizations³

Professor Ara Saenovič Babloyan (Armenia), Mrs Carina Vance Mafla (Ecuador), Dr Liow Tiong Lai (Malaysia), Dr Pe Thet Khin (Myanmar) and Dr Bernard Valentin (Seychelles).

Meeting of 22 January 2013: Dr Liow Tiong Lai (Malaysia, Chairman), Mrs S. Abgarian (alternate to Professor Ara Saenovič Babloyan, Armenia), Dr Francisco Vallejo (alternate to Mrs Carina Vance Mafla, Ecuador), Dr Pe Thet Khin (Myanmar) and Dr Bernard Valentin (Seychelles).

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

² Decision EB131(5). This also reflects the membership as of January 2013, including the change in representatives for Mexico and Switzerland.

³ Decision EB131(6).

3. Léon Bernard Foundation Committee¹

The Chairman and Vice-Chairmen of the Executive Board, members ex officio, and a member of the Executive Board from a Member State of the WHO European Region.

Meeting of 23 January 2013: Dr Joy St. John (Barbados, Chairman), Dr Ren Minghui (China) and Dr Ahmed Jamsheed Mohamed (Maldives), and Professor Rajko Ostojić (Croatia).

4. Sasakawa Health Prize Selection Panel²

The Chairman of the Executive Board, member ex officio, a representative of the Founder and a member of the Executive Board.

Meeting of 22 January 2013: Dr Joy St. John (Barbados, Chairman), Professor K. Kiikuni (representative of the Founder) and Dr Udval Natsag (Mongolia).

5. United Arab Emirates Health Foundation Selection Panel³

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

Meeting of 22 January 2013: Dr Joy St. John (Barbados, Chairman), Mr Rashed Al Shamsi (representative of the Founder) and Dr Jamal Thabet Nasher (Yemen).

6. State of Kuwait Health Promotion Foundation Selection Panel⁴

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

Meeting of 23 January 2013: Dr Joy St. John (Barbados, Chairman), Mr Haider S.H.Y.A. Abulhasan (representative of the Founder) and Dr Saleh Ali Al-Marri (Qatar).

7. Dr LEE Jong-wook Memorial Prize Selection Panel⁵

The Chairman of the Executive Board, member ex officio, a representative of the Founder and a member of the Executive Board.

Meeting of 22 January 2013: Dr Joy St. John (Barbados, Chairman), Ms Hyun Kyong Kim (representative of the Founder) and Mr Pascoe Kase (Papua New Guinea).

¹ Decision EB131(7).

² Decision EB127(4).

³ Decision EB131(8).

⁴ Decision EB129(3).

⁵ Decision EB129(4).

SUMMARY RECORDS

FIRST MEETING

Monday, 21 January 2013, at 09:40

Chairman: Dr J. ST. JOHN (Barbados)

1. OPENING OF THE SESSION AND ADOPTION OF THE AGENDA: Item 1 of the Provisional agenda (Documents EB132/1 and EB132/1 (annotated))

The CHAIRMAN declared open the 132nd session of the Executive Board and welcomed all participants, in particular the new Board members: Dr Udval Natsag (Mongolia), Mr Rodrigo Reina (Mexico), Dr Zelibeth Valverde (Panama), Mr Pascoe Kase (Papua New Guinea), Professor Awa Maria Coll Seck (Senegal), Mr Pascal Strupler (Switzerland) and Dr Maria Sarmento P. da Costa (Timor-Leste).

Election of Vice-Chairmen

The CHAIRMAN said that Dr Silberschmidt, the Board member designated by Switzerland, who had been elected as a Vice-Chairman at the Board's 131st session, had been replaced by Mr Strupler. The Member States of the European Region proposed that Mr Strupler should be elected as a Vice-Chairman for the remainder of the term.

Dr Dankoko, the Board member designated by Senegal, who had also been elected as a Vice-Chairman at the Board's 131st session, had been replaced by Professor Coll Seck. The Member States of the African Region proposed that Dr de Assunção Saíde of Mozambique should be elected as a Vice-Chairman for the remainder of the term.

If there was no objection, she would take it that those proposals were acceptable to the Board.

It was so decided.

Adoption of the agenda

The CHAIRMAN drew attention to item 15.1, Reports of advisory bodies, and proposed that the subitem concerning the Advisory Committee on Health Research be deleted as no meeting had been held in the period 2011–2012.

It was so agreed.

Dr VALVERDE (Panama), noting that, annually, more than 50 million people required palliative care, said that the lack of access to such care was a public health problem in some 100 countries. She noted the decision to defer to the 134th session of the Executive Board an item on strengthening of palliative care as a component of integrated treatment throughout the life course, and suggested that, in order to facilitate discussion of the item, the Secretariat should prepare a report including initiatives, programmes and challenges in the area of palliative care.

The agenda, as amended, was adopted.¹

Mr ESPINOSA SALAS (Ecuador) said that Ecuador and Panama wished to propose a draft resolution on World Psoriasis Day for the consideration of the Board, whose discussion of the issue would help to raise awareness of the condition.

The CHAIRMAN pointed out that the agenda had already been adopted and urged members to follow the Rules of the Procedure of the Executive Board.

Professor HALTON (Australia) said that the Board's agenda was an extremely heavy and significant one. Although psoriasis represented a serious burden for some individuals, the subject should be raised in the normal manner, consistent with the Board's Rules of Procedure.

Mr KOLKER (United States of America) suggested that, in order to avoid overloading the agenda, the subject of World Psoriasis Day should be considered by the Board at its 133rd session.

The DIRECTOR-GENERAL said that she appreciated the importance of psoriasis. However, the approach taken by Ecuador and Panama, in proposing a draft resolution without prior discussion, was unusual. The Secretariat would need time to prepare a document on the public health implications of psoriasis for consideration at the 133rd session of the Board in May. The Board members concerned might wish to submit their draft resolution for consideration in conjunction with that document.

Mr ESPINOSA SALAS (Ecuador) and Dr VALVERDE (Panama) expressed support for the approach suggested by the Director-General.

The CHAIRMAN said that, if she heard no objection, she would take it that the Board agreed to take up the issue of psoriasis at its 133rd session in May 2013.

It was so decided.

2. ORGANIZATION OF WORK

Mr MIŠKINIS (Lithuania) 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. He requested that, at the 132nd 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.

¹ Document EB132/1 Rev.1.

The CHAIRMAN said that the “traffic light” system would be used to limit the length of general statements and she encouraged the presentation of regional statements.

Item 14.1, Appointment of the Regional Director for the Americas, would be discussed in an open meeting, attended by only members of the Board, their alternates and advisers, and one representative of each Member State not represented on the Board and of each Associate Member, in accordance with Rule 7 of the Rules of Procedure. No official record would be prepared.

In response to a question by Dr REN Minghui (China), she proposed that the discussion of agenda item 5 on WHO reform should focus on four themes: (1) WHO’s hosting arrangements for health partnerships and proposals for harmonizing work with nongovernmental organizations; (2) the possibility of shifting the financial year, the scheduling of sessions of governing bodies, the methods of work of the governing bodies and the role of WHO in global health governance; (3) the report of the Joint Inspection Unit of the United Nations system on the review of management and administration of WHO and of decentralization in WHO and the Director-General’s response to the Unit’s recommendations; and (4) modalities for the second stage of the independent evaluation of the WHO reform process and implementation of WHO reform – progress report and implementation plan. She urged speakers to respect those groupings in their deliberations.

She further proposed that under agenda item 7, Promoting health through the life course, item 7.1 on monitoring the achievement of the health-related Millennium Development Goals should be taken up together with item 7.2 on follow-up actions to recommendations of the high-level commissions convened to advance women’s and children’s health, and that the second part of item 7.1 on health in the post-2015 development agenda would be discussed thereafter.

3. REPORT BY THE DIRECTOR-GENERAL: Item 2 of the Agenda (Document EB132/2)

The DIRECTOR-GENERAL, introducing her report, underlined the unprecedented number of items on the Board’s agenda. The challenges facing public health, such as climate change, antimicrobial resistance, the rise of chronic noncommunicable diseases, rising expectations for health care, and shrinking budgets, although considerable, were not insurmountable, and were being tackled through the development of new instruments and approaches.

Innovation, which included finding ways to make better use of what already existed, was a powerful research and development tool, especially when driven by unmet needs not commercial profit incentives. The establishment of ambitious, comprehensive and appealing goals was conducive to progress, as was the use of policies to maximize the impact of new tools.

Better use was being made of legislation and regulatory control to reduce threats to health at their source. She welcomed the increasing engagement of Member States in negotiations leading to new policies and instruments for global health governance; the recently adopted protocol to the WHO Framework Convention on Tobacco Control illustrated what could be achieved when multiple sectors of government collaborated in the name of health.

The emerging culture of accountability and the trend towards independent monitoring were welcome and would help to foster the optimum use of resources and provide valuable guidance.

The killing of health workers distributing polio vaccines, in December 2012, was a despicable and grievous tragedy that had come at a time when much progress had been made towards eradicating the disease. She praised the continued dedication and determination of the staff and country teams engaged in eradication efforts.

New avenues for collaboration with the private sector were beginning to yield results and heralded a new approach to establishing a structured and predictable process for ensuring fair access to medical products during an emergency, and strengthening preparedness. The successes already achieved showed that health diplomacy worked.

WHO reform was progressing. She emphasized the primacy of the programme budget as the central accountability instrument guiding the work of WHO. She commended the work of the Programme, Budget and Administration Committee, and expressed the hope that the atmosphere of

mutual trust that had characterized the second extraordinary meeting of that Committee in December 2012 would prevail in the discussions on the reform process.

Professor COLL SECK (Senegal), speaking on behalf of the Member States of the African Region, welcomed the results achieved over the previous year in many important areas. The health situation in the African Region was improving, partly as a result of better access to vaccines and progress in the areas of HIV/AIDS, malaria and maternal and child mortality but not in all countries. Much remained to be done on communicable diseases, which remained the leading cause of death, and infectious diseases with epidemic potential, such as cholera, meningitis and viral haemorrhagic fevers.

Countries were experiencing a rapid increase in noncommunicable diseases, and she welcomed the draft comprehensive global monitoring framework for the prevention and control of noncommunicable diseases. All Member States should ensure that the indicators and targets set out in the framework were incorporated in the draft action plan for the prevention and control of noncommunicable diseases 2013–2020.

States must review their health policy, taking into consideration the social determinants of health, and health ministries had an important role to play in that regard. Positive change was heralded by governments' recognition of the need to combat social inequalities in access to health care and to establish systems for universal coverage. Finance ministries were recognizing the need to collaborate with health ministries; following a ministerial conference (Tunis, 4 and 5 July 2012), African health and finance ministers had issued a joint declaration recommending concrete measures to enhance value for money, sustainability and accountability in the health sector in order to achieve universal health coverage and accelerate progress towards internationally agreed development targets.

Universal health coverage depended on strong health systems, adequate infrastructure and powerful health information systems. Health system strengthening remained a top priority. The acute shortage of human resources in health was a matter of concern. Staff levels would have to be increased by an average of 140% to remedy the shortage of health workers, and all Member States should implement the WHO Global Code of Practice on the International Recruitment of Health Personnel urgently.

Access to high-quality medicines continued to present challenges in the Region, and Member States had high expectations of the mechanism on substandard/spurious/falsely-labelled/falsified/counterfeit medical products. Most countries in the Region were unable to use the flexibilities built into the Agreement on Trade-Related Aspects of Intellectual Property because they did not have the appropriate level of industrial and technological development in the pharmaceutical field. Moreover, the provision in the Doha Declaration on the TRIPS Agreement and Public Health that developed-country Members should provide incentives to their enterprises and institutions to promote and encourage technology transfer to least-developed countries was not widely applied.

She welcomed the draft twelfth general programme of work, but called for it to place more emphasis on communicable diseases. Efforts must be made to ensure that health remained a top priority in the post-2015 development agenda; the new challenges and objectives should take account of the Millennium Development Goals that had not been fully achieved.

Mr MIŠKINIS (Lithuania), speaking on behalf of the European Union and its Member States, said that the reform programme, which had started well in 2012, would enable WHO to respond to global health challenges and would help to preserve WHO's credibility and independence as a public health organization and its leadership as the United Nations specialized agency on health. The European Union remained committed to the reform process and would engage constructively on all aspects thereof. Written feedback on the draft twelfth general programme of work and the proposed programme budget would be provided after the Board's deliberations, and he emphasized the need for continued engagement before the meeting of the Programme, Budget and Administration Committee in May.

He commended the Secretariat's work in 2012 on noncommunicable diseases and looked forward to the discussions on the draft action plan for the prevention and control of

noncommunicable diseases 2013–2020. The global monitoring framework would enhance the collective, multisectoral response to their global burden and threat.

The European Union welcomed the draft resolution on follow-up of the report of the Consultative Expert Working Group on Research and Development: Finance and Coordination. It also welcomed the adoption of the Protocol to the WHO Framework Convention on Tobacco Control.

The collective progress made in 2012 on substandard/spurious/falsely-labelled/falsified/counterfeit medical products was disappointing. Further advances should be made in the coming year.

The European Union remained committed to seeking solutions to global health challenges, and a smaller, more focused agenda would be conducive to better governance.

Mr KOLKER (United States of America) said that 2012 had been a good year for global health and global health governance. His Government welcomed the extensive consultations that had been held and looked forward to the Board's adoption of recommendations made in major areas such as noncommunicable diseases, mental health, substandard/spurious/falsely-labelled/falsified/counterfeit medical products, and research and development.

He noted with satisfaction that important areas, such as budgetary approval, interaction with partnerships and human resources management, were included in the discussions on reform. The future WHO must be much more transparent and results-oriented at all levels. Although promising steps had been made, it must further articulate the outputs of its work and clarify the programmatic implications of changes. The draft twelfth general programme of work also needed more clearly described outcomes and outputs.

The move towards more transparent budgeting did not mean that Member States should begin to micromanage the Organization. The Director-General should have the authority to use resources to undertake the work set out in the general programme of work, and the discretion to make changes when required. He held the staff in high regard but human resources reform was also critical, and a more flexible system should be introduced to enable the Secretariat to adapt to changing technical needs and ensure that it employed the best technical experts.

Although poliomyelitis was closer than ever to being eradicated, it was unlikely that the transmission of residual wild poliovirus would be interrupted by the end of 2014. The recent tragic murder of health workers distributing polio vaccines was a vivid reminder of the challenges faced. If deadlines continued to slip and stakeholders gave up on eradication, the results would be devastating; the goal of poliomyelitis eradication must remain a programmatic issue of the utmost importance for WHO.

Professor OSTOJIĆ (Croatia), speaking on behalf of the Member States of the European Region, welcomed the Director-General's commitment to implementation of the reform programme, which was essential to ensure that WHO was fit for purpose. The Secretariat should hold further consultations with Member States on the draft twelfth general programme of work and the proposed programme budget 2014–2015 before the Sixty-sixth World Health Assembly in May 2013 in order to quantify costs at the three levels of the Organization. He welcomed the Secretariat's intention to strengthen elements focusing on the results chain, differentiation of labour, costing of outputs, country-level engagement and the evaluation framework before the Health Assembly, which would help to support the elaboration of robust principles and mechanisms for the allocation of resources between the levels of the Organization. Clear and regular communication and engagement at all levels were necessary to support the introduction of the high-level implementation plan and the allocation of funding from assessed contributions.

Dr REN Minghui (China) expressed the hope that continued consultation with Member States, civil society, academia and the private sector would establish health as a key priority on the post-2015 development agenda.

The prevention and control measures introduced since 2011 in response to the imported cases of poliomyelitis in his country had effectively curbed the spread of poliovirus and China had regained its poliomyelitis-free status. China was currently assisting Pakistan and some African countries in the eradication of poliomyelitis and would increase that assistance as necessary. He congratulated States

Parties on the adoption of the Protocol to Eliminate Illicit Trade in Tobacco Products. Noting the report of the Joint Inspection Unit and the preliminary recommendations of the study of the costs of administration and management at WHO,¹ he averred that the reform process was on track. His country would continue to support that process.

Mr STRUPLER (Switzerland) said that Member States should continue to engage actively in discussions on the post-2015 development agenda, in order to ensure that health was a major focus of that agenda; issues such as the environmental, economic and social determinants of health, noncommunicable diseases and mental health were of particular importance. Success in those areas depended on a multisectoral approach and WHO should define its role in implementing that approach through the ongoing process of organizational reform, centred on the twelfth general programme of work 2014–2019 and the programme budget 2014–2015. However, much work remained to be done on both of those documents to ensure mutual coherence; the discussions were likely to be complex and efforts should be made not to further complicate them.

Ms STIRØ (Norway) called for coordinated efforts to achieve the health-related Millennium Development Goals by 2015. Referring to agenda item 7.2, Health in the post-2015 development agenda, she expressed strong support for the work of the United Nations Commission on Life-Saving Commodities for Women and Children, which would be the subject of a draft resolution to be proposed by her delegation and others.

Significant progress had been made over the past two years in the prevention and control of noncommunicable diseases and she welcomed WHO's leading role, including the successful consultations in November 2012. The reform process was vitally important, and she supported the proposals made by the Programme, Budget and Administration Committee at its second extraordinary meeting to improve the financing of WHO.

She expressed concern at the increasingly aggressive strategies used by the tobacco industry to stop countries from implementing the WHO Framework Convention on Tobacco Control and welcomed the Director-General's clear stand. It should be noted that both Australia and Norway had been successful in court proceedings against the tobacco industry during the previous year. Member States should not allow themselves to be intimidated by the industry but should fight for tougher tobacco control measures.

Dr LIOW TIONG LAI (Malaysia), welcomed the work so far on WHO reform and the Director-General's report, but expressed concern that the Board's heavy agenda might restrict the amount of time for discussion of major issues that required more attention than others. A more focused agenda would undoubtedly benefit both the Secretariat and Member States. The agenda for governing body meetings should reflect the changing burden of diseases at the global level, and it was also important to ensure that the health-related components of the post-2015 development agenda fully reflected both the current burden of diseases and the predicted course of public health issues over the next 10 to 20 years.

Professor HALTON (Australia) welcomed the consultative approach adopted by the Director-General in advancing the reform process, which was crucial to improving the financing, human resources and structures of the Organization. The Director-General and the regional directors should be better empowered to run the Organization. On the question of the work to be done in the "post-Millennium Development Goals" framework, she agreed with the Director-General that health diplomacy was both effective and necessary. She welcomed the increased focus on noncommunicable diseases and thanked the Director-General for her continued support for efforts to resist the tobacco industry's interference in public health policy. Australia had been the first country in the world to introduce plain packaging for all tobacco products. Turning to the eradication of poliomyelitis, she

¹ Documents EB132/5 Add.6 and EBPBAC17/INF./2, respectively.

expressed condolences in relation to the recent tragic killing of health workers distributing polio vaccines in Pakistan. The impact of the violence in the Syrian Arab Republic on access to health care was also a matter of serious concern.

Ms DÁVILA CHÁVEZ (Mexico) said that her country's newly elected President was fully committed to ensuring access to quality health care for all its citizens. Mexico had made significant progress in its efforts to achieve universal coverage but challenges remained. International cooperation was crucial to those efforts and evidence-based decision-making was of vital importance.

Ms DUPUY LASSERRE (Uruguay),¹ welcoming the agreement reached on the comprehensive global monitoring framework, including indicators, and a set of voluntary global targets for the prevention and control of noncommunicable diseases, expressed hope that the negotiations to be held in March 2013 on a global action plan would be fruitful. She highlighted the successful outcome of the fifth Conference of the Parties to the WHO Framework Convention on Tobacco Control, at which the Seoul Declaration had been approved.² The Declaration served to renew Parties' commitment to the implementation of the Convention through international cooperation, regardless of obstacles raised by the tobacco industry against national public health measures. Uruguay had already signed the recently adopted Protocol to Eliminate Illicit Trade in Tobacco Products and encouraged other States to do the same. She expressed appreciation of the documents prepared by the Secretariat on monitoring the achievement of the Millennium Development Goals and the inclusion of health in the post-2015 development agenda,³ and welcomed the technical support provided by WHO in the preparation of the annual full-day meeting on the rights of the child to be held by the Human Rights Council of the United Nations in March 2013. She welcomed the recent adoption of the Minamata Convention on Mercury; WHO should take note of the adoption of the Convention and consider the role it could play in its implementation.

Dr FITSCHEN (Germany)¹ said that the budget as an accountability instrument should be added to the list of five well-chosen elements in the Director-General's report that were to guide the work of the Board at the current session. The Board needed to establish a clear framework for the proposed programme budget 2014–2015 and the draft twelfth general programme of work 2014–2019 so that Member States could develop a common political will in relation to both matters at the Sixty-sixth World Health Assembly. Further clarification was needed on the planned financing dialogue that was to take place after the Health Assembly. It was to be hoped that the current session would provide an opportunity for Member States to gain a clear understanding of how the financing dialogue would function and how the roles of the governing bodies would be strengthened within the priority setting, financing and accountability framework.

Mr COSME (France)¹ said that his country shared the desire for a clear and coherent vision for the modernization of WHO; in that regard, the results of the funding discussions at the second extraordinary meeting of the Programme, Budget and Administration Committee were extremely encouraging. He welcomed the decentralization of WHO, but acknowledged that that process itself presented challenges in terms of coherence and efficiency. Accountability and transparency should be established as central pillars at the three levels of the Organization. Better synergies between the different levels of governance, in particular between headquarters and the regional offices, were also vital. In order to ensure effective implementation of the reform process, a clear action plan, with a detailed time frame and suitable communications strategy, was required. It was also crucial that

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

² Decision FCTC/COP5(5).

³ Documents EB132/11 and EB132/12, respectively.

Member States had an overall view of the reforms and their implications, particularly with regard to the budget and human resources. A clear and differentiated engagement framework with all non-State actors, such as nongovernmental organizations, partnerships and foundations, was needed in order to ensure WHO's credibility and independence and to avoid conflicts of interest. With regard to the post-2015 development agenda, his country was committed to strengthening global health governance and welcomed the Director-General's efforts to include universal health coverage as a key theme in that agenda.

Ms AKSEL'ROD (Russian Federation),¹ welcoming the steps taken to reform the Organization, said that the high-level implementation plan was transparent and appropriate, reflecting all the important elements of the reform process. Her Government shared the concerns of others about the increasing global burden of noncommunicable diseases. In recent years, WHO had played a significant role in the prevention and control of those diseases and, as a result of the active participation of both the Secretariat and Member States, progress had been made in achieving goals related to noncommunicable diseases. However, more work was still needed at the global and regional levels and the mobilization of additional resources was essential. Her country had participated in the development of a monitoring system for such diseases and, at the national level, was in the process of introducing a similar system to be integrated into its national health information system. Her Government had adopted a national health programme up to the year 2020 and drafted a law on protecting the public's health from tobacco use. A coordinated approach by all Member States was needed to address global, regional and national health-related challenges.

Dr HENG (Singapore)¹ paid tribute to the commitment of the Director-General which had enabled WHO to become increasingly effective, efficient and responsive in fulfilling its global mission. Owing to the continuously changing global health landscape, reforms were essential and the draft twelfth general programme of work reflected that fact, with a greater focus on more strategic priorities and clearly articulated proposed impacts and outcomes, to ensure greater transparency and accountability.

Mr NABEEL (Pakistan),¹ expressing appreciation for the condolences offered by members over the recent deaths of workers distributing polio vaccines in his country, said that his Government was fully committed to the eradication of the disease; in the previous year, despite the challenges faced, there had been a 65% reduction in cases of poliomyelitis. He looked forward to the forthcoming discussions on the reform agenda, which would have significant and pivotal consequences for both global health and the Organization.

The DIRECTOR-GENERAL, welcoming speakers' comments, said that more information would be provided on issues such as the programme budget and the financing dialogue before the Health Assembly in May 2013. Steps would be taken to ensure that the level of detail requested was reflected in the next budget; the Global Policy Group was keen to be accountable to Member States and to provide them with the best available information.

During the current discussion, several important issues had been highlighted, such as noncommunicable diseases, greater progress towards achievement of the Millennium Development Goals and the position of health in the post-2015 development agenda. WHO would continue to work with Member States to address those issues. With regard to the noncommunicable diseases monitoring framework, it would be important to assess how the programme budget could be used to operationalize work in that area. She acknowledged suggestions regarding the United Nations Commission on Life-Saving Commodities for Women and Children; it would indeed be prudent to make use of existing,

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

affordable interventions. She encouraged Member States to express their views frankly on how best to move forward in the area of reform.

4. REPORTS OF THE PROGRAMME, BUDGET AND ADMINISTRATION COMMITTEE OF THE EXECUTIVE BOARD: Item 3 of the Agenda (Documents EB132/3 and EB132/43)

Dr THABET NASHER (Yemen), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, drew attention to the reports of its seventeenth meeting (document EB132/43) and its second extraordinary meeting (document EB132/3). The following items covered in the report of its seventeenth meeting were not on the Board's agenda: the general management update and efficiency savings and cost containment measures taken in WHO; the report of the Office of Internal Oversight Services; the implementation of the internal and external audit recommendations; the report of the Independent Expert Oversight Advisory Committee; and the reports of the Joint Inspection Unit.

Professor HALTON (Australia), referring to the report on WHO's management,¹ said that it was vital to ensure that all the component costs of doing business were itemized in the reform process and that the capital master plan was included.

Dr AMMAR (Lebanon) said that, at the Committee's second extraordinary meeting, Member States had agreed, after a long discussion, that a potential increase in assessed contributions could be considered in the long term (document EB132/3, paragraph 6). However, that strategically important agreement had not been reflected in the Committee's decisions. It was important that the Board provide information on the agreement to the Health Assembly.

Mr KOLKER (United States of America), acknowledging the increased workload faced by the Secretariat in preparing for the current session, noted that paragraph 4 of the decision taken by the Programme, Budget and Administration Committee at its second extraordinary meeting² had included a request to the Director-General "to provide further information on logistics and participation in relation to the financing dialogue to the Executive Board at its 132nd session in January 2013." Although that deadline was not firm, the Secretariat should direct its attention to that request as soon as possible. He supported the outcomes agreed at that meeting, which had been valuable, and urged their endorsement at the current session.

Mr MIŠKINIS (Lithuania), speaking on behalf of the European Union and its Member States, requested clarification of the modalities of the financing dialogue and the potential legal implications of the proposed draft appropriation resolution and amendments to the Financial Regulations. Improving the financing of WHO should be a means to improve its performance and better deliver other aspects of the reform agenda, such as staff management and country-level activities. The governing bodies must have a clear role regarding the outcome of the financing dialogue and the resource mobilization strategy, and he therefore asked the Director-General to present options for their performance of that role to the Programme, Budget and Administration Committee at its next meeting, in May 2013. He welcomed the plan to create a web-based portal to support the financing dialogue, and urged its launch as soon as possible.

He agreed that an increase in assessed contributions was not an option in the short- and medium-term; the current overall funding level was adequate and it was likely that WHO would

¹ Document EBPBAC17/INF./2.

² Document EB132/3, paragraph 13.

continue to be funded from a variety of sources. The funding must be aligned with the agreed priorities. He welcomed the proposals regarding incentives for unearmarked funding, and suggested that those proposals could take into account existing practices across the United Nations system, including the recent quadrennial comprehensive policy review adopted by the United Nations General Assembly. A coordinated approach to resource mobilization was vital across all three levels of the Organization for the programme budget to be fully financed and aligned with organizational priorities. He welcomed the proposal to broaden the donor base, particularly with regard to emerging donors but with the caveat that links with private commercial entities would be considered by the Board at its next session. He further welcomed the proposals on improved financial reporting and the strengthening of internal financial controls. The first financing dialogue and the coordinated resource mobilization strategy should be thoroughly assessed before the beginning of the biennium 2016–2017.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) suggested that the meetings of the Programme, Budget and Administration Committee be held in December so as to allow time for its report to be disseminated for consideration by the Board at its January session. The Committee, at its second extraordinary meeting, had affirmed that funding was a key element of reform. He had comments on the several proposals made on how to tackle the issue. The proposed programme budget 2014–2015 should be approved by the Health Assembly and the priorities and objectives should match available funding. There should be further study on ways to obtain additional voluntary contributions, although it should be requested that such contributions not be earmarked in order to enable their effective use. The coordinated mobilization of resources and their management should be vital elements of both measures to improve funding and WHO reform. Exploration of ways to increase the number of donors should also be considered, as long as that did not jeopardize the integrity and independence of WHO or the primacy of Member States when it came to governance and decision-making.

Mr STRUPLER (Switzerland) said that the outcomes of the discussions of the Programme, Budget and Administration Committee at its second extraordinary meeting should make it possible to match financial resources to the priorities set and to improve significantly the predictability and sustainability of funding. However, discussions at the Committee's seventeenth meeting the previous week showed that several issues, such as the modalities of the new financing dialogue, remained outstanding. Turning to the role of the Committee, he said that WHO's different governing bodies had different responsibilities, particularly in respect of monitoring and management; it should not therefore be necessary to discuss the same issues in the same way at all levels of governance. Moreover, problems with the quantity and availability of documents often undermined the quality of the discussions. Accordingly, in order to ensure that the different governing bodies fulfilled their specific roles, new working methods should be considered, such as the establishment of specialized subgroups of the Executive Board.

Dr BAYE LUKONG (Cameroon), speaking on behalf of the Member States of the African Region, said that the entire proposed programme budget 2014–2015 should be approved by the Health Assembly in May 2013 in order to ensure alignment and transparency in WHO's work. She welcomed the proposed programme budget element for poliomyelitis; the Region would make every effort to ensure that eradication soon became a reality.

Given the worrying financial situation of WHO, Member States in the Region would continue to seek to identify new funding sources, find ways to increase domestic resources and endeavour to make better use of existing resources. Efforts should be made to make the financing dialogue both a reality and a success. Steps should be taken to enable payment of assessed contributions in two currencies.

She urged the resource mobilization task force to do its utmost to ensure that the 14% funding shortfall in the Programme budget 2012–2013 was reduced.

The staff were the Organization's most vital resource, and it was therefore crucial that recruitment and staffing changes should be aligned with priorities, in particular at country and regional levels. She welcomed the capacity-building efforts for staff at all levels and the drive to achieve gender balance, and applauded the Director-General's zero tolerance for mismanagement and

harassment. The excellent study of the costs of administration and management at WHO¹ provided vital information and would assist in ensuring that managerial decisions were based on evidence. She encouraged close cooperation between the Office of Internal Oversight Services and other entities, especially the Independent Expert Oversight Advisory Committee. The Secretariat should always give due attention to recommendations from governing body committees.

Dr EL MENZHI (Morocco) approved the report in document EB132/3, which accurately reflected the decisions taken by the Programme, Budget and Administrative Committee at its second extraordinary meeting. He recalled the request made by the Regional Committee for the Eastern Mediterranean at its fifty-ninth session held in October 2012² for Member States to consider the possibility of increasing the level of assessed contributions. That debate should take place in the context of the WHO reform process and with full commitment to supporting the regional offices in order to strengthen their potential and resources for policy implementation.

The DIRECTOR-GENERAL, noting that several requests had been made for further information on the financing dialogue, said that she intended to provide information on logistics before the end of the session. The most pressing issues currently were the type of documents needed for the dialogue and the expected outcome, as those issues had not been discussed by the Programme, Budget and Administration Committee at its second extraordinary meeting.

With regard to the availability of funding, it was important to ensure that WHO lived within its means. Although the Secretariat could no doubt do more to improve efficiency, Member States should be aware that requesting more activities without providing funding presented problems for the Organization. She urged Member States to consider the financial implications of all draft resolutions discussed during the session as there was no additional funding available for either the current or next biennium.

She welcomed the recognition that the reform process was beginning to have a positive effect and urged Member States to work together with the Secretariat to continue that trend.

The meeting rose at 13:00.

¹ Document EBPBAC17/INF./2.

² Resolution EM/RC59/R.6.

SECOND MEETING

Monday, 21 January 2013, at 14:40

Chairman: Dr J. ST. JOHN (Barbados)

1. REPORT OF THE REGIONAL COMMITTEES TO THE EXECUTIVE BOARD: Item 4 of the Agenda (Document EB132/4)

The CHAIRMAN drew attention to the report that had been prepared pursuant to decision WHA65(9) on governance reforms, as part of the efforts to enhance harmonization and alignment between the global and regional levels of the Organization.

Professor HALTON (Australia) welcomed the report of the regional committees as a good first step but suggested that the Secretariat, in cooperation with the regional directors, review the approach and format used, with a view to providing an overview of the outcomes both within each region and across the six regions.

Dr DE ASSUNÇÃO SAÍDE (Mozambique), speaking on behalf of the Member States of the African Region, welcomed the innovation. The outcomes of the regional committees' sessions would enrich discussions at the global level and allow harmonization of work and sharing of experiences among regions. All regions had variously made progress towards improving health and achieving the health-related Millennium Development Goals. The South-East Asia Region and the African Region had made commendable efforts to eradicate poliomyelitis. However, the political instability in some countries in the African Region, particularly Mali, might exacerbate the humanitarian crisis and jeopardize some of the progress made in improving health.

Member States in the African Region were committed to universal health coverage and poverty reduction, but needed continuous capacity-building and provision of technical support by WHO for health system strengthening. Sufficient skilled human resources were also essential; emphasis should be placed on managing the health workforce, training and retaining staff and attracting health workers back to the profession, for instance by improving working conditions. During the discussions of the Regional Committee for Africa, Member States had emphasized the need to incorporate a human rights approach in all health policies and programmes and to cover the needs of marginalized and vulnerable groups in national legal frameworks.

In discussions of WHO reform, some regional committees had recognized the need to embrace innovative financing approaches, increase the level of assessed contributions and optimize global health initiatives in order to strengthen national health systems and raise additional funds to support disease control. All levels of the Organization should be involved in finalizing the draft twelfth general programme of work and the proposed programme budget 2014–2015 and in resource allocation.

Dr REN Minghui (China) said that the report was a positive step in the WHO reform process. Such a report would help to enhance harmonization and alignment between the regional committees and the Board and should routinely be included on the Board's agenda.

Dr AMMAR (Lebanon) sought clarification of how the regional committee reports would contribute to streamlining of the work of the governing bodies and to the development of the twelfth general programme of work.

The DIRECTOR-GENERAL, noting the suggestion by the member for China for the routine inclusion of a report of the regional committee sessions on the Board's agenda, said that the report was an important tool for harmonizing the work of the Organization, increasing synergy across its three levels and facilitating an understanding of the priorities, concerns and issues under discussion in the regions. The regional committee reports also provided a comprehensive summary of deliberations at the regional level, which was very helpful to her, particularly when she had been unable to attend a particular session. In addition, the reports enabled the Secretariat to identify issues of regional concern that should be included on the global health agenda.

The format of the report would be discussed with the regional directors in order to elicit a clearer analysis of the main messages and lessons emanating from the six regional committee sessions; in that regard, she noted that the reports of the regional committees differed in length, format and degree of detail. As to how the regional committee reports would be used in the development of the twelfth general programme of work, they provided a means of identifying the issues of greatest concern across countries and regions. The six individual reports underlined the importance placed by Member States on certain matters, including achievement of the Millennium Development Goals, the International Health Regulations (2005), noncommunicable diseases, social determinants of health, health system strengthening, primary health care, universal health coverage and essential medicines. Efforts were made to ensure that all subjects of importance to Member States were addressed, but it was not always possible to do so, in particular owing to budgetary constraints; an example was the issue of psoriasis, which had been raised during the previous meeting. The inputs of the regional committees were vital to the WHO reform process.

Dr ALWAN (Regional Director for the Eastern Mediterranean) noted the action taken by several regional committees, including the Regional Committee for the Eastern Mediterranean, to harmonize their Rules of Procedure in response to the WHO reform process and the decisions taken by the Health Assembly in May 2012. The Regional Committee for the Eastern Mediterranean had also responded to the recommendations of the Board by strengthening managerial processes in the work of the Regional Office. The Member States of the Region had reached consensus on and shown strong commitment to the WHO reform process, particularly in relation to the categories for priority setting endorsed by the Health Assembly. The strategic directions adopted by the Regional Committee included health system strengthening; maternal, reproductive and child health and nutrition, noncommunicable diseases, the unfinished agenda of communicable diseases, and emergency preparedness and response, which were almost identical to the categories endorsed by the Health Assembly.

Dr JAKAB (Regional Director for the European Region), affirming that the regional directors would work with the Director-General to strengthen the format and content of future reports, said that reporting by the regional committees to the Board was an important aspect of the WHO reform process and would strengthen the links between the Organization's regional and global governance structures. The Standing Committee of the Regional Committee for the European Region, whose membership included one Member State of the European Region, served as an important interface between the Board and the Regional Committee, thereby further reinforcing those links.

She also noted that the venue of the next session of the Regional Committee for the European Region had been changed to Izmir, Turkey (but with the dates unchanged: 16–19 September 2013).

The Board noted the report.

2. NONCOMMUNICABLE DISEASES: Item 6 of the Agenda

Draft comprehensive global monitoring framework and targets for the prevention and control of noncommunicable diseases: Item 6.1 of the Agenda (Document EB132/6)

The CHAIRMAN drew attention to the strong recommendation of the Formal Meeting of Member States (document EB132/6, Annex, paragraph 6) that the Board should consider the report with a view to recommending to the Health Assembly the adoption of the global monitoring framework and the set of voluntary global targets without reopening discussion thereon.

Dr CUYPERS (Belgium), speaking on behalf of the Member States of the European Region, said that the challenges posed by the increasing burden of noncommunicable diseases required a response at all levels of governance. The risk factors associated with noncommunicable diseases should be tackled in parallel with social, environmental and economic determinants, with a focus on health equity.

The Member States in the Region supported the draft comprehensive global monitoring framework and the set of voluntary global targets and indicators. Together they constituted a landmark in the global response to noncommunicable diseases and demonstrated WHO's leadership on the issue. WHO, the directing and coordinating authority for health within the United Nations system, should use its unique technical authority and convening power to facilitate Member States, other United Nations organizations, development partners and all relevant stakeholders to work towards an integrated and coordinated systemic response to noncommunicable diseases through health system strengthening and implementing evidence-based public health policies across all sectors. He supported the recommendation to forward the complete framework to the Health Assembly.

The Member States of the Region also welcomed the draft action plan for the prevention and control of noncommunicable diseases 2013–2020 (document EB132/7) and the integration of the draft comprehensive global monitoring framework and voluntary targets therein. The Region would actively engage in the further development of that plan as well as the draft comprehensive mental health action plan 2013–2020 (document EB132/8).

Mr MIŠKINIS (Lithuania), speaking on behalf of the European Union and its Member States, endorsed the comments made by the member for Belgium.

Professor NICKNAM (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, supported the draft comprehensive global monitoring framework. All countries must strengthen their health information systems by adopting the framework and by building capacity to address its three components. The countries of the Region had welcomed the inclusion of the voluntary target to reduce premature mortality from noncommunicable diseases by 25% by 2025 as called for in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases.

At the October 2012 session of the Regional Committee for the Eastern Mediterranean, Member States had reached consensus on a set of five voluntary global targets, relating to tobacco use, salt/sodium intake, raised blood pressure, physical inactivity and diabetes. Many countries had been reluctant to include additional targets owing to limited surveillance capacity. It was important to select targets on the basis of not only evidence and cost-effectiveness, but also feasibility and affordability of implementation. The Member States of the Region would support the proposed set of nine voluntary global targets if there were consensus on them, but he urged placing emphasis, in both the global action plan and national action plans, on building surveillance capacity, which would be crucial in monitoring indicators and targets.

Dr ÁLVAREZ LUCAS (Mexico), welcoming the attention to health determinants in the report, expressed support for the set of indicators and ambitious voluntary global targets. Monitoring trends and assessing progress towards the targets, however, would need adequate health information systems

and indicators in place. The Secretariat at headquarters and regional offices should provide long-term support, resources and technical advice to Member States in order to help them achieve the targets. Support would be needed particularly with regard to financing, multisectoral coordination and action on the health determinants associated with noncommunicable diseases, including diet and lifestyle. Through cooperation with other Member States in the Region, progress had been made against tobacco use and the harmful use of alcohol.

Mr McIFF (United States of America), applauding the consultative process, commended the Secretariat's technical and policy work to fulfil the first of WHO's responsibilities set out in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases. The draft comprehensive global framework provided a sound basis for monitoring important trends in noncommunicable diseases, their major risk factors and action to address them. Although ambitious, the voluntary global targets were well-balanced and achievable. He fully endorsed the framework, the set of 25 indicators and nine voluntary global targets, and supported the recommendation that the Sixty-sixth World Health Assembly adopt them without reopening discussion on their substance. Member States and interested stakeholders should continue their engagement in finalizing the draft action plan on prevention and control of noncommunicable diseases.

Dr UDVAL NATSAG (Mongolia) expressed appreciation for the work of headquarters and the regional offices in facilitating consultations on the comprehensive global monitoring framework and the voluntary global targets and indicators. She supported the recommendation that the Sixty-sixth World Health Assembly adopt the framework and the set of targets and the integration of the targets and indicators into the draft action plan for the prevention and control of noncommunicable diseases. Noting that the WHO Framework Convention on Tobacco Control had proved a powerful tool in reducing tobacco use, she proposed that WHO should develop a similar framework convention aimed at reducing alcohol use. Her President had already raised this proposal with the United Nations Secretary-General.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) noted that the formal meeting had led to welcome consensus on the risk factors to be controlled and the targets to be pursued in order to achieve progress in the prevention and control of noncommunicable diseases. He strongly supported the recommendation that the Health Assembly adopt the draft comprehensive global monitoring framework and the proposed targets and indicators and agreed that discussion on them should not be reopened.

Dr MYINT HTWE (Myanmar) welcomed the draft comprehensive global monitoring framework and expressed appreciation for the inclusion of age-standardized indicators. He encouraged headquarters and regional offices to provide technical support to enable Member States to review the information being collected by their national databases on noncommunicable diseases in order to pinpoint areas that required improvement and to identify any gaps. Strengthening health information systems on noncommunicable diseases and improving the analytical capability of health professionals would be crucial to ensuring the reliability of data on indicators and risk factors, which would make it possible to adjust prevention and control activities as needed.

Dr AZODOH (Nigeria), speaking on behalf of the Member States of the African Region, supported the recommendation of Member States at their Formal Meeting that the Health Assembly should adopt the framework and global targets without reopening discussion on them. Implementation of the framework would contribute to global efforts to prevent and control noncommunicable diseases. The framework, indicators and targets should be integrated into the draft action plan for the prevention and control of noncommunicable diseases 2013–2020. In monitoring indicators, factors such as equity, gender, age and socioeconomic status, should be taken into account. Countries in the African Region faced considerable challenges in establishing reliable data, especially baseline data, on the large number of proposed indicators and targets; she called on the Secretariat to provide support to Member States in that task. She supported the recommendation to submit the framework and the set of voluntary global targets for adoption by the Sixty-sixth World Health Assembly.

Dr REN Minghui (China) expressed appreciation for the efforts of Member States and the Secretariat in reaching consensus on the draft comprehensive global monitoring framework. The framework, set of indicators and voluntary global targets were evidence-based and practicable and would guide Member States in monitoring noncommunicable diseases; he therefore supported their adoption. He encouraged the Secretariat to provide Member States with additional detailed documents to explain further the indicators and their measurement.

Dr EL MENZHI (Morocco) supported the draft comprehensive global monitoring framework, welcoming its inclusion of equity and the main social determinants of health. Some countries were successfully monitoring indicators such as incidence of cancer and prevalence of tobacco use, but they lacked the necessary tools to monitor the large number of indicators and targets established under the draft framework and would need financial and technical support from the international community in order to conduct epidemiological studies, monitor risk factors and assess the impact of national measures to prevent and control noncommunicable diseases. He suggested the creation of a fund for the prevention and control of noncommunicable diseases, similar to the Global Fund to Fight AIDS, Tuberculosis and Malaria, as his country had proposed during the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases in September 2011.

Mr STRUPLER (Switzerland), expressing support for the draft comprehensive global monitoring framework, said that, although voluntary, the targets were crucial to global efforts to reduce mortality from noncommunicable diseases. It would not suffice to monitor only those indicators that could easily be measured. Others must also be monitored, even if the task proved challenging. Moreover, the monitoring process should evolve in the light of the experience gained during the initial years of implementation of the draft action plan for the prevention and control of noncommunicable diseases 2013–2020. The monitoring framework should be used by all stakeholders in developing and implementing programmes to tackle noncommunicable diseases. The target of a 25% relative reduction in premature mortality would only be achieved with the involvement of sectors other than health; a multisectoral approach and shared vision were therefore essential. Actions should be taken on the basis of the framework, the draft action plan for the prevention and control of noncommunicable diseases and a multisectoral approach. Only then could coherent national strategies be developed and implemented.

Dr AMMAR (Lebanon), noting the recommendation that the draft comprehensive global monitoring framework and voluntary targets be adopted without reopening discussion, said that the draft action plan for the prevention and control of noncommunicable diseases must recognize differences in national capacities and degree of development of Member States' national health systems, especially health information systems. The indicators and targets should therefore be pilot tested in countries that had the capacity for data collection and analysis. That experience could be used to extend up implementation of the framework in other Member States with the support of the Secretariat. Many countries used the STEPwise approach to surveillance, which provided age-standardized indicators for groups of people over the age of 25 years, but the age-standardized indicators contained in the draft framework called for data on groups over the age of 18 years. Substantial WHO technical and financial support would be needed to enable Member States to strengthen their health information systems and collect the data needed to monitor those indicators.

Dr JAMSHEED MOHAMED (Maldives) said that the draft monitoring framework and the draft action plan would play an important role in the global effort to reduce the burden of noncommunicable diseases. However, Member States, especially smaller and resource-poor countries, would need technical support from the Secretariat to enable them to build the capacity to implement the framework and action plan. Member States should cooperate through information-sharing and active engagement at the regional and global levels. In particular, international collaboration was needed in the control at borders of harmful goods such as tobacco and unhealthy foods and beverages, which were major contributors to many noncommunicable diseases.

Mr LIOW TIONG LAI (Malaysia) commended WHO's work in fulfilling the commitments of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. He endorsed the recommendation that the Health Assembly adopt the draft comprehensive global monitoring framework and the voluntary global targets without reopening discussion on them. The report of the Formal Meeting reflected the importance attached to preventing and controlling noncommunicable diseases at a global level and of the commitment of Member States in that regard. The next crucial step would be the implementation of the framework and targets. He called upon the Secretariat to provide support to ensure that all Member States could collect the necessary morbidity and mortality data.

Dr VALVERDE (Panama) supported the recommendation that the draft comprehensive global monitoring framework and the set of voluntary global targets should be submitted to the Sixty-sixth World Health Assembly for adoption. Without wishing to reopen discussion on the framework and targets, she wished to point out that the indicator relating to access to palliative care as assessed by morphine-equivalent consumption of strong opioid analgesics (excluding methadone) could be construed to mean that the use of morphine should be restricted to cancer patients. That indicator should be clarified in the draft action plan for the prevention and control of noncommunicable diseases 2013–2020.

Dr VALLEJO (Ecuador) welcomed the draft comprehensive global monitoring framework. The proposed set of targets and indicators would support efforts at the national level. Progress had been made globally in tobacco control, but the results had not been easily achieved. In Ecuador, legislation on tobacco control had recently been enacted, and measures aimed at preventing harmful alcohol use were envisaged. Referring to the draft action plan for the prevention and control of noncommunicable diseases 2013–2020, he urged headquarters and the regional offices to focus on developing a policy on palliative care for cancer patients.

Dr SARMENTO P. DA COSTA (Timor-Leste), expressing strong support for the draft comprehensive global monitoring framework, suggested that some countries and regions might wish to include additional indicators and targets in order to monitor progress under national and regional strategies for the prevention and control of noncommunicable diseases, in line with their circumstances. Globalization, lifestyle and diet changes, and high rates of tobacco and alcohol use had led to a rise in noncommunicable diseases in her country, but it still faced a heavy burden of communicable diseases – it was currently facing epidemics of dengue and measles. Multisectoral involvement, including ministries other than health and United Nations organizations, with the participation of nongovernmental organizations, the private sector, and the local community, was essential in order to address the risk factors for noncommunicable diseases, as was prevention through a primary health care approach. The shortage of human resources in Timor-Leste and the limited capacity of the health information system to capture reliable data, particularly on noncommunicable diseases, hindered evidence-based decision-making. The country would welcome international support through WHO in order to strengthen its national health information system and build capacity for data collection.

Professor OSTOJIĆ (Croatia) expressed support for the draft comprehensive global monitoring framework and targets, and agreed that it should be submitted to the Sixty-sixth World Health Assembly for adoption. He also supported the proposed structure of the draft action plan for the prevention and control of noncommunicable diseases 2013–2020. A whole-of-government approach and multisectoral action were crucial to the prevention and control of noncommunicable diseases. Governments should take the lead in the development of national policy frameworks for the reduction of risk factors, and national policies and programmes for the prevention and early detection of diseases, such as cancer-screening programmes, were important. Several such programmes had been implemented in Croatia.

Mr ALLMAN (Barbados) welcomed the consultative process and the consensus on the draft comprehensive global monitoring framework and agreed with the recommendation that the global monitoring framework, including indicators, and the set of voluntary global targets for the prevention and control of noncommunicable diseases should be submitted to the Sixty-sixth World Health Assembly for adoption. Barbados attached great importance to the struggle against noncommunicable diseases, particularly hypertension, diabetes and obesity, which were having a significant impact on its population. Smaller States would face challenges in implementing the policies that would flow from the framework, and collaborative effort at the national and regional levels would therefore be essential.

Ms POLL (Costa Rica)¹ said that her country accorded high priority to the prevention and control of noncommunicable diseases and welcomed the successful conclusion of the work on the comprehensive global monitoring framework. She urged the Board to endorse the framework with its indicators and set of targets, and encouraged Member States to incorporate the voluntary targets into their national strategies. The framework should be integrated into the draft action plan for the prevention and control of noncommunicable diseases 2013–2020.

Mr KLEIMAN (Brazil)¹ outlined the significant challenge that noncommunicable diseases posed to his country. In collaboration with academic institutions, nongovernmental organizations and medical organizations, the Government had drawn up an intersectoral action plan for the prevention and control of noncommunicable diseases, which was in line with WHO's draft action plan and global policies. The mortality rate of those diseases had fallen by 20% in the past 10 years, but rates for cancer and diabetes continued to increase.

He supported the comprehensive global monitoring framework, whose construction was an important step forward in tackling noncommunicable diseases on a global scale. The framework should be integrated into the draft action plan for the prevention and control of noncommunicable diseases 2013–2020 as the two were components of a single strategy. Work on the action plan should continue in a transparent and inclusive manner in order to ensure that it would be an effective tool for achieving the global targets and monitoring the indicators as well as reflecting national and regional realities.

Dr PRIETO ABAD (Colombia)¹ said that the draft action plan for the prevention and control of noncommunicable diseases 2013–2020 should include health promotion as a central strategy for preventing noncommunicable diseases and enhancing well-being. The action plan should distinguish principles from approaches, be evidence-based, and should include an objective relating to social mobilization and promotion of community participation as a means of empowering individuals, families and communities. It should include indicators relating to poverty (a structural risk factor for noncommunicable diseases), other social, economic and demographic variables, and availability of human resources. A mechanism should be put in place to link action plans for the prevention and control of noncommunicable diseases with the action plan for the prevention of avoidable blindness and visual impairment. Lower respiratory tract diseases, a growing problem in Colombia and other countries, should be included among the diseases to be monitored. The research component should include health economics, cost-effectiveness analyses of health systems and studies on inequities in relation to noncommunicable diseases, and participatory action. In addition, education on physical activity should be provided in workplaces and communities.

Dame Sally DAVIES (United Kingdom of Great Britain and Northern Ireland)¹ emphasized her Government's commitment to the prevention and control of noncommunicable diseases, the leading cause of mortality and morbidity, and had made progress in reducing morbidity and mortality due to cardiovascular disease, cancer and respiratory illnesses related to smoking. However, more needed to be done, including empowering people to help themselves. Since the Political Declaration of the High-

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

level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases work had focused on the four main risk factors for noncommunicable disease: tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity. As a minimum, agreement should be reached on indicators and global targets for those risk factors. The proposed set of indicators provided a sound basis for action. Mental health, the subject of another draft action plan before the Board, was an important aspect of noncommunicable diseases that merited increased attention.

Ms AKSEL'ROD (Russian Federation)¹ said that the conclusion of the work on the comprehensive global monitoring framework and agreement on a set of voluntary global targets represented a significant global achievement. The next step would be implementation of the global action plan for combating noncommunicable disease, with focus on achieving the agreed global targets. To that end, population-based prevention measures should be implemented and efforts should be directed towards reducing common risk factors, including tobacco use, excessive consumption of alcohol, unhealthy diet and physical inactivity. A coordinated multisectoral approach, including the participation of government bodies, civil society and the private sector, was essential. Global efforts to prevent and control noncommunicable diseases should be spearheaded by WHO as the lead agency for health in the United Nations system.

Mr EISELE (FDI World Dental Federation), speaking at the invitation of the CHAIRMAN and also on behalf of the World Medical Association, the International Council of Nurses, the International Pharmaceutical Federation and the World Confederation for Physical Therapy and the World Health Professions Alliance, commended the report and the consensus it presented. However, the suggested indicators and targets ignored some important objectives identified in the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases. There was a need to strike a better balance between mortality and morbidity and the priority to protect young people from exposure to risk factors, including unhealthy diets. The absence of any targets for sugar consumption was regrettable and there should be a specific indicator aimed at reducing sugar intake to no more than 10% of total energy intake. The inclusion of indicators and targets for all noncommunicable diseases, including oral diseases, would serve to highlight the importance of strengthening health systems, particularly through the deployment of primary care teams comprising a variety of health professionals, which had proved to be an efficient way of reducing the burden of noncommunicable diseases.

Dr CHESTNOV (Assistant Director-General) welcomed the consensus reached during the Formal Meeting of Member States to conclude the work on the comprehensive global monitoring framework, noting that the work on noncommunicable diseases was directly linked to WHO reform and that the success of the reform process would be judged largely on the extent to which the Organization was successful in curbing such diseases.

The global monitoring framework and indicators would be incorporated into the draft action plan for the prevention and control of noncommunicable diseases 2013–2020. He had noted the concerns raised with regard to databases and the need for a global registry, not just for cancer but also for other diseases, and for cooperation to improve information systems. Most of those concerns would be dealt with in the course of future work on the draft action plan. He thanked Board members from the Eastern Mediterranean Region for articulating their particular concerns and said that the Secretariat would continue to take account of the individual needs of all regions.

It was gratifying that Member States believed that WHO was the right organization to spearhead global efforts in respect of noncommunicable diseases. It would indeed play that role, within the limits of its resources and recognizing that an intersectoral approach was essential.

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

The work undertaken would enable the Secretariat to report on progress made on the comprehensive global monitoring framework, targets and indicators in accordance with paragraph 65 of Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, which requested the Secretary-General, in collaboration with Member States, WHO, and relevant funds, programmes and specialized agencies of the United Nations system to present to the General Assembly at the sixty-eighth session a report on the progress achieved in realizing the commitments made in the Political Declaration.

The DIRECTOR-GENERAL recalled the lengthy process that had culminated in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and thanked Member States, nongovernmental organizations, private-sector entities, academics and scientists for their valuable contributions. The Secretariat would continue that work with a view to improving the health of people in all countries.

The CHAIRMAN said that she had asked the Secretariat to prepare a draft decision that would read: “The Executive Board, having considered the report of the Formal Meeting of Member States to conclude the work on the comprehensive global monitoring framework, including indicators, and a set of voluntary global targets for the prevention and control of noncommunicable diseases, decided to endorse the comprehensive global monitoring framework, including indicators, and a set of global voluntary targets for the prevention and control of noncommunicable diseases, as detailed in Appendix 1 and Appendix 2 respectively of document EB132/6, and further decided to forward the report and the appendices to the Sixty-sixth World Health Assembly for adoption. In addition, the Executive Board requested the Director-General to prepare a proposal for a draft resolution for consideration by the World Health Assembly whereby it would adopt the framework.”

She took it that the proposed wording of the draft decision was acceptable.

The decision was adopted.¹

Draft action plan for the prevention and control of noncommunicable diseases 2013–2020:
Item 6.2 of the Agenda (Documents EB132/7 and EB132/7 Corr.1)

Mr ROMERO PUENTES (Cuba) said that in order to deal with noncommunicable diseases, their risk factors and social determinants effectively, multisectoral action and a health-in-all-policies and whole-of-government approach were needed. Tackling risk factors required a comprehensive strategy that took account of the culture and capacity of different countries and that focused on three main areas: policy-making, community activities and individual care, including health promotion and prevention and control of diseases through sustainable integrated programmes.

The draft action plan for the prevention and control of noncommunicable diseases 2013–2020 constituted a mechanism for reaching the agreed targets. The tobacco-related provisions in the action plan should be updated in line with the decisions taken during the fifth session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control. Although Cuba was not a Party to the Framework Convention, like other non-parties it was committed to tobacco control, had implemented many of the measures called for in the Convention, and had achieved a significant reduction in tobacco use. He would propose that the same types of actions as were envisaged in the global strategy to reduce the harmful use of alcohol – for example, in relation to leadership, awareness and commitment – should also be included in the section on tobacco control.

Mr MIŠKINIS (Lithuania), speaking on behalf of the European Union and its Member States, said that Croatia, the former Yugoslav Republic of Macedonia, Montenegro, Iceland, Serbia, Armenia,

¹ Decision EB132(1).

Bosnia and Herzegovina, the Republic of Moldova, Romania and Georgia also aligned themselves with his statement. He welcomed the integration of the global monitoring framework, indicators and voluntary global targets into the draft action plan. Process objectives and indicators should be included in the action plan in order to show progress not only through outcomes but also through actions performed. Indicators also needed to be devised for the objectives that still lacked them. Existing WHO strategies and tools relating to tobacco use, harmful use of alcohol, unhealthy diet and physical inactivity should be linked to the draft action plan, as should the draft comprehensive mental health action plan.¹

In addition, a regional dimension should be introduced into the draft action plan such that global and regional activities were interlinked and mutually supportive. However, there should be only one global monitoring system covering all aspects of the comprehensive global monitoring framework and the action plan. Given the multidimensional nature of noncommunicable diseases and the potential for competing interests, broad consultation of all stakeholders would be needed before taking decisions. In implementing the action plan, Member States should make their own decisions according to their national circumstances. A systemic, society-wide response was required, together with a health-in-all policies approach addressing the social, environmental and economic determinants of health and health equity. The action plan should not be seen in isolation, but as a cross-cutting instrument whose aim was to reduce the burden of noncommunicable diseases.

Dr MYINT HTWE (Myanmar) said that, in further developing the draft action plan, which he welcomed, it would be essential to involve all technical units across headquarters and the regional offices in order to avoid duplication, improve coordination during the implementation phase and foster a sense of ownership at all three levels of the Organization. Several technically sound regional strategies had been developed to deal with different noncommunicable diseases; they should be reviewed and used in further work on the action plan. The Secretariat might also wish to consider putting them together in a single compendium and making it available on the WHO web site. Country offices would have an important role to play in implementing the action plan because they could work closely with health ministries, different agencies and nongovernmental organizations at country level and incorporate some of the relevant activities contained in the action plan in country office workplans. It was crucial to ensure that the actions proposed in Appendix 2 of the report for United Nations funds, programmes and agencies were actually being implemented at country level. To that end, the Board might wish to consider including in the action plan a mechanism for its implementation in a step-wise manner in countries, with the involvement of the various partners and stakeholders.

Dr AL-MARRI (Qatar), speaking on behalf of the Member States of the Eastern Mediterranean Region, congratulated WHO for initiating action to implement the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. The countries of the Region fully supported the draft action plan and welcomed the six objectives and overarching principles, which were appropriate. However, the overarching principles of human rights and universal access and equity could be combined into a single principle. The countries of the Region also supported the structure of the objectives and actions, which was essentially the same as the 2008–2013 action plan for the global strategy for the prevention and control of noncommunicable diseases. The separate sections describing actions to be taken by the Secretariat, Member States and international partners were welcome, but those dealing with the Secretariat and Member States contained too much unnecessary or irrelevant information; it should be clearer and more sharply focused. The actions allocated to the Secretariat were too broad and did not always relate to those allocated to Member States. For example, there was no clear statement of what specific actions were needed in order to strengthen countries' capacity to tackle noncommunicable diseases. In particular, a clear road map was needed for addressing weaknesses in countries' capacity for surveillance, integrating management of noncommunicable diseases into primary health care, and

¹ Document EB132/8.

strengthening human resources. It was therefore essential to revise the current draft taking into account the key needs of Member States in clear and specific terms.

Dr SHEKU DAOH (Sierra Leone), speaking on behalf of the Member States of the African Region, said that the burden of noncommunicable diseases was increasing the pressures on health services. It was therefore important to strengthen health promotion and prevention efforts. The risk factors and social determinants associated with noncommunicable diseases were driven by economic transition, globalization of trade and marketing, changes in food consumption patterns, and cultural beliefs and values and required commitment and action at both global and national government levels.

It was important to bear in mind the obstacles that had hindered successful implementation of the 2008–2013 action plan, namely weak political commitment, inadequate national funding and weak regulation and enforcement of national policies on prevention and control of key risk factors for noncommunicable diseases. It was also important to strive to achieve equity between countries, build capacity in developing countries and facilitate access to affordable medicines and diagnostics and transfer of technologies and expertise within the framework of North–South, South–South and triangular cooperation.

Mr McIFF (United States of America) said that the draft action plan accurately reflected the recommendations made by Member States during the second informal consultation in November 2012 and provided a strong basis for action. He supported the plan's goal and appreciated the balance between prevention and control. He particularly appreciated the inclusion of objective 5 on research and development and objective 6 on strengthening monitoring and surveillance activities. All proposed actions for Member States under each objective should be based on the best available evidence and be amenable to adaptation in keeping with the national context and development of the existing knowledge base. The narrow focus of the action plan on selected interventions, such as those described as "best-buys", was too prescriptive. Instead, the Secretariat should provide support to Member States in evaluating and implementing evidence-based options that suited their needs and capacities.

Multisectoral action was crucial in preventing noncommunicable diseases and managing their long-term consequences. He endorsed WHO's leadership role in facilitating coordinated action among organizations in the United Nations system, development banks and other regional and international organizations. Before the next Health Assembly, WHO should explore how best to harmonize its leadership role across the United Nations system. Furthermore, governments, multilateral and civil society organizations and the private sector needed to work together in effective and sustainable ways on the social and environmental factors that contributed to noncommunicable diseases. All the actors involved must be treated equally and given a voice. The contribution of the nongovernmental sector had been useful and he asked for their input to be made before Member States took part in further consultations on the draft action plan.

In the work before the Health Assembly, consideration could be given to collectively developing a single omnibus draft resolution on noncommunicable diseases, encompassing the comprehensive global monitoring framework, the action plan and recommendations on multisectoral action.

Dr AMMAR (Lebanon) said that the draft action plan rightly maintained the structure of the 2008–2013 action plan for the global strategy for the prevention and control of noncommunicable diseases. He welcomed its identification of separate actions for Member States, the Secretariat and national partners. Some indicators were not compatible, however, with the capacity of information systems in many developing countries and the targets were too ambitious. Many of the proposed actions for Member States resembled principles and recommendations and needed to be more pragmatic; they should take account of Members' specificities and be adapted to national priorities. Some Secretariat actions were very broad and not directly linked to countries' actions. They should be more focused and take account of differences between regions. It would be more useful to have plans tailored to the regional level, with targets and actions that could be adapted by the regional committees. Interventions by international partners, on the other hand, should be centrally coordinated, particularly where financial resources were concerned, and resources should be allocated with the

framework of an inclusive and transparent dialogue, in keeping with WHO reform. The draft action plan needed to be revised before being submitted to the Health Assembly.

Mr LIOW TIONG LAI (Malaysia) commended the draft action plan, which accurately reflected the discussions during the second informal consultation in November 2012. The next consultation, scheduled to take place in March 2013, should be a formal meeting to finalize the action plan. As the comprehensive global monitoring framework had been unanimously endorsed, the way forward was clear. The challenge facing Member States was how best to implement the action plan within different settings. In addition, all relevant United Nations and international partners needed to endorse the global action plan and take part in implementing it. National action plans could not be developed and endorsed exclusively by health ministries if they were to be implemented effectively. WHO remained the lead agency in the United Nations system for health, but the support of other relevant United Nations bodies was essential if the agreed targets were to be reached. He expressed confidence that the Director-General would be able to enlist the necessary support and recommended that the draft action plan be adopted by the Sixty-sixth World Health Assembly.

Dr Ren Minghui took the Chair.

Dr ÁLVAREZ LUCAS (Mexico) expressed support for the objectives and strategies set out in the draft action plan, which provided a broad framework that countries would need to adapt to accommodate their response capacity. It would be essential to identify which levels of government would carry out the various actions proposed for Member States. The actions envisaged under objective 4 for human resource development were particularly important and should receive greater emphasis. Resources available in the academic and private sectors should be taken into account in assessing current response capacity. International exchanges for training should be encouraged and successful training models should be shared.

Professor HALTON (Australia), welcoming the draft action plan, concurred that the action plan should be adaptable to the circumstances of individual countries. She supported the proposed informal consultation in March 2013 and expected the final document to elaborate further the issues raised by Member States. In the preparation of the draft action plan, more reflection was needed in some areas, particularly in order to allow the necessary flexibility. More consideration should be given to the perspectives of indigenous peoples and to maternal, child and sexual health issues.

Dr LARSEN (Norway) welcomed the draft action plan and the integration of the draft global monitoring framework and voluntary global targets therein. Member States' work needed well-functioning health systems centred on primary health care, with skilled health workers who could diagnose and provide essential treatment or refer individuals with noncommunicable diseases. He thus also welcomed objective 4 on health systems (paragraphs 41 to 46 of the action plan) and asked the Secretariat to seek synergies between efforts to achieve universal health coverage and action on noncommunicable diseases and to ensure internal integration of WHO's programmes. He welcomed the embedding of social, economic and environmental determinants of health in the draft action plan, which could also further reflect the association between mental health and noncommunicable diseases. He observed that the draft action plan for the prevention and control of noncommunicable diseases 2013–2020 and the draft comprehensive mental health action plan 2013–2020 had been developed in parallel for good reasons. Although the Secretariat planned to report every five years on progress in implementing the action plan, he would prefer intermediate reporting in relevant documents.

He supported the plan to hold an informal consultation in March 2013 and encouraged stronger participation by civil society in that meeting. During the informal consultations on the draft comprehensive mental health action plan held in November 2012, academics and representatives of nongovernmental organizations had discussed the draft action plan with Member States before the latter had held a separate informal consultation. That approach had worked well.

Dr UDVAL NATSAG (Mongolia) proposed that “launching negotiations to conclude an international convention on alcohol control” should be added to the proposed actions for Member States in paragraph 38 of the draft action plan. She further proposed that wording requesting WHO to draft an international convention on reducing the harmful use of alcohol should be added in paragraph 39.

Ms EPHREM (Canada)¹ commended WHO’s leadership in preparing the draft action plan and the good progress made, and in advancing the work on the global monitoring framework, both of which represented significant steps towards meeting a key commitment under the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. However, the global monitoring framework needed to be integrated into the action plan in order to clarify how the actions taken would support the achievement of targets. Given that countries were at different stages in preventing and controlling noncommunicable diseases, the draft action plan should include a phased approach to implementation. That would help Member States to prioritize actions at a pace suited to their circumstances and to choose from a full spectrum of evidence-based interventions rather than just the “best buys” identified in the draft action plan. Options for strengthening and facilitating multisectoral action for prevention and control of noncommunicable diseases, as discussed by the United Nations General Assembly, should be included in the next draft of the action plan. She looked forward to the informal consultation to be held in March 2013.

Dr THAKSAPHON THAMARANGSI (Thailand)¹ welcomed the draft action plan. The challenge would be to implement it successfully. He endorsed the proposal that it needed to include an implementation mechanism, which should be geared towards achieving the global targets. At the same time, it should address the need to support countries in setting and reaching their own national and subnational targets as that would contribute to the achievement of global targets. That action should be included under the first objective.

The current draft needed more work in order to reconcile the sometimes-conflicting interests and concerns of Member States. The identification of goals and objectives should be based on evidence. The action plan should place public benefit above any conflict of interest among different stakeholders. Unfortunately, the draft action plan did not adequately address that important issue. Neither did it envisage adequate support for Member States in addressing social determinants of health, including how to prevent the detrimental impact of bilateral and multilateral trade agreements.

In objective 4, the action plan should include provision of support to Member States in promoting the availability and accessibility of essential medicines and technologies, which were crucial for functioning health systems. Some essential medicines were expensive and unaffordable in low-income countries. The draft action plan should better reflect the call in the Political Declaration of the United Nations High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases for full use of the flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights. Thailand would participate in the third informal consultation and would continue to contribute to the further development of the action plan.

Dr NIU (International Labour Organization) said that ILO had participated in the preparations for the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and welcomed the draft global plan of action, which would serve as a road map for implementing the Political Declaration. The United Nations Secretary-General had noted that part of the burden of noncommunicable diseases was attributable to occupational risk factors including exposure to chemical, physical, biological, ergonomic and psychosocial hazards at work and that regulation to prevent exposure to such hazards must be implemented. Annually an estimated 2.02 million workers died from work-related diseases, most of which were noncommunicable

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

diseases. ILO had been working with governments to implement international labour standards aimed at preventing occupational diseases, and planned to strengthen its programme on prevention of occupational diseases in the coming year, working closely with its constituents and other partners. In that connection, he welcomed the fact that the draft action plan provided opportunities for the involvement of international partners. ILO could usefully contribute to the action plan. It had selected "Prevention of occupational diseases" as the theme for World Safety and Health at Work Day 2013 and looked forward to working closely with WHO on the action plan.

Mr EISELE (FDI World Dental Federation), speaking at the invitation of the CHAIRMAN, welcomed the approach taken in preparing the draft action plan based on a set of overarching principles and six objectives, but expressed regret at the omission of oral diseases. Such diseases were linked to major chronic diseases, such as diabetes, HIV/AIDS and cardiovascular diseases. That link had been recognized in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases as risk factors, and oral health should be included explicitly in the revised action plan.

MS DI GIROLAMO (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, said that, although the report recognized that many risk factors for noncommunicable diseases lay beyond the reach of health policy and that significant health gains would be made by addressing social determinants such as education and gender, such an approach was articulated only weakly in the global monitoring framework. The narrow focus on four diseases and four behavioural risk factors could promote a vertical approach rather than a more broadly integrated primary health care one. The proposed strategy could also lead to an artificial fragmentation in the approach to different chronic conditions. She suggested that consideration should be given to integrating all action plans relating to prevention and control of noncommunicable diseases.

The proposed engagement with partners in the private sector gave cause for concern, particularly the potential influence of the pharmaceutical industry in shaping the research agenda and public health strategies. She therefore urged Member States to ensure that potential conflicts of interest were properly managed.

Dr SEYER (World Medical Association), speaking at the invitation of the CHAIRMAN, welcomed the draft global action, but expressed regret that, although the life-course approach was included in the plan's overarching principles, it had not been reflected in the global monitoring framework. Children were an important target group in the prevention of noncommunicable diseases and should be included in the targets and indicators on physical activity, obesity, alcohol and tobacco use. Reducing the burden of noncommunicable diseases required a holistic, people-centred approach built around primary health care, including treatment, rehabilitation and oral health. She suggested that such an approach be included under objective 4 in the draft action plan.

Mr ADAMS (Union for International Cancer Control), speaking at the invitation of the CHAIRMAN and on behalf of the International Diabetes Federation, the International Union Against Tuberculosis and Lung Disease and the World Heart Federation, which together made up the NCD Alliance, congratulated WHO on its leadership in fulfilling the commitments made in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. Agreement on a set of targets had provided a vision of what should be achieved. The draft action plan would provide a road map for reaching those targets. He suggested that Member States might consider five priorities for the action: effective leadership; sustained resources; synergy between the action plan and the broader health and development agenda; multisectoral engagement; and accountability, including biennial reporting on implementation of the global action plan by the Secretariat to the Health Assembly and United Nations General Assembly. The NCD Alliance stood ready to support the Secretariat and Member States in the development and implementation of the global action plan.

Ms GROVES (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, welcomed the draft action plan. It encouraged the establishment of synergies with other noncommunicable diseases, including neurological, musculoskeletal and mental health disorders, which would maximize opportunities for preventing and managing all chronic diseases. The action plan recognized the importance of universal health coverage; acknowledged that noncommunicable diseases impeded economic and social development; and highlighted the role of cross-sector partnerships and the full and active participation of people living with such diseases – all of which were welcome. However, the potential of civil society, particularly patients' organizations, was not fully explored in the draft action plan and she urged that the proposed actions for the international community be expanded to reflect the contribution they could make to health promotion, prevention and the management of noncommunicable diseases. She welcomed inclusion of the global monitoring framework in the action plan, although the targets, objectives and indicators needed to be better integrated to maximize their impact. All policies, programmes and strategies should be based on patient-centred health care.

Dr CHESTNOV (Assistant Director-General) observed that the proposals contained in the draft action plan had all come from Member States. With regard to the need for further guidance in developing the action plan, the Secretariat would produce a second draft action plan in February 2013 incorporating members' comments. The Secretariat proposed to hold informal dialogues with relevant nongovernmental organizations and selected private-sector entities on 6 and 7 March 2013, to be followed by an informal consultation with Member States and organizations in the United Nations system on 11 and 12 March 2013 (with an option to continue the discussions on the morning of 13 March).¹ It would review the inputs and submit a revised draft of the action plan to the Sixty-sixth World Health Assembly.

There were both objective and subjective difficulties in preparing such a document. Over the previous 12 years, WHO had been working to raise noncommunicable diseases to the top of the political agenda, and the time had come to put words into action, which would require much hard work. It was time, for example, to determine how the Organization would harmonize its work with nongovernmental organizations and the private sector, which was essential in order to avoid conflicts of interest. He understood that universal coverage needed to be a component of the action plan and recognized WHO's responsibility in supporting countries in implementing the plan.

Dr St. John resumed the Chair.

The DIRECTOR-GENERAL said that, having received and compiled the comments and inputs from Member States and other contributors, the next step for the Secretariat would be to find the right balance between, for example, the flexibility favoured by some Member States – which necessarily required a broad approach – and the more focused approach urged by others. As had been pointed out, it was also necessary to bear in mind that countries were at different stages of development and therefore had different priorities. The Secretariat strove to produce documents that would be relevant to all Member States and useful in the development of national plans. At the same time, it recognized the need to limit the number of documents produced. With that in mind, it would endeavour to comply with the request by Member States that the next version of the action plan should be linked to previous action plans on harmful use of alcohol, tobacco control and mental health.

The member for Mongolia had called on the Secretariat to initiate the development of an instrument relating to the harmful use of alcohol along the lines of the WHO Framework Convention on Tobacco Control. The preparation of the Framework Convention had been a major undertaking, and a move in the direction of a similar convention on alcohol would require consensus by Member States. It had become clear in recent years that, although Member States agreed on the objective of reducing the

¹ The Secretariat would confirm the dates after the Board's session.

harmful use of alcohol, not all supported the idea of a convention. The Secretariat stood ready to carry out the wishes of Member States, but it could not start work on a convention until the matter had been discussed and agreed by Member States. Hence, it would probably not be possible to include the wording requested before the next version of the action plan was submitted to the Health Assembly.

The CHAIRMAN said that, in the absence of further comment, she would take it that the Board wished to note the report and that it agreed to the process outlined for preparing the final draft action plan for consideration by the Sixty-sixth World Health Assembly, including the informal consultations in March.

It was so agreed.

The meeting rose at 17:25.

THIRD MEETING

Tuesday, 22 January 2013, at 09:10

Chairman: Dr J. ST. JOHN (Barbados)

NONCOMMUNICABLE DISEASES: Item 6 of the Agenda (continued)

Draft comprehensive mental health action plan 2013–2020: Item 6.3 of the Agenda (Document EB132/8)

Dr MYINT HTWE (Myanmar) said that developing countries needed to strengthen the mental health workforce, including paramedics and other health workers, in order to ensure the effective implementation of the draft comprehensive mental health action plan 2013–2020. In those countries, mental health care often had to compete with other health priorities. As mental health professionals could not easily be recruited from other countries because of the cultural sensitivities and specificities of each country, he requested the Secretariat's support for both short-term and long-term training programmes, to be provided through WHO collaborating centres and mental health associations.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) observed that mental disorders covered a wide range of conditions, some of which, if left untreated, often led to suicide. Most mental health services in Cuba had been transferred to primary health-care institutions that provided a link between the community and general hospitals, including paediatric services. Implementation of the mental health action plan should centre on primary care, supported by the wider health system, with a greater emphasis on health promotion and prevention aimed at children of both sexes, adolescents and the elderly. The action plan should also include strategies to tackle the damaging effects of natural disasters on mental health. He fully supported the draft action plan.

Dr AL-MARRI (Qatar), speaking on behalf of the Member States of the Eastern Mediterranean Region, acknowledged that the growing global burden of mental disorders, their impacts on health and their social, human rights and economic consequences underlay the need to develop policies and strategies for disease prevention and promoting mental health, including the comprehensive mental health action plan. He expressed support for the consultative process and the resulting draft action plan, with its international, regional and national targets. It would furthermore afford to people with mental disorders the opportunity to exercise fully their human rights, thus affirming the fundamental principle of no health without mental health. It also entailed a new challenge and commitment, however, on the part of Member States to elaborate related national action plans. Support would be required in order to implement such plans, as the human and other resources needed for dealing with psychosocial conditions were in short supply.

Mr KASE (Papua New Guinea) said that the social, human and economic difficulties associated with the growing burden of mental disorders were having a major impact on the already weakened health systems of countries in the Western Pacific Region. He commended the draft action plan and supported its submission to the Sixty-sixth World Health Assembly. His Government looked forward to receiving WHO's leadership and guidance in implementing the plan and putting in place the appropriate systems, structures and human resources to respond to the difficulties.

Professor COLL SECK (Senegal), speaking on behalf of the Member States of the African Region, expressed appreciation for the draft comprehensive action plan. More than 80% of people with mental disorders in low-income countries received no treatment and the few specialized health facilities were concentrated in urban areas; an alarming number of mentally ill people wandered in towns and the country. A regional consultation in August 2012 had underlined key points in the action plan, including the need to strengthen multisectoral collaboration; to improve the prevention and treatment of mental disorders through primary health care; to train specialized human resources; to treat addictions by means of substitution therapy; to promote the rights of persons with disabilities, including mental disorders; to support the creation and strengthening of organizations of the people concerned and their families; and to supplement information systems by adding basic mental health indicators.

She asked why there were no objectives in the draft action plan specific to health-system strengthening, a prerequisite for many of the proposed actions. A footnote should be inserted for the indicator pertaining to global target 3.2 explaining the term “completed suicides” for the benefit of non-health sector actors.

Dr REN Minghui (China) welcomed the Secretariat’s work to promote mental health at the global level and its analysis of the burden of disease associated with mental disorders, the impact on the patients’ families, and the lack of adequate mental health care and human resources. Endorsing the principle of “no health without mental health”, he said that his Government’s work in the field of suicide prevention had already led to a significant reduction in the suicide rate and, hence, it would be difficult for his country to attain the target of a further 20% reduction by 2020 (global target 3.2).

Dr JAMSHEED MOHAMED (Maldives), endorsing the statement by the member for Myanmar, said that the integrated and holistic nature of the draft action plan would be crucial to its successful implementation, especially in developing countries. Among the main obstacles hindering the promotion of mental well-being in the community and universal access to mental health services as a fundamental human right was that of tackling the underlying social determinants of mental health. Timely access to appropriate medicines was especially difficult in small countries without a local pharmaceutical industry, such as his, which had been striving to provide free medicines to people with mental disorders for 20 years. WHO had a key role to play in overcoming basic procurement and logistics-related problems by promoting better collaboration and coordination among Member States and in facilitating resource mobilization.

Mental disorders were a much-neglected problem in many parts of the world, and high levels of stigmatization and discrimination led to the violation of individuals’ basic human rights. Given that many Member States lacked the necessary expertise and an appropriate sociopolitical and legal environment to implement the action plan, he urged the Secretariat to maintain its support and commitment as the global leader in public health.

Ms PENEVEYRE (Switzerland) congratulated the Secretariat on forging a common vision in the draft action plan from the range of different viewpoints on mental health, which was an important and sensitive subject that continued to receive insufficient attention. She welcomed the call for a reappraisal of approaches to treatment and prevention in order to redirect resources towards smaller-scale structures that were better integrated into society, which would help to improve the continuity of care and the integration of patients; and that the plan recognized the importance of the social determinants of health and the need for equity. Furthermore, mental health should be considered throughout the life-cycle, with the health sector committed to preventing any discrimination based on gender identity or sexual orientation. She attached great importance to activities to monitor the mental health of health workers themselves, including humanitarian workers. A reliable knowledge base would be needed in order to assess the efficacy of any action undertaken.

Dr VALLEJO (Ecuador) said that the draft action plan would provide a powerful impetus for a positive approach to mental health, with a particular emphasis on the need for multisectoral collaboration. It highlighted the actions to be taken to reduce the high rate of mental health problems, offering indicators for assessing the progress and impact of those actions in Member States. The targets proposed for 2020 were realistic and achievable with the continuous support of WHO and the sharing of information and experience. The draft action plan would serve to guide his Government in its efforts to develop a mental health model as part of its new mental health policy, which would include promotion and prevention activities, as well as mental health service provision at the primary, secondary and tertiary levels. He therefore supported the draft action plan.

Mr KOLKER (United States of America) commended the substantive and ambitious draft action plan. He fully supported the overall goal of the plan and its six cross-cutting principles, which were the outcome of an inclusive process; nothing should prevent its adoption by the Sixty-sixth World Health Assembly. His delegation and others had submitted in writing some suggested amendments to the Secretariat, and he requested that a brief period be allocated for an online technical consultation before the next Health Assembly in order to improve the targets and indicators, without revisiting the substance of the draft. Particular emphasis should be placed on the need to ensure that all mental health programmes safeguarded patients' personal data, which was an important incentive when encouraging people to seek treatment. He stated that an item on Alzheimer's disease would be proposed for inclusion on the provisional agenda of the Board's session in May 2013.

Professor NICKNAM (Islamic Republic of Iran) supported the draft action plan, but listed points for further consideration. First, the group of persons at high risk of mental disorders should be extended to include illicit drug users, a growing number of whom were occupying beds in his country's psychiatric hospitals. Secondly, the treatment gap for mental disorders (global target 2) could be bridged through a dual strategy of strengthening the primary health care system and introducing family-practice programmes; WHO's *mhGap Intervention Guide* provided robust guidelines that would help general practitioners to do some of the complex work of psychiatrists in a simpler form, especially in the area of psychological support. Thirdly, the action plan would help to strengthen information systems, evidence and research (objective 4 of the draft action plan) if patient-centric case details were entered into digital "suicide registries". Information systems were crucial for monitoring mental health and illicit drug use, predicting trends and assessing the effectiveness of interventions, but the value of surveys as a complementary tool should not be neglected.

Dr GRABAUSKAS (Lithuania), speaking on behalf of the European Union and its Member States, said that Croatia, the former Yugoslav Republic of Macedonia, Montenegro, Iceland, Serbia, Bosnia and Herzegovina, the Republic of Moldova, Armenia, Georgia and Norway aligned themselves with his statement. With depression predicted to become a leading contributor to the global burden of disease by 2030, the European Union endorsed the current focus on mental health and appreciated the quality and structure of the draft action plan. It especially welcomed the recommended distribution of tasks among the main stakeholders. It fully agreed with the plan's vision, principles and approaches, but wanted to see a stronger focus on social inclusion and equal opportunities for people with mental health problems. Multisectoral collaboration was crucial to promotion and prevention activities, and should at least involve the social, employment, education, criminal justice and housing sectors.

He drew attention to the need to integrate mental health into general health-service provision, especially primary health care, and to encourage the development of non-institutionalized services. Children and youth should be designated as key target groups for health promotion and disease prevention strategies; efforts must be made to combat stigmatization, which undermined the willingness of people with mental health disorders to seek assistance and aggravated the social impact of mental disorders; the frequent co-occurrence of mental and physical health problems should be tackled by establishing firmer links between the draft action plan and the existing 2008–2013 action plan for the global strategy for the prevention and control of noncommunicable diseases. He agreed with the objective of suicide prevention, but noted that improved monitoring and reporting at the

global level would increase the number of cases recorded. Mental health must be regarded as a high priority for action, with adequate resource allocation.

Dr EL MENZHI (Morocco) commended the draft action plan, with its key targets and indicators for continuous monitoring and evaluation of implementation. In addition to an emphasis on multisectoral collaboration, it also sought to forge links with other WHO programmes and strategies. Its implementation would require constant provision of support from the Organization to Member States in training and technical assistance, and the mobilization of human resources at the national level. He strongly supported the plan.

Dr AMMAR (Lebanon) said that the multisectoral approach to mental health would benefit from a focus on the education sector as a key vector for change. Among the considerations to be taken into account in the final draft of the action plan was the fact that more than half of all mental disorders began at school age, stemming from adverse childhood events such as physical and sexual abuse. Close partnerships should be developed between health and education ministries in order to explore how best to empower teachers, pupils and parents to recognize mental disorders and prevent adverse events in childhood. The treatment gap affecting mental disorders, in developed and developing countries alike, was the result of a lack of information rather than stigmatization. He suggested that mental health insurance should be included in any health insurance policies offered by both the public and the private sectors.

Mr LIOW TIONG LAI (Malaysia) drew attention to the fact that mental health promotion and the prevention of mental health disorders were public health priorities in his country, as reflected in the establishment of a mental health promotion advisory council and the introduction of a five-year plan to reduce the national suicide rate. He fully supported the adoption of the draft action plan. The efforts that Member States would have to make to collect data and measure progress against the specified indicators would require multi-agency collaboration and a uniform data collection methodology in order to enable global comparisons.

Dr UDVAL NATSAG (Mongolia) fully supported the draft action plan, agreeing with its objectives, principles and approaches and the proposed action for Member States. Mental health problems and the associated burden of disease varied between and within countries, according to the infrastructure and the social, cultural and economic contexts. There was a growing need to assess the disease burden and the role of evidence-based interventions. Her country's Parliament had recently approved a revised law on mental health. Mongolia had launched its first mental health survey but progress had been slow owing to a lack of technical and financial capacity. She therefore urged WHO to mobilize resources to strengthen health information systems and research capacity for informing local, national and regional policy-making. She also drew attention to the urgent need for increased resource allocation at the national and international levels for effective school-based mental well-being programmes.

Professor HALTON (Australia) observed that her country prioritized mental health, having a minister holding that portfolio. She joined previous speakers in commending the draft action plan. It was, on the whole, an excellent document, but it should give more attention to early intervention, which had the potential to prevent a lifelong struggle with mental health problems, as well as on workforce participation, in order to keep people with mental disorders connected to the broader community, an aspect that was fundamental to human rights. Furthermore, some of the targets needed slight adjustment, in view of the reporting difficulties encountered by some countries owing to problems with issues such as civil registration and assessing suicide rates. Global target 2 on reduction of the treatment and service gap, which dealt principally with qualitative issues, might also require amendment.

Professor OSTOJIĆ (Croatia) said that mental health care was a public health priority, as mental health disorders frequently began in early adulthood and continued as a chronic condition, requiring significant health-care input and adversely affecting the quality of life of patients and their families. He noted the need to shift mental health care from large specialized institutions to community-based public health institutions; to promote the exchange of best practices; to improve mental health monitoring; to identify approaches to raise public awareness of mental health and, hence, to minimize the stigmatization of mental disorders. Emphasis should therefore be placed on cooperation between health systems and civil society, including nongovernmental organizations. He fully supported the draft action plan.

Dr ÁLVAREZ LUCAS (Mexico) commended the draft action plan, which would have a major impact on a problem of global proportions. Drawing attention to objective 4, however, he said that the global target for 80% of countries to collect and report at least a core set of mental health indicators every two years was too vague and that the action plan should identify the minimum set of epidemiological information that countries would have to report in order to make comparable and exchangeable data available on suicides and the other issues highlighted in the document.

Dr SARMENTO P. DA COSTA (Timor-Leste), recalling that Timor-Leste was a new, post-conflict country, said that its population was experiencing many mental health problems that affected adults and children alike, but that it lacked relevant data on the subject. She was therefore grateful to WHO for having developed the draft action plan, and strongly supported the overall goal. The plan should take into account the need for appropriate institutional, legal, financing and service arrangements to meet mental health needs, as well as the fact that incorporating mental health services into the existing health-care system rendered them not only more effective, but also less stigmatizing. Community-based care was more acceptable and sustainable than a tertiary service. Primary prevention strategies should include the promotion of mental well-being as well as treatment. Furthermore, a strong civil society, with the commitment of governments, the involvement of relevant stakeholders and the clear identification of areas of action, would make mental health policies, laws and services more effective and accountable. Mental health issues should be incorporated into other relevant sectoral policies.

Dr AL-HINAI (Oman)¹ drew attention to the fact that many mental, neurological and substance use disorders began before the age of 14 years and urged multisectoral collaboration for universal and targeted interventions. Member States should revise and update their national action plans, develop mental health legislation and allocate sustainable resources in order to establish the framework for meaningful action aimed at providing integrated mental health services to bridge the treatment gap. He supported the draft action plan.

Ms EPHREM (Canada)¹ strongly supported the draft action plan. Given the importance of its targets and indicators for monitoring and measuring progress in its implementation, she requested time to review their feasibility and to consult with stakeholders. She therefore endorsed the suggestion by the member for the United States of America for an online consultation.

Dame Sally DAVIES (United Kingdom of Great Britain and Northern Ireland)¹ echoed the comments by the member for Australia on early intervention. She welcomed the draft action plan and applauded the inclusive and collaborative manner in which it had been drawn up. Mental health was central to her Government's social policy, in which it was regarded as being of an equal status to physical health. She took a personal interest in tackling stigmatization and supporting mental well-

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

being in the workplace, as well as in observing the effects of continuing austerity on the general mental health of the population, a matter that could be taken up at the global level within WHO.

Mr DESIRAJU (India)¹ joined the previous speakers in expressing appreciation and support for the draft action plan. Considerable progress had been made in the mental health agenda over the previous year. Member States would have important work to do at the national level, in which the Secretariat would, he hoped, be ready to lend its support.

Dr WIRANPAT KITTITHARAPHAN (Thailand)¹ welcomed the draft action plan as a significant step in tackling mental health problems, especially in view of its balanced approach to promotion, prevention, treatment and rehabilitation. Effective implementation of the plan would need synergies with other global, regional and national strategies and plans. Other factors determining implementation included: the state of readiness of health systems, especially the mental health workforce, and attitudes in society towards people with mental disorders. At present, the draft action plan did not address the need for a whole-of-society approach. Thailand was willing to participate in the further discussions, including the proposed online consultation. The final draft of the plan should include an indicator and target for resource mobilization, and the issue of the Global Mental Health Observatory should be reconsidered.

Ms NAUGHTON (CBM), speaking at the invitation of the CHAIRMAN, congratulated WHO on the draft action plan, and expressed her appreciation of the consultative process that had enabled her Organization to provide input. CBM, which was currently translating, adapting and using WHO's *mhGap Intervention Guide* to improve services for people with mental health disorders in the poorest communities, supported the objective of improving access to good quality, community-based care and treatment, which it regarded as part of a holistic process of social inclusion. She further commended WHO's innovative work to address human rights abuses faced by people with psychosocial disabilities through its QualityRights initiative. The draft action plan captured the need for multisectoral collaboration at all levels in order to tackle the continued marginalization and stigmatization faced by people with psychosocial disabilities and to ensure their active participation in the implementation and monitoring of the action plan.

Ms YAMADA (World Federation for Mental Health), speaking at the invitation of the CHAIRMAN, noted that the draft action plan reflected, to a significant extent, the views expressed by participants in the consultative process that had culminated in its elaboration, including the results of a survey of 500 civil-society organizations conducted by her own organization. It could therefore be assumed that there was extensive global support for the draft action plan and for its adoption by the World Health Assembly in May 2013. Her organization had drafted a People's Charter for Mental Health, based on the findings of the above-mentioned survey, which discussed possible further action by governments and nongovernmental organizations. Strong international support was already emerging for a special session of the United Nations General Assembly on mental disorders and their inclusion in the Sustainable Development Goals from 2015.

Dr CHESTNOV (Assistant Director-General) thanked speakers for their comments and affirmation that the plan was comprehensive, well-structured and results-based. The final draft would reflect their suggestions regarding health system strengthening with provision of support by the Secretariat, and the prioritization of such subjects as suicide, Alzheimer's disease, human rights and stigmatization. In the context of the close links between physical and mental health, there would be common ground in the medium term between the mental health action plan and the action plan for the global strategy for the prevention and control of noncommunicable diseases, and joint planning could

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

be undertaken in those areas. Aside from the issues of statistics and measurement, the training of senior managers, registries, the social determinants of health, multifunctionality and legislation, attention could also be paid to the mechanisms used by the Convention on the Rights of Persons with Disabilities, as well as the use of indicators and references in national reports. More work would also need to be done on indicators and guidance on preparation of national plans.

The DIRECTOR-GENERAL affirmed that the draft comprehensive mental health action plan was indeed the first plan of its kind to have been developed by colleagues within the Organization, but that had only been possible because of the extensive and inclusive consultation, including the input of Member States, civil society and other sectors. It had been a learning process for the Secretariat. The draft action plan would be revised in the light of specific comments and suggested changes. All comments on ways of improving the indicators and targets should be submitted to the Secretariat. The online consultation requested by the member for the United States of America would be arranged. She suggested that the consultation should continue until the end of February 2013; the draft action plan would then be revised for submission to the Sixty-sixth World Health Assembly for its consideration.

The CHAIRMAN took it that the Board wished to take note of the report and to approve the process outlined by the Director-General for the finalization of the draft comprehensive mental health action plan 2013–2020, for submission to the Sixty-sixth World Health Assembly.

It was so agreed.

Draft action plan for the prevention of avoidable blindness and visual impairment 2014–2019:
Item 6.4 of the Agenda (Document EB132/9)

The CHAIRMAN drew attention to a draft resolution on universal eye health: a global action 2014–2019, which read:

The Executive Board,
Having considered the report on universal eye health: a draft global action plan 2014–2019,

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

The Sixty-sixth World Health Assembly,

PP1 Having considered the report and draft global action plan 2014–2019 on universal eye health;

PP2 Recalling resolutions WHA56.26 on elimination of avoidable blindness and WHA62.1 and WHA59.25 on prevention of avoidable blindness and visual impairment;

PP3 Recognizing that the global action plan 2014–2019 on universal eye health builds upon the action plan for the prevention of avoidable blindness and visual impairment for the period 2009–2013;

PP4 Recognizing the linkages between some areas of the global action plan 2014–2019 on universal eye health and efforts to address noncommunicable diseases and neglected tropical diseases,

1. ENDORSES the global action plan 2014–2019 on universal eye health;
2. URGES Member States:
 - (1) to strengthen national efforts to prevent avoidable visual impairment including blindness, through, inter alia, better integration of eye health into national health plans and health service delivery, as appropriate;

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

<p>1. Resolution: Universal eye health: a global action plan 2014–2019</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): n/a</p> <p>How would this resolution contribute to the achievement of the Organization-wide expected result(s)?</p> <p>There is no link to the Programme budget 2012–2013. The implementation of the action plan will commence in 2014.</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): n/a</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) Six years (covering the period 2014–2019)</p> <p>(ii) Total: US\$ 32.07 million (staff: US\$ 27.37 million; activities: US\$ 4.70 million)</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).

Preparatory work on the draft of Universal eye health: a global action plan 2014–2019 was funded within the Programme budget 2012–2013, but the implementation of the action plan is to commence in 2014.

Total: US\$ nil (staff: US\$ nil; activities: US\$ nil)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

n/a

Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

No, as the implementation of the action plan will commence in 2014.

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

n/a

(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.

n/a

4. Funding

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

n/a

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

Not applicable.

Mr REINA (Mexico), speaking as a cosponsor of the draft resolution, said that several other States, including Australia, Libya and the United States of America, had joined the sponsors. The draft action plan had been developed following fruitful consultations, with the participants having worked constructively to formulate quantifiable global objectives. It was underpinned by five cross-cutting principles, and proposed three indicators linked to the overall global target of reducing by 25% the prevalence of visual impairment by 2019 from the 2010 baseline. Due attention had been given to the need to consider the situation of adolescents and to the problem of discrimination.

Some amendments had been made to the draft resolution before the current meeting. The word “Towards” had been inserted at the beginning of the title. Subparagraph 2(5) had been deleted and replaced with the following text, which was designed to bring the draft resolution into line with WHO reform by avoiding any need to engage additional resources: “to consider programme and budget implications related to implementation of this resolution within the context of the broader programme budget”. The word “high” in the first line of subparagraph 3(2) had been deleted, and the words “an increase in the” towards the end of that subparagraph had been replaced by “appropriate”. He invited the Board to adopt the draft resolution.

Dr VALVERDE (Panama) said that, according to Panama’s first national disability survey conducted in 2006, some 2.6% of the population suffered from visual impairment, and that the national plan for the social integration of people with disabilities included measures to provide those people with the appropriate care. She welcomed the draft action plan, which she considered to be a valuable tool for guiding Member States in their efforts to deal with the estimated 80% of cases of

visual impairment, including blindness, that were avoidable. Its multisectoral approach was exemplary, and the core vision and five principles should be replicated in other WHO action plans. Panama, which had joined the sponsors of the draft resolution, congratulated the Organization on its work and urged the regional offices and Member States to implement the action plan when it was adopted.

Dr VALENTIN (Seychelles), speaking on behalf of the Member States of the African Region, said that avoidable blindness and visual impairment were major problems in the Region, affecting some 36 million people, a number that was expected to increase further by 2020. He supported the draft action plan because of its emphasis on: strong advocacy to raise awareness of the problem; policy, planning and programme development; research, monitoring and evaluation; and coordination and partnership, which had been much in evidence during the drafting of the plan. Some action plans had already been put in place at the regional level, including a successful onchocerciasis programme in 11 countries of western Africa. Avoidable blindness and visual impairment should feature prominently in the draft twelfth general programme of work, and further efforts were required to mobilize additional resources in order to meet the targets set out in the draft action plan.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that there were about 60 000 blind people in his country (0.5% of the population), of whom half suffered from cataracts. The benefits of a collaborative approach to eye health could be seen in the results of the *Operación Milagro* programme, which his country had developed jointly with the Bolivarian Republic of Venezuela and which had treated more than 2.3 million people in 36 countries since its launch in 2004. Cuba had one of the highest cataract surgery rates in the world. He supported the draft action plan and endorsed the amendments proposed by the member for Mexico.

Mr KOLKER (United States of America) expressed his appreciation for WHO's long-standing leadership in efforts to reduce the level of preventable blindness and for its activities to improve data collection and surveillance, expand research, promote multisectoral action and define global targets and national indicators. He noted the critical link between avoidable blindness and communicable diseases, notably the neglected tropical diseases, as well as noncommunicable conditions such as diabetic retinopathy. WHO should continue to promote the provision of vision care that reflected the disease burden in individual Member States and was fully integrated into the health-care system. He urged the Board to adopt the draft resolution.

Mr KASE (Papua New Guinea) affirmed the significant health, social and economic burden that avoidable blindness and visual impairment placed on individuals and communities. The draft action plan provided a good basis on which the Secretariat, Member States and partners could build to improve access to eye-care services which were integrated into the wider health-care system and funded by governments. The proposed actions could be adapted to the needs of individual Member States. The indicators would be valuable for monitoring and evaluating progress towards the targets set in the draft action plan, but adequate funding and implementation by all stakeholders and technical support from WHO would be essential. He supported the draft resolution.

Dr MYINT HTWE (Myanmar) expressed support for the draft action plan. It included many indicators but, in many developing countries, the relevant databases needed to be improved and updated. The strengthening of information systems should therefore be considered central to the implementation of the action plan. WHO should provide the relevant technical support.

Dr EL MENZHI (Morocco) commended the unstinting efforts of WHO to prevent avoidable blindness and visual impairment. Despite much progress in the implementation of the previous action plan, avoidable blindness and visual impairment remained a significant global public health issue owing to their considerable social and economic impact on individuals and communities; yet around 80% of cases were preventable or curable. The draft action plan provided an opportunity to

consolidate the gains already achieved and contribute to new initiatives, such as the draft action plan for the prevention and control of noncommunicable diseases, and he urged the Board to adopt it.

Ms LIU Yue (China) said that China had been participating in the “Vision 2020: Right to Sight” initiative since 1999, and was implementing a national programme that would run until 2015. Free cataract treatment had been made available to many low-income patients as part of wider health reforms, and more than 1.4 million operations had already been undertaken. Before the action plan was submitted to the Health Assembly for approval, it should be strengthened by including country-specific and region-specific targets and strategies that would aid implementation.

Professor HALTON (Australia) said that the draft action plan built successfully on the achievements of its predecessor. The issue was of continued importance, given the negative effects of ageing and chronic disease on eye health and the particular impacts on indigenous populations. She expressed her support for the targets included in the draft action plan, commending its emphasis on research. Australia was pleased to cosponsor the resolution and called upon the Board to adopt it.

Professor NICKNAM (Islamic Republic of Iran) said that eye health services should be integrated into primary health care in order to achieve universal, affordable and equitable access for visually impaired patients to the necessary eye-care and rehabilitation services. Collaborating with the education, social and welfare sectors and building partnerships with civil society and the private sector would be important in the prevention of avoidable blindness.

Dr THABET NASHER (Yemen), recognizing the importance of eliminating avoidable blindness and visual impairment, especially in countries with a high burden of disability, underscored the need for a multisectoral approach and for the Secretariat to provide technical support and capacity building. His country wished to sponsor the proposed draft resolution.

Dr AZODOH (Nigeria) said that, owing to the country’s high burden of avoidable blindness and visual impairment, and following the United Nations High-level Meeting on Non-communicable Diseases in 2011, her Government had declared the improvement of eye health came under Millennium Development Goal 6. As a result, more attention and resources had, accordingly, been devoted to avoidable blindness and visual impairment. She therefore underscored the need to increase resources and strengthen health systems as part of the proposed action plan.

Dr GRABAUSKAS (Lithuania), speaking on behalf of the European Union and its Member States, welcomed both the action plan and the draft resolution, to which he proposed some amendments. A new paragraph should be inserted after the third preambular paragraph, to read: “Recognizing that globally, 80% of all visual impairment can be prevented or cured and that about 90% of the world’s visually impaired live in developing countries”. In the operative part, the words “including universal, equitable access to services” should be inserted at the end of subparagraph 2(2); a new subparagraph should be inserted after subparagraph 3(1) to read: “to further develop the action plan in particular with regard to the inclusion of universal and equitable access to services”; and subparagraph 3(2) should be reformulated to read: “to continue to give priority to the prevention of avoidable visual impairment, including blindness, and to consider allocating resources for the implementation of the global action plan 2014–2019 on universal eye health”.

Mr ARIAS PALACIO (Bolivarian Republic of Venezuela)¹ expressed support for the draft action plan and pledged his country’s commitment to its implementation, adding that he would keep the Secretariat informed of Venezuela’s progress. The cataract surgery programme conducted jointly

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

by his own country and Cuba was an excellent example of South–South cooperation. The programme had produced excellent results in the region and could be used as a model for other projects elsewhere.

Dr CICOONA (Italy)¹ said that, despite the progress made in recent years in tackling avoidable blindness and visual impairment, the most poor and vulnerable populations remained the most affected. Italy had worked to implement the relevant Health Assembly resolutions and had developed national guidelines and an inventory of development activities in that area, but he was concerned at the potential lack of support from the international community for a disability that could often be prevented or cured using cost-effective interventions. The draft action plan provided a good basis for action, but could be further improved before it was submitted to the Health Assembly for adoption, particularly through the inclusion of indicators for quality of eye care, references to trachoma and onchocerciasis, which were not addressed either in the draft action plan or in activities to combat neglected tropical diseases, and a greater focus on rehabilitation. He supported the draft resolution and the amendments proposed on behalf of the European Union.

Dr ATTAYA LIMWATTANAYINGYONG (Thailand)¹ welcomed the draft action plan, but said that her country had some concerns. The vision of the draft action plan included a reference to people with unavoidable vision loss achieving their full potential, but there was a lack of a corresponding proposed action. The ambitious goals of the plan required the integration of effective and efficient eye health-care services and information systems into national health services, especially at the primary health-care level.

Lessons could be learnt from initiatives in many parts of the world providing high-quality, low-cost cataract treatment. Such cost-effective measures should be prioritized, with WHO also facilitating research into other feasible interventions to prevent blindness. Childhood blindness should also be made a priority, through school eye health programmes to detect common eye problems and thus avoid the lifelong adverse effects of blindness or visual impairment, as well as programmes to eliminate other preventable causes such as measles or vitamin A deficiency. With an ageing global population, other issues such as diabetic retinopathy, glaucoma and age-related macular degeneration were expected to increase; affordable medicines and treatments were thus of great importance, especially in low-income and middle-income countries, and should receive more attention in the draft action plan. Finally, the proposed implementation mechanism should be made clear.

Ms ALSHOURA (Saudi Arabia)¹ said that the draft global action plan, built as it was on studies drawn from the current action plan for the prevention of avoidable blindness and visual impairment and on proposals by Member States and international partners, would function as a cornerstone for improving access to universal eye health services integrated into primary health care delivery systems. Having endorsed the resolution² on follow-up on regional action regarding decision EB130(1) on implementation of that action plan, adopted by the Regional Committee for the Eastern Mediterranean in October 2012, Saudi Arabia was pleased likewise to endorse the draft resolution.

Dr CHESTNOV (Assistant Director-General) thanked the delegates for their comments. Much had been achieved by WHO over the decades, and it was essential that efforts be directed into the areas where they were most needed. Primary care was crucial, as the first contact with the medical system could initiate early intervention and help to prevent blindness.

Even after an action plan had been adopted, it remained a political document: guidance on the way it should be put into practice would need discussions at the international, regional and national levels and the preparation of operational business plans. The Secretariat's efforts should probably be focused on implementing the plan in line with the preferences of Member States. Drawing on

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

² Resolution EM/RC59/R.5.

individual countries' experiences was crucial, so the development of bilateral relationships was a key aim, opening up more ways of preventing blindness. The ageing of populations was a concern, but the link with visual impairment was not straightforward. Conditions such as trachoma and cataract deserved more attention; in that connection, it would be possible to expand in the draft action plan the section on scientific evidence which could be applied to the prevention of blindness. The economic aspects should also not be overlooked: other actors, such as economists, could be brought in to supply arguments for persuading finance ministries to release more funding for the prevention of blindness.

The DIRECTOR-GENERAL said that much more needed to be done to prevent avoidable blindness and visual impairment, as interventions could be very cost-effective and were essential, especially for young people, who had so much potential ahead of them. More work needed to be done to promote eye health in the education sector, including awareness-raising and, if necessary, the provision of spectacles.

Centres that provided low-cost, safe and effective cataract surgery had been set up in various countries and she looked forward to WHO's facilitating the transfer of technology and know-how, particularly as an ageing global population would mean increased demand for such surgery.

The CHAIRMAN took it that the Board wished to take note of the Secretariat report containing the draft action plan for the prevention of avoidable blindness and visual impairment 2014–2019.

It was so agreed.

At the invitation of the CHAIRMAN, Ms ROSE-ODUYEMI (Office of the Governing Bodies and External Relations) read out the amendments. The title would read: "Towards universal eye health: a global action plan 2014–2019". A new preambular paragraph PP3bis would read: "Recognizing that globally 80% of all visual impairment can be prevented or cured and that about 90% of the world's visually impaired live in developing countries". At the end of subparagraph 2(2) the words "including universal and equitable access to services" should be added after "national priorities,". The existing text of subparagraph 2(5) would be replaced by the following: "to consider programme and budget implications of this resolution within the context of the broader programme budget". A new subparagraph to follow paragraph 3(1) would read: "to further develop the action plan in particular with regard to the inclusion of universal and equitable access to services". Subparagraph 3(2) would be revised to read: "to continue to give priority to the prevention of avoidable visual impairment, including blindness, and to consider allocating resources for the implementation of the global action plan 2014–2019 on universal eye health".

The CHAIRMAN took it that the Board agreed to approve the draft resolution on universal eye health: a global action plan 2014–2019, as amended.

The resolution, as amended, was adopted.¹

Disability: Item 6.5 of the Agenda (Document EB132/10 and EB132/10 Add.1)

Dr VALLEJO (Ecuador) said that the member countries of the Union of South American Nations, on whose behalf he spoke, had done much work on the issue of disability, often through effective South–South cooperation and by developing policies on access to health services for disabled people and protecting their rights. It was estimated that around 15% of the global population lived with some form of disability and that, more worryingly, there was a high prevalence among children, despite the fact that many of those disabilities could be prevented.

¹ Resolution EB132.R1.

He urged the Board to adopt the draft resolution, but first wished to propose some amendments. A new paragraph should be inserted after the fourth preambular paragraph, to read: "Recognizing existing national and regional efforts to facilitate the enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity". In the ninth preambular paragraph, the words "a comprehensive multisectoral approach is required to meet the multiple barriers faced by persons with disabilities and that" should be inserted between "that" and "mainstreaming". In the operative part, the words "and that successful programmes and good practices are developed in different regions" should be added at the end of subparagraph 2(3). In subparagraph 2(5), the words "habilitation and" should be added before "rehabilitation across the life-course". The words "and intensify collaboration with a broad range of stakeholders including organizations of the United Nations, academia, the private sector and organizations of persons with disabilities" should be added in subparagraph 3(2) after "Member States", and subparagraph 3(6) should be reformulated to read, "to prepare, in consultation with all the relevant United Nations organizations, a comprehensive cross-organizational disability WHO action plan with measurable outcomes, based on the evidence in the *World report on disability*, in line with the Convention on the Rights of Persons with Disabilities and the outcomes report of the High-level Meeting on Disability "The way forward: a disability-inclusive development agenda towards 2015 and beyond" for consideration by Member States by the Sixty-seventh Health Assembly through the Executive Board".

Dr AZODOH (Nigeria), speaking on behalf of the Member States of the African Region, said that many persons with disabilities had unmet needs in the areas of health care, social services and employment, especially in developing countries. Such issues could be resolved through provision of simple but effective programmes at the national and international levels. The Region recognized the important role played by WHO in supporting national policies, promoting dialogue on disability and introducing guidelines for rehabilitation in order to maximize the opportunities and potential of persons with disabilities. In addition to that work, WHO should also facilitate the collection of data on the needs of those with a disability, with a view to identifying lasting solutions and enhancing their status.

All Member States should implement the approach taken in the Convention on the Rights of Persons with Disabilities, recognizing disability and human rights as issues of development. There needed to be improved investment in national disability programmes and services and increased international support for capacity building and provision of assistive devices for use by those with a disability to aid rehabilitation and prevent social exclusion. She supported the draft resolution and looked forward to the United Nations High-level Meeting on Disability and Development later in the year.

Dr VALVERDE (Panama) said that disability was a matter of human rights and development, as asserted in the Convention on the Rights of Persons with Disabilities, and Panama had implemented a strategy and national action plan prioritizing the issue. A national survey in 2006 had shown that one in three people lived with some form of disability, with most being indigenous people or living in rural areas. The average age of those with disabilities was 44 years for men and 47 years for women. She was concerned by WHO's data that indicated that half all those with a disability could not afford health care, compared with a third of those without a disability. Panama wished to sponsor the draft resolution. Any action plan on disability should emphasize the need for universal access to health services and the human rights of people with disabilities.

Dr GRABAUSKAS (Lithuania), speaking on behalf of the European Union and its Member States, supported the draft resolution but proposed some amendments, in particular to bring certain parts of the text in line with the wording of the Convention on the Rights of Persons with Disabilities. In the third preambular paragraph, the words "national policies and" should be inserted after "requires that". A new paragraph should be inserted after the sixth preambular paragraph to read: "Recognizing the responsibility of Member States to ensure, within existing resources, equal access to health services and care for people with disabilities" and a further paragraph should be inserted after the

seventh preambular paragraph to read: “Recognizing the important role that formal and informal carers play in supporting people with disabilities and that whilst informal carers cannot substitute the role of the national and local authorities, they do need particular attention from the authorities to help them with their tasks. Noting that their role is increasing in the context of the sustainability of the health systems and in the context of ageing of the population”. In the eighth preambular paragraph, the word “care” should be replaced with “services”.

In the operative part, the standard footnote should be inserted after “URGES Member States” in paragraph 2, to read: “And, where applicable, regional economic integration organizations.” In subparagraph 2(2), the language of the Convention on the Rights of Persons with Disabilities should be used, with the words “with full participation of people with disabilities and” being replaced with “in close consultation with and active involvement of persons with disabilities, including children with disabilities, through”. A new subparagraph should be inserted after subparagraph 2(4) to read: “to ensure that informal carers, in supplementing the services provided by health authorities, receive adequate training and support” and another subparagraph should be inserted after subparagraph 2(6) to read: “to prohibit and prevent discrimination against persons with disabilities in the provision of health services in order to promote equality”. In subparagraph 3(3), the word “sexual” should be inserted after “adolescent health” and the wording of subparagraph 3(4) should also reflect that of the Convention on the Rights of Persons with Disabilities, with the words “are consulted closely and involved actively through” replacing the word “and” after the second instance of “people with disabilities”.

Mr SANNE (Norway) expressed support for the draft resolution and the amendments proposed by the member for Ecuador but proposed one further amendment: in subparagraph 2(2), the words “as appropriate” should be inserted after “representative organizations”.

Mr KOLKER (United States of America) supported the proposed amendments and added some of his own: in subparagraph 2(4), the words “to ensure” should be replaced with “to work to ensure” and the two instances of “people” should be replaced with “persons”. In subparagraph 2(5), “including mental health services” should be inserted after “rehabilitation services”. In subparagraph 2(6), the word “and” should be replaced with a comma after “access” and the words “and participate fully in” should be inserted after “benefit from”.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the report contained valuable data and approaches. Disability was a serious problem and would only continue to grow as the population expanded and aged. Cuba had drawn up plans addressing the matter, both in 1995 and more recently. Ministers had agreed that any disability initiative should be both intersectoral and multidisciplinary; as such, the Ministry of Labour and Social Security was responsible for managing the programme and establishing a national council for the care of people with disabilities, comprising representatives of numerous ministries – ranging from public health, education and culture to construction, transport, and communications and electronics; the Cuban Institute of Radio and Television; the Workers’ Central Union of Cuba; and organizations representing people with disabilities. A comprehensive study of people with disabilities had been conducted in Cuba between 2001 and 2013 and had served as a model for similar studies in the Bolivarian Republic of Venezuela, Ecuador, Nicaragua, the Plurinational State of Bolivia and Saint Vincent and the Grenadines between 2007 and 2010, identifying more than 1.2 million people with disabilities and preparing project and service proposals for addressing the identified disabilities.

He supported the draft resolution, as amended by the member for Ecuador, but said that he would need to consider the amendments submitted by the members for Lithuania, Norway and the United States of America.

Mr REINA (Mexico) expressed strong support for the draft resolution, as amended, as it provided an accurate picture of the situation globally regarding disability and set out appropriate actions for implementation.

Professor NICKNAM (Islamic Republic of Iran) welcomed the report. The time was right for the Health Assembly to consider the issue of disability, as the Convention on the Rights of Persons with Disabilities and a number of WHO reports and resolutions could be used to inform the discussions. Failing to address the matter appropriately, however, would have repercussions on progress towards achieving global development objectives. Measures would be needed to capitalize on the current momentum in the area of disability, including the implementation of the recommendations in the *World report on disability* and development of national strategies with a focus on improving registries, raising awareness, research funding and capacity building. Primary health-care systems should also be strengthened, as recommended in WHO's community-based rehabilitation guidelines, if people with disabilities were to make a greater contribution to the development of their societies.

He urged WHO to recognize disability as a global development priority and to build capacities within health systems so as to provide affordable, equitable services to patients. WHO should also build partnerships with civil society, the private sector and organizations of disabled people in order to facilitate equitable access to rehabilitation services and education and improve livelihoods.

Dr AMMAR (Lebanon) said that her country had adopted a cross-sectoral approach to dealing with disability and echoed the calls of civil society organizations to address the issue at the next Health Assembly. Lebanon supported the draft resolution, as amended.

Dr AL-MARRI (Qatar) expressed support for the draft resolution and the amendments proposed by the member for Ecuador, which made the text more universal in scope.

Professor HALTON (Australia), after expressing support for the proposed amendments to the draft resolution, said that many persons with disabilities were not able to enjoy their full human rights and, in particular, access to health care. Proactive action was needed to improve health outcomes in the area of disability. She raised concerns about some of the amendments proposed by the member for Lithuania, emphasizing the need to ensure that the resolution's provisions did not go beyond the mandate of WHO in areas such as the training of carers.

Dr AZODOH (Nigeria) supported the draft resolution as amended by the member for Ecuador. It was increasingly important to look beyond the traditional causes of disability to new causes such as violence or workplace accidents. She called for greater intersectoral collaboration at all levels.

Ms PRIETO ABAD (Colombia)¹ underscored the importance her Government attached to the issue of disability. Further to the challenges posed to those with disabilities in the areas of health care, education, transport and employment, she suggested including the concept of infrastructure, which presented significant obstacles for that sector of the population. The report referred to low levels of education among children with a disability, which she noted would also lead to poor levels of education among adults with a disability. Data collected on disability should be disaggregated by gender and ethnic group. Given the differences between men and women, and differences among age groups, the data would contribute to better policy-making in that area.

Colombia had proposed and established the Andean Policy for the prevention of disability, and for the care and integral habilitation and rehabilitation of people with a disability, and had developed various national policy guidelines on habilitation and rehabilitation and a related strategy. A manual on best practices in manufacturing was being prepared for the design and adaptation of medical prostheses and external orthopaedic braces, and other instruments were being developed to serve as a model for others in the region.

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

Dr HOLM (Sweden)¹ underlined the importance that his country attached to the Convention on the Rights of Persons with Disabilities. He welcomed the increased attention that the United Nations had placed on disability but urged that it be translated into tangible action. The United Nations High-level Meeting on Disability and Development later in the year would be a timely opportunity to discuss disability, human rights and poverty reduction in the context of the post-2015 development agenda. Data and indicators, such as those provided in the *World report on disability*, would be invaluable and should be standardized and internationally comparable so as to facilitate effective monitoring of progress. He supported the draft resolution, especially its provisions on improved data collection and definitions and the call for the Secretariat to participate in the preparations for the High-level Meeting.

Ms MATSOSO (South Africa)¹ supported the draft resolution and the proposed amendments, particularly those regarding the prevention of discrimination and the use of language consistent with that of the Convention on the Rights of Persons with Disabilities. In most societies, insufficient attention was paid to the challenges faced by persons with disabilities in terms of health care, social services and employment, all of which needed to be met through integrated multisectoral action to ensure that those with disabilities had the same opportunities as those without.

Ms WISEMAN (Canada)¹ said that all countries must ensure access for people with disabilities to the necessary health and social services. After expressing Canada's support for the draft resolution, she suggested that subparagraph 2(3) should be amended by inserting "sex- and age-disaggregated" after "appropriate".

Mr KOLKER (United States of America) seconded that amendment.

Mr ARIAS PALACIO (Bolivarian Republic of Venezuela)¹ requested that the Board should consider, at some future date, the possibility of establishing a minimum quota for employment of staff with disabilities at WHO, which would set a good example for countries to follow. Such a standard was already enshrined in labour legislation in his country and others in the region.

Ms REITENBACH (Germany)¹ welcomed all efforts to make the development agenda more inclusive of disability, noting that the Convention on the Rights of Persons with Disabilities provided clear guidance for countries on ways of ensuring disability-inclusive policies. In that context, Germany had developed an action plan that provided for the inclusion of persons with disabilities in German organizations and development cooperation, and for the strengthening of cooperation with civil society, the private sector and multilateral actors in the area of disability.

Dr WIRANPAT KITTITHARAPHAN (Thailand)¹ welcomed the *World report on disability* as a landmark and emphasized Thailand's commitment to implementing its recommendations in national programmes. With disability on the agenda at the next Health Assembly and the High-level Meeting on Disability and Development taking place in 2013, she affirmed her Government's pledge to advocate for a disability-inclusive development agenda.

The outcomes of those forums would, however, be worthless if national health and social service systems were not sufficiently prepared in advance and, in that regard, she had some concerns. Access to services was a fundamental right for people with disabilities and needed to be improved in terms of infrastructure, funding and human resources. Sustained political commitment, appropriate policies and investment were also essential and consistent definitions for and classifications of disability were needed across different programmes and services. People with disabilities should not be viewed as a homogenous group, but rather as a set of diverse groups requiring particular policies

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

and services. She urged the Secretariat to provide support to developing countries in strengthening their disability information systems.

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

The meeting rose at 12:40.

FOURTH MEETING

Tuesday, 22 January 2013, at 14:30

Chairman: Dr J. ST. JOHN (Barbados)

1. STAFFING MATTERS: Item 14 of the Agenda.

Appointment of the Regional Director for the Americas: Item 14.1 of the Agenda (Document EB132/37)

The meeting was held in open session until 15:30, when it resumed in public session.

At the request of the CHAIRMAN, Dr AMMAR (Lebanon), Rapporteur, read out the following resolution on the appointment of the Regional Director for the Americas adopted by the Board during the open meeting:¹

The Executive Board,
Considering the provisions of Article 52 of the Constitution of the World Health Organization;

Considering the nomination made by the Regional Committee for the Americas at its sixty-fourth session,

1. APPOINTS Dr Carissa Faustina Etienne as Regional Director for the Americas as from 1 February 2013; and

2. AUTHORIZES the Director-General to issue a contract to Dr Carissa Faustina Etienne for a period of five years as from 1 February 2013, subject to the provisions of the Staff Regulations and Staff Rules.

The CHAIRMAN congratulated Dr Etienne on her appointment.

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

Dr ETIENNE (Regional Director-Elect for the Americas) said that it was a great honour to be appointed Regional Director for the WHO Region of the Americas and Director of the Pan American Health Organization (PAHO). She thanked Member States and the Executive Board for giving her the opportunity to contribute to the health and well-being of the people of the Americas, a Region that was playing an increasingly important role on the global stage. In her earlier career, as a doctor on the island of Dominica she had worked towards the reform of the Dominican health system, and had served as Assistant Director of PAHO and subsequently as Assistant Director-General at WHO. Her experience had taught her how to work best across the three levels of WHO to ensure maximum impact on people's lives. It was important for health systems to evolve to meet contemporary needs,

¹ Resolution EB132.R2.

and the reforms undertaken in Dominica and other countries in the Region had provided valuable experience. There was a strong political commitment to achieving health goals, the right to health was being included in constitutions, progress had been made in improving access to health services, and the social and environmental determinants of health were being addressed in the context of the prevention and treatment of health conditions.

A willingness to embrace innovation had helped countries in the Region to eradicate poliomyelitis, eliminate measles, dramatically increase access to antiretroviral treatment and attain the health-related Millennium Development Goals, with the exception of the reduction of maternal mortality. She would continue to work with Member States to develop new approaches to effective and coherent delivery, and ensure that experiences were shared across the organization. Recognizing that countries' experiences were uneven, she committed herself to working with PAHO's Member States to fill health gaps within and between countries and prioritize vulnerable and marginalized populations on the basis of a rights-based, multisectoral approach to health involving a wide range of both State and non-State partners. Such an approach would be crucial to completing the so-called "unfinished agenda", in particular with regard to communicable and noncommunicable diseases, maternal and child health and emerging health challenges.

Good health was rooted in equity, universality, solidarity and inclusiveness. Universal health coverage would improve health, and was attainable; the entire population should have access to all health services without fear of financial implications. Such coverage required social and financial protection measures, a well-trained workforce, an organized delivery system, and reliable supplies of safe and effective medicines and technologies. Strong health systems should be maintained under an approach embodying the fundamental principles of primary health care, within a coordinated framework for the expansion of access to essential health services, as part of the mandate laid down in WHO's Constitution. Universal health care ought to be a prominent component of the post-2015 development agenda, which required political will at national, local and community levels and community empowerment. A holistic approach should be taken to strengthening health systems and services.

It was wrong to second-guess or ignore the needs and expectations of different kinds of people and she pledged to make country ownership a reality and ensure that all stakeholders had a role in local and national health-related decision-making. In terms of new approaches to expanding technical cooperation, many Member States of PAHO had an abundance of capacity, and she would work to strengthen networks and facilitate the exchange of skills and experience within her Region and with other regions.

Having spoken about change at the 28th Pan American Sanitary Conference, she welcomed the opportunity to lead a respected organization like PAHO. She paid tribute to the current Director, Dr Roses Periago, and her predecessors. She looked forward to leading PAHO in a new era of public health, and to making the Organization more effective, more accountable and more transparent. She was committed to working with the Member States of the Americas and other regions to ensure that PAHO and WHO were able to meet the challenges of the twenty-first century.

She thanked the governments and individuals that had helped her during her tenure as Assistant Director-General for Health Systems and Services. She recalled that their joint achievements included the publication of *The world health report 2010. Health systems financing: the path to universal coverage*; the WHO Global Code of Practice on the International Recruitment of Health Personnel; the reinforcement of the WHO Prequalification Programme; the strengthening of WHO support to national health policy and planning processes; the first WHO strategy on health policy and systems research and the further development of the International Health Partnership to improve aid effectiveness.

She looked forward to the continuation of collaborative endeavours in the Americas and beyond.

At the invitation of the CHAIRMAN, Dr AMMAR (Lebanon), Rapporteur, read out the following resolution expressing appreciation to the outgoing Regional Director for the Americas adopted by the Board during the open meeting:¹

The Executive Board,

Desiring, on the occasion of the retirement of Dr Mirta Roses Periago as Regional Director for the Americas, to express its appreciation of her services to the World Health Organization;

Mindful of her lifelong devotion to the cause of international health, and especially recalling her ten years of service as Regional Director for the Americas;

Recalling Resolution CSP28.R8 (2012), adopted by the Pan American Health Organization (PAHO), Regional Office of WHO for the Americas, which designates Dr Mirta Roses Periago as Director Emeritus of the Pan American Sanitary Bureau,

1. EXPRESSES its profound gratitude and appreciation to Dr Mirta Roses Periago for her invaluable contribution to the work of WHO; and
2. ADDRESSES to her on this occasion its sincere good wishes for many further years of service to humanity.

The DIRECTOR-GENERAL, congratulating Dr Etienne, said that WHO had lost an Assistant Director-General, but PAHO had gained an experienced leader, one who was committed to the right of poor and marginalized populations to access high-quality health care, who had a passionate concern for primary health care and attached great value to equity, social justice, solidarity, multisectoral action and community participation. As a result of *The world health report 2010*, which had been produced under her direction, a growing number of governments had strengthened their commitment to attaining universal health coverage. Dr Etienne's achievements made her well qualified to lead PAHO, an Organization that cared greatly about equity, the right to health and pan-American solidarity.

She thanked Dr Roses Periago for contributing so much to health in the Americas and never wavering in her commitment to primary health care, and said that she had learnt a great deal from working with her.

Dr DAULAIRE (United States of America) thanked Dr Roses Periago for her commitment to the health and well-being of people across the Americas, and to social justice. Under her leadership, the Region of the Americas had seen the elimination of endemic measles, rubella and congenital rubella syndrome; PAHO had played a leading role in addressing noncommunicable disease prevention and in drawing global attention to the importance of immunization.

He welcomed Dr Etienne back to the Regional Office in her new role as Regional Director and Director of PAHO, and congratulated health ministers across the Americas on having elected another inspiring woman. The Region had a record of stellar achievements in public health, and its Member States would continue to work together in the face of great challenges. Dr Etienne had a wealth of expertise in health system strengthening, and was committed to reducing health disparities and addressing the social determinants of health. Stronger health systems would also help support preparedness and response capacities for public health emergencies, and were necessary to address the growing regional and global burden of noncommunicable diseases. Dr Etienne and the other regional directors would play a vital role in the WHO reform process at the regional level, and across all three levels of the Organization, to enable WHO to meet global health challenges in the years to come.

¹ Resolution EB132.R3.

Dr VALLEJO (Ecuador) asked the Chairman to give the floor to the representative of Peru, to speak on behalf of the Member States of the Union of South American Nations.

Mr WIELAND (Peru),¹ speaking on behalf of the Member States of the Union of South American Nations, welcomed Dr Etienne as the Regional Director for the Americas. In its 110 year history, PAHO had been the driving force behind major public health achievements: the eradication of smallpox and poliomyelitis, a significant reduction in maternal and child mortality, an increase in life expectancy by up to 30 years, and an expansion in provision of services and potable water. Cooperation was a key factor in improving quality of life and health in particular. Despite high economic growth in recent years, inequality and social disparities remained a feature of life throughout the Region. Health was a personal and political issue, and there was a need to address the social determinants of health and the goal of universal health coverage, which should be a focus of the post-2015 development agenda. Expanded coverage should go hand in hand with high-quality services appropriate to the multicultural communities of the Region; and resources and experiences should be shared between States, and with those States that most needed them. He was confident that PAHO, under Dr Etienne's wise leadership, would continue to meet the needs of its Member States, as it had previously under Dr Roses Periago, whom he thanked for her excellent work. The Member States of the Union of South American Nations would continue to promote health for all across the Region.

Dr VALVERDE (Panama), welcoming Dr Etienne as Regional Director, recalled that PAHO was the oldest public health organization in the world. Part of the United Nations system, and serving as the WHO Regional Office for the Americas, PAHO was also the specialized agency for health within the Inter-American System. She praised Dr Etienne for her social vision and commitment to public health, as well as her vast experience in such matters as primary health care, strategies to achieve universal health coverage, and policies to improve maternal and child health. In her new post, she would be working to improve the health and quality of life of all persons in the Region.

She commended the dynamic leadership displayed by Dr Roses Periago during her 10 years as Regional Director, during which time life expectancy in the Region had increased by four years between 2000 and 2010, mortality had decreased by 11%, progress had been made towards attaining the Millennium Development Goals, social protection had been expanded and the Health Agenda for the Americas 2008–2017 had been developed.

Mr LICEAGA (Mexico) congratulated Dr Roses Periago on a decade of unflagging commitment to health in the Americas and wished her well for the future. He welcomed the election of Dr Etienne, and wished her success in her new role. He reiterated Mexico's commitment to the health of the Americas and to strengthening cooperation in the Region.

Dr REN Minghui (China) congratulated Dr Etienne on her appointment as Regional Director. During her term as Assistant Director-General, she had actively supported health system development, including the reform of China's health care system and its interim independent evaluation. He wished her success in her new post, and thanked Dr Roses Periago for her contribution to global public health.

Dr AZODOH (Nigeria) recalled the many achievements of Dr Roses Periago, and thanked her for her work. She congratulated Dr Etienne on her appointment as the new Regional Director for the Americas, and thanked her for her work on promoting the strengthening of health systems during her tenure at WHO, which formed a solid basis for future progress in that area.

Dr VALENTIN (Seychelles), speaking on behalf of the Member States of the African Region, congratulated Dr Etienne on her election as Regional Director and Director of PAHO. Given her

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

education, professional background and commitment to WHO, and her experience in a small country that had faced significant health challenges, she would undoubtedly achieve maximum impact in addressing the priority health challenges of the Americas, and that impact would resonate globally. The Region would continue to work with Dr Etienne and the Region of the Americas, sharing experiences and best practices, so that both regions could grow and succeed together. He thanked Dr Roses Periago for her services to the Americas and the world.

Ms PENEVEYRE (Switzerland) joined other speakers in congratulating and welcoming Dr Etienne, and in thanking Dr Roses Periago.

Dr CUYPERS (Belgium), highlighting the importance attached by Belgium to health system strengthening, said that Dr Etienne's experience in that regard would benefit the Region of the Americas. Furthermore, her appointment was a good illustration of mobility within the Organization and an asset to the reform process. He congratulated her on her appointment, and wished her every success.

Dr WILLIAMS (Barbados) thanked Dr Roses Periago for her contribution to improving health systems in the Region, and commended her for the many health goals that had been achieved under her leadership. On behalf of Barbados and the other member countries of the Caribbean Community, she congratulated Dr Etienne on her appointment as Regional Director of the Americas and Director of PAHO. Dr Etienne had already demonstrated her capabilities in her previous work in PAHO and as Assistant Director-General at WHO; her strategies for improving health delivery and her awareness of the social determinants of health augured well for the delivery of health systems and health care across the Region. She pledged support to Dr Etienne in her new role.

Dr THABET NASHER (Yemen), speaking on behalf of the Member States of the Eastern Mediterranean Region, congratulated Dr Etienne on her election and thanked Dr Roses Periago for her work.

Mrs FARANI AZEVÊDO (Brazil)¹ congratulated Dr Etienne on her appointment as Regional Director and Director of the Pan American Sanitary Bureau, which was a clear recognition of her accomplishments and indication of her capacity to guide PAHO through the new challenges to public health. Dr Etienne's solid experience and commitment to addressing public health needs had been demonstrated in her work as head of a WHO cluster encompassing several programmes and initiatives strongly supported by Brazil. Her previous experience in working for both WHO and PAHO would benefit the Region as a whole and serve her well in her efforts to strengthen relations between the two organizations. Brazil and PAHO were key partners in promoting health in the Americas, and that long history of cooperation and common achievement would continue under the leadership of Dr Etienne.

She thanked Dr Roses Periago for her outstanding work as Regional Director; under her leadership, health in the Region had improved substantially.

Ms MATSOSO (South Africa),¹ congratulating Dr Etienne on her appointment, wished her every success and commended the unwavering commitment and selfless leadership that she had demonstrated in her previous work at WHO and PAHO.

Ms FERNÁNDEZ DE LA HOZ ZEITLER (Spain)¹ thanked Dr Roses Periago for her excellent work and her contribution to the field of health over the previous 10 years. She congratulated Dr Etienne and wished her success in her new post. She reiterated Spain's continued commitment to close collaboration with PAHO.

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

Mr TOBAR (Argentina)¹ thanked Dr Roses Periago for her two terms of service as Regional Director and her contribution to health in the Americas. As the first woman, and the first Argentine, to serve as Director of PAHO, she had introduced institutional reforms, strengthened the organization's leadership role and improved relations with the United Nations and other inter-American organizations. She had raised the profile of public health, placing it on the agenda of summit meetings and regional and subregional forums. He wished her an enjoyable retirement and much success in her future life.

He wished Dr Etienne every success in her work and assured her of Argentina's support in addressing regional and global health challenges.

The CHAIRMAN, paying tribute to Dr Roses Periago, said that she was a tireless public health warrior who continued to contribute to the health and development of the Region of the Americas, and whose value to WHO would not end with her retirement.

She congratulated Dr Etienne, whose earlier statement had shown that she intended to fulfil and even exceed the great expectations placed on her.

Dr ROSES PERIAGO (Regional Director for the Americas) said that not even her three decades of service in the field of public health had prepared her for the gracious comments from members and representatives. She thanked her colleagues who had worked with her in the pursuit of health-for-all goals. The activities undertaken in her Region during her mandate were described in the Quinquennial Reports of the Director for 2003–2007 and 2008–2012, and had been inspired by the principles of cooperation, solidarity, equity, transparency, best available evidence and accountability.

The global and regional public health architecture was becoming more complex, but only WHO had the mandate, legal basis and membership to be a credible source of norms, standards and policy advice. New alliances in public health were critical to improving the response to global, regional and national health needs, and WHO required strong leadership to confront growing challenges and remain relevant and fit for purpose. Unity in diversity was a basic principle, as well as an asset, and WHO had implemented that principle by defining common goals within differing national contexts. WHO promoted engagement, ownership, knowledge and resource sharing, capacity building, autonomy and sovereignty, seeking to strengthen the role of health ministries and relying on collaboration with other stakeholders in the development of binding agreements like the International Health Regulations (2005) and the WHO Framework Convention on Tobacco Control.

WHO's decentralized structure and country presence reflected the successes already achieved by PAHO, which had celebrated its 110th anniversary in December 2012. As new integration systems were established, WHO was well positioned to develop cooperation mechanisms to achieve health for all through universal health coverage. Initiatives should be harmonized, not standardized; the experience with poliomyelitis indicated that similar problems might require context-specific solutions. The lessons thus learnt had paved the way for the launch of World Immunization Week, the United Nations high-level meeting on noncommunicable diseases, the centrality of health in the global development agenda reflected in the Millennium Declaration, eradication and elimination initiatives, and the development of new technologies and innovation in health care and disease prevention. As the late Dr Lee Jong-wook had said in the preface to WHO's Eleventh General Programme of Work: "a realistic view of the future requires an informed understanding of the past".

Public health depended on solidarity and the pursuit of equity, which meant that the Millennium Development Goals were not an exercise in data reporting but should effect a change in people's living conditions. Stigmatization and discrimination should not be allowed to be a factor in the treatment of HIV/AIDS, maternal mortality, the persistence of neglected infectious diseases, or the lack of access to good-quality health services. For that reason, efforts were focused on defining priority populations and vulnerable countries as well as priority health topics. The first influenza

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

pandemic of the current millennium had begun in the Americas and had spread throughout the world within months, putting to the test the transparency and solidarity required for an effective public health response. Natural disasters like the tsunami in Banda Aceh, Indonesia, the earthquake in Haiti and the damage to the Fukushima nuclear plant in Japan had been testing moments for WHO's leadership and had stirred Member States to reaffirm their willingness to share information and resources. Despite losses and mistakes, WHO had responded to the best of its knowledge and capacity and had protected people's health.

Having served WHO for 29 years, she had learnt from her mentors, supervisors, collaborators, and colleagues, and above all from the suffering and expectations of ordinary people. She had seen diseases eradicated from the world and from the Region. She had contributed to strengthening WHO and the United Nations and to creating new integration institutions, the most recent being the Union of South American Nations and the Caribbean Public Health Agency. With the renewal of primary health care, she had witnessed the harnessing of new information and communication technologies to improve people's health and institutional performance.

WHO would continue to respond to future public health challenges, taking advantage of recent transformation efforts as well as the decisive support of Member States and other partners, and capable and committed teams and individuals, like Dr Etienne, to whom she pledged her full support. She thanked all her colleagues for their kindness, advice and generous support and said that it had been a particular honour to work with five WHO Directors-General and two Regional Directors.

2. NONCOMMUNICABLE DISEASES: Item 6 of the Agenda (continued)

Disability: Item 6.5 of the Agenda (Documents EB132/10 and EB132/10 Add.1) (continued from the third meeting)

Miss NAUGHTON (CBM), speaking at the invitation of the CHAIRMAN, congratulated WHO on its work in the field of disability, in particular the *World report on disability* which had improved the data available for use in policy-making and whose recommendations provided a framework for action. The national and international launch of the report and the dialogue with other stakeholders had raised the profile of the issue and provided a firm basis for national actions to implement the Convention on the Rights of Persons with Disabilities.

Community-based rehabilitation guidelines had been developed and were being rolled out in a participatory and collaborative manner; CBM would continue to collaborate with WHO to promote their implementation, while promoting inclusive development and improved access to services in low-resource settings. WHO's guidelines on the provision of manual wheelchairs formed the basis of national and regional capacity-building programmes to make wheelchairs available to people in low-income and middle-income countries. She looked forward to the planned rehabilitation guidelines, which would fill a gap in normative standards in that area. Internal processes to make WHO more inclusive and accessible were a good example of the implementation of the Convention. She called on WHO to continue its work in the field of disability, in particular through the inclusion of a range of stakeholders in planning and implementation.

Professor GUTENBRUNNER (International Society of Physical and Rehabilitation Medicine), speaking at the invitation of the CHAIRMAN, supported the report on disability, and the recommendations contained therein.

Mr MONSBAKKEN (Rehabilitation International), speaking at the invitation of the CHAIRMAN, welcomed the draft resolution and the comments made by the member for Ecuador. Six years after the adoption of the Convention on their rights, persons with disabilities still faced many obstacles in accessing services such as health care and rehabilitation, and were often marginalized, particularly in developing countries. He urged adoption of the draft resolution by the Health Assembly

in May. He emphasized the importance of the High-level Meeting on Disability, scheduled to take place in New York in September 2013, and commended WHO's work to place disability on the global agenda.

Mrs KACHAJE (World Blind Union), speaking at the invitation of the CHAIRMAN and on behalf of the International Disability Alliance, expressed appreciation of the increased attention given to persons with disabilities in WHO's work, as reflected in the level of resources dedicated to the *World report on disability* and other initiatives. She supported the draft resolution but considered that more and better statistics were needed and that it also should refer to the collection of data on environmental factors and to affordability; Article 12 of the Convention on equal recognition before the law should be referred to in paragraph 3(2); paragraph 3(3) should include a reference to violence; paragraph 3(4) should include a reference to strengthening consultation with persons with disabilities and their representative organizations, as provided for under Article 4(3) of the Convention; and paragraph 2(6) should include the need to scale up, and make available nationally, community-based inclusive development programmes consistent with the Convention, and to consider their inclusion in the relevant local authority budget.

Professor BRINTNELL (World Federation of Occupational Therapists), speaking at the invitation of the CHAIRMAN, commended WHO's continued and progressive action to highlight disability and its impact on individuals' human rights and participation in society. She supported the draft resolution and the proposed amendments thereto. The *World report on disability* was a challenging document that provided an agenda for the future, and her organization had worked to promote its content around the world. The language of the Convention should be taken into account in the draft resolution, particularly with regard to mental health and the psychosocial issues related to activity limitation, which were important in furthering rehabilitation and recovery principles across multiple conditions, including noncommunicable diseases. She supported WHO's efforts to mainstream disability, and said that her organization would continue to collaborate proactively with WHO.

Dr CHESTNOV (Assistant Director-General) said that the Secretariat had taken note of the guidance provided; comments would be reflected in the draft resolution before its submission to the Health Assembly. Many speakers had referred to the *World report on disability*, an innovative document that had been distributed in some 50 countries. An intersectoral approach and cooperation would be necessary in order to tackle disability and it should be included in the post-2015 development agenda.

He noted the view expressed by several speakers that the United Nations Convention on the Rights of Persons with Disabilities was a high-level political document that placed an onus on countries to ensure that they fulfilled the obligations that they had already accepted. The WHO Task Force on Disability had been formed in 2008 in response to the Convention. The Secretariat fully supported the requests to define a set of disability standards; he would provide information on existing standards to members of the Board upon request.

He acknowledged the endorsement of the Organization's participation in the High-level Meeting of the United Nations General Assembly on Disability and Development to be held in New York in September 2013.

The CHAIRMAN said that the Secretariat would circulate a conference paper incorporating the various amendments proposed by speakers. In the meantime she took it that the Board noted the report.

The Board noted the report.

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

3. PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 7 of the Agenda

Monitoring the achievement of the health-related Millennium Development Goals: Item 7.1 of the Agenda (Document EB132/11)

Follow-up actions to recommendations of the high-level commissions convened to advance women's and children's health: Item 7.2 of the Agenda (Document EB132/13)

The CHAIRMAN drew attention to a draft resolution on implementation of the recommendations of the Commission on Life-Saving Commodities for Women and Children proposed by Libya, Nigeria, Norway and the United States of America, which read:

The Executive Board,

Having considered the reports on monitoring the achievement of the health-related Millennium Development Goals; and on the follow-up of the recommendations of the Commission on Information and Accountability for Women's and Children's Health and on the work done to follow up the recommendations and implementation plan of the United Nations Commission on Life-Saving Commodities for Women and Children,¹

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

The Sixty-sixth World Health Assembly,

PP1 Recalling resolutions WHA63.15 on monitoring the achievements of the health-related Millennium Development Goals and WHA65.7 on implementation of the recommendations of the Commission on Information and Accountability for Women's and Children's Health;

PP2 Recalling also that the United Nations Secretary-General called upon the global community through the *Global Strategy for Women's and Children's Health* to work together to save 16 million lives by 2015;

PP3 Acknowledging the pledges and commitments made by a large number of Member States and partners to the United Nations Secretary-General's Global Strategy for Women's and Children's Health;

PP4 Recognizing that millions of women and children die needlessly every year from conditions easily prevented with existing, inexpensive medical commodities;

PP5 Recognizing also the need urgently to address and overcome the barriers that prevent women and children from accessing and using appropriate commodities;

PP6 Welcoming the report of the United Nations Commission on Life-Saving Commodities for Women and Children, which estimates that 6 million lives can be saved within five years by improving access to 13 specific, overlooked commodities and related products;

PP7 Welcoming also the actions recommended by the Commission on Life-Saving Commodities for Women and Children and the implementation plan to deliver the actions;

PP8 Acknowledging that the Commission on Life-Saving Commodities for Women and Children's recommended actions will also increase access to a broader set of commodities;

¹ Documents EB132/11 and EB132/13.

PP9 Acknowledging also the need to promote, establish or support and strengthen the health services needed by women and children from before pregnancy to delivery, during the immediate post-delivery period, and childhood;

PP10 Reaffirming the importance of facilitation of technology transfer on mutually agreed terms between developed and developing countries as well as among developing countries as appropriate;

PP11 Acknowledging the role of the independent Expert Review Group in reviewing the progress made in implementing the recommended actions,

1. URGES Member States to put into practice, as appropriate, the implementation plan on life-saving commodities for women and children, including:

- (1) improving the quality, supply and use of the 13 life-saving commodities and building upon information and communication technology best practices for making these improvements;
- (2) developing plans to implement at scale appropriate interventions to increase demand for and utilization of health services and the 13 life-saving commodities, particularly among underserved populations;
- (3) addressing financial barriers to ensure the poorest members of society have access to the 13 life-saving commodities and any other appropriately related commodities;
- (4) improving regulatory efficiency by harmonizing registration requirements and streamlining assessment processes, including granting priority review to the life-saving commodities;
- (5) implementing proven mechanisms and interventions to ensure that health-care providers are knowledgeable about the latest national guidelines for maternal and child health;

2. REQUESTS the Director General:

- (1) to work with UNICEF, UNFPA, World Bank, UNAIDS, UN Women, national, regional and international regulators, private sector actors and other partners to promote and assure the availability of safe quality commodities;
- (2) to work with and support Member States in improving regulatory efficiency, standardizing and harmonizing registration requirements and streamlining assessment processes including granting priority review to the products belonging to the life-saving commodities;
- (3) to provide support to the independent Expert Review Group in its work of assessing progress in the United Nations Secretary-General's Global Strategy for Women's and Children's Health and implementation of the recommendations of the United Nations Commission on Life-Saving Commodities for Women and Children;
- (4) to report annually until 2015 to the World Health Assembly, through the Executive Board, on progress achieved in the follow-up of the recommendations of the Commission on Life-Saving Commodities for Women and Children in connection with the agenda item concerning promoting health through the life course.

Annex to resolution on follow up to recommendations of the Commission on Life-Saving Commodities for Women and Children

COMMODITY BY LIFE STAGE	
Maternal health commodities	
1	Oxytocin – post partum haemorrhage (PPH)
2	Misoprostol – post-partum haemorrhage
3	Magnesium sulfate – eclampsia and severe pre-eclampsia
Newborn health commodities	
4	Injectable antibiotics – newborn sepsis
5	Antenatal corticosteroids (ANCs) – preterm respiratory distress syndrome
6	Chlorhexidine – newborn cord care
7	Resuscitation devices – newborn asphyxia
Child health commodities	
8	Amoxicillin – pneumonia
9	Oral rehydration salts (ORS) – diarrhoea
10	Zinc – diarrhoea
Reproductive health commodities	
11	Female condoms
12	Contraceptive implants – family planning/contraception
13	Emergency contraception – family planning/contraception

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

<p>1. Resolution: Implementation of the recommendations of the Commission on Life-Saving Commodities for Women and Children</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): 4 and 11</p>	<p>Organization-wide expected result(s): 4.7, 11.1, 11.2, 11.3</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 Member States to improve the quality, supply and use of life-saving commodities for women's and children's health, and to take the necessary actions for reducing maternal and child mortality and achieving Millennium Development Goals 4 and 5.</p>	
<p>Does the programme budget already include the products or services requested in this resolution? (Yes/no)</p>	
<p>Additional resources will be required to support work on prequalification, quality assurance, demand creation and for other actions identified for implementing recommendations of the Commission, particularly in relation to technical support by WHO.</p>	

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) Three years (covering the period 2013–2015)
- (ii) Total: US\$ 20 million (staff: US\$ 6 million; activities: US\$ 14 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\$ 5.83 million (staff: US\$ 830 000; activities: US\$ 5 million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

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\$ 5.83 million

(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.

Headquarters: one staff member at grade P.5, one at grade P.4 and one at grade P.3, each post requiring skills in commodity management and quality assurance.

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).

There is a funding gap of US\$ 5.83 million (US\$ 2.60 million pledged, source of funds: Norway via the secretariat of the United Nations Commission on Life-Saving Commodities for Women and Children; US\$ 3.23 million, source of funds: mobilization strategy pending).

Professor COLL SECK (Senegal), speaking on behalf of the Member States of the African Region, said that, although they had made good progress towards achievement of Millennium Development Goal 6 (Combat HIV/AIDS, malaria and other diseases), much remained to be done in relation to Goals 4 (Reduce child mortality) and 5 (Improve maternal health). It was estimated that nine countries in the Region had reduced the child mortality rate by at least 4% per year. The maternal mortality ratio had been impacted by lack of access to health-care services, the low numbers of births attended by skilled personnel, lack of contraceptive services, the geographical situation and women's lack of empowerment. Achievement of Goals 4 and 5 was an urgent priority in the Region and the international attention that had been given to the subject through the Secretary-General's Global Strategy for Women's and Children's Health had been welcome. She appreciated that Strategy's emphasis on expanded access to innovative products and WHO's commitment to strengthening the quality of products, ensuring regulatory efficiency and scaling up access to emergency contraception

through its lead role in the United Nations Commission on Life-Saving Commodities for Women and Children. Workshops had been organized in the African Region in order to develop a road map for implementation of the Strategy. The support of the African Union, WHO and its partners was sought in implementing the Commission's recommendations through the mobilization of resources, ensuring that countries and partners fulfilled their commitments in relation to the Strategy, and promoting improved coordination. She supported the draft resolution.

Dr LARSEN (Norway) said that the Millennium Development Goals had given the world clear and measureable objectives, in particular, improving maternal and child health. Furthermore, the Secretary-General's Global Strategy for Women's and Children's Health had produced landmark results in a short space of time. The Commission on Life-Saving Commodities for Women and Children, which had been set up to support the Strategy, had identified 13 essential commodities and made 10 recommendations on improving access to them. A detailed implementation plan had been drawn up in order to ensure rapid progress and numerous countries had pledged their commitment to its recommendations in the ministerial communiqué of the Implementation Meeting of the UN Commission on Life-saving Commodities for Women and Children (Abuja, 14–16 October 2012).

The draft resolution called for support for the Commission's recommendations and the implementation plan and underlined the crucial role of WHO in the follow-up of the recommendations for which it had special responsibility. He invited Member States to join in sponsoring the draft resolution.

Dr DAULAIRE (United States of America) welcomed the progress made by some Member States towards achieving the health-related Millennium Development Goal targets; the reduction in child mortality in low-resource countries, especially in Africa, had been encouraging. He urged Member States to maintain a focus on the Goals as a guiding principle for the work of WHO and to intensify their support for activities related to attaining the Goals by 2015.

Following the launch of the Global Strategy for Women's and Children's Health, Ethiopia, India and his Government, in collaboration with UNICEF, had issued a Call to Action to end all preventable child deaths; to date, more than 160 countries had signed a pledge in support of that initiative.

It was a matter of concern that the pace of progress in reducing maternal and neonatal mortality had been slower than for child mortality and more understanding was required of the reasons for success in some countries and the lack of progress in others. As stated in the recommendations of the Commission on Information and Accountability for Women's and Children's Health, improving data on maternal, neonatal and infant mortality was critical to better monitor impact and he therefore urged Member States to implement the Commission's recommendations.

As a sponsor of the draft resolution, he commended it to the Board.

Dr GRABAUSKAS (Lithuania), speaking on behalf of the European Union and its Member States, said that Croatia, the former Yugoslav Republic of Macedonia, Montenegro, Iceland, Serbia, Albania, Ukraine, the Republic of Moldova, Armenia and Georgia aligned themselves with his statement. Pursuit of the Millennium Development Goals, with their focus on results and health outcomes, had led to an estimated 40% decline in the under-five-year-old child mortality rate and maternal mortality ratios globally since 1990. However, those rates were still unacceptably high and persistent inequalities within and between countries hampered progress. The European Union was committed to supporting the achievement of the Millennium Development Goals by 2015 and believed that progress could be accelerated by tackling cross-cutting challenges such as health system strengthening, social and environmental determinants, education, water and sanitation.

WHO should continue to inform the global community on the most efficient ways to realize the best health outcomes for women and children and to support the prioritization and development of integrated programmes within national health strategies and intersectoral development frameworks. Inclusive leadership, gender equality, a rights-based approach and good governance were essential for achieving the health-related Millennium Development Goals.

Insufficient progress had been made on universal access to reproductive health and a special emphasis was required on sexual and reproductive health programmes, in particular for young people. In addition, harmful barriers to women's health, including financial barriers and discriminatory laws, must be removed.

HIV/AIDS incidence was still rising in eastern Europe and the proportion of young women under the age of 24 years infected by HIV had increased. There was still a need to focus on prevention that targeted key populations and youth in order to reverse that trend.

WHO's continued efforts at coordination among global health partners and strengthening of the International Health Partnership would be crucial to achieving the Millennium Development Goals. WHO country offices needed to be better equipped in order to provide support to partner countries in the delivery of their national plans and priorities.

The European Union was supportive of the Commission on Information and Accountability for Women's and Children's Health and the United Nations Commission on Life-Saving Commodities for Women and Children. Those global efforts demonstrated a positive commitment to the still neglected areas of maternal, newborn and child health. The European Union was also supportive, within the context of the health system strengthening approach, of WHO's actions to help to meet Millennium Development Goals 4 and 5 under the umbrella of the United Nations Secretary-General's Global Strategy for Women's and Children's Health. In accordance with aid effectiveness principles, he asked WHO to ensure that national reporting was managed efficiently, without creating an undue burden for countries.

He supported adoption of the draft resolution without amendment.

Ms LIU Yue (China) endorsed the findings of the report contained in document EB132/11. Countries should do their utmost to achieve the Millennium Development Goals by 2015; it would be helpful to analyse the main reasons for any failure. Attention should focus on areas that lagged behind expectations, taking into account the issue of equity in resource allocation. Health system strengthening was an essential part of achieving the Millennium Development Goals and it should be made a central element of external support from international organizations.

Noting the report on follow-up actions to recommendations of the high-level commissions convened to advance women's and children's health (document EB132/13), she highlighted the importance of the recommendations of the Commission on Information and Accountability for Women and Children's Health. She asked whether the recommendations on life-saving commodities had been fully implemented by WHO and whether they were reflected in the draft proposed programme budget 2014–2015.

Dr ÁLVAREZ LUCAS (Mexico), referring to document EB132/13, said that Mexico agreed with the recommendations of the high-level commissions convened to advance women's and children's health and endorsed the analysis of the United Nations Commission on Life-Saving Commodities for Women and Children on the barriers to access to those commodities. He supported the draft resolution on implementation of the Commission's recommendations.

Professor OSTOJIC (Croatia), referring to Millennium Development Goal 6, said that investment in capacity development was essential to eliminating transmission of HIV from mother to child and between serodiscordant couples. There should be greater investment in strengthening health-care systems in terms of human resources and infrastructure. Croatia had contributed to the global fight against HIV through the WHO Collaborating Centre for HIV Surveillance in Zagreb. The Centre had trained more than 1800 professionals from 86 countries in HIV surveillance and evaluation of HIV interventions and had provided technical support to more than 20 countries. The Centre would continue to apply the latest scientific evidence and knowledge transfer to the most affected countries.

Mr ALLMAN (Barbados) said that Barbados had taken several initiatives in pursuance of the Millennium Development Goals and the Global Strategy for Women's and Children's Health, including the provision of antiretroviral therapy to prevent mother-to-child transmission of HIV.

Guidelines had been implemented to identify high-risk pregnancies, midwives received continuous education, and nurses had been trained in neonatal care. Pregnant women had access to antenatal and postnatal care and pregnant adolescent and unbooked mothers were referred to social services for assessment and follow-up. The antenatal care unit at the island's main hospital had been expanded.

A gender-based violence screening tool had been piloted in a rural area and would soon be piloted in an urban area. New vaccines had been added to the Expanded Programme on Immunization and nurses underwent continuous training on the administration of vaccines. The Family Planning Association, a nongovernmental organization, gave support to the public at reduced cost.

Women and children played a crucial role in development and therefore investing in their health helped to build stable, peaceful and productive societies; it allowed them to realize their fundamental human rights and stimulated economic productivity and growth. He supported the follow-up actions to recommendations of the high-level commissions convened to advance women's and children's health and looked forward to continued support from PAHO and WHO in implementing them. He supported the draft resolution.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that, in 2012, Cuba had recorded an infant mortality rate of 4.6 per 1000 live births and a maternal mortality ratio of 21.5 per 100 000 live births; it had thus achieved its Millennium Development Goal targets in those areas.

He agreed with the recommendations of the Commission on Life-Saving Commodities for Women and Children, which should be disseminated through country-based awareness-raising programmes. As the issue of health transcended many boundaries, a cross-sectoral approach would be needed in order to achieve the health-related Millennium Development Goals by 2015.

Dr JAMSHEED MOHAMED (Maldives) said that the Member States of the South-East Asia Region had recorded impressive progress with regard to many of the Millennium Development Goal indicators, with tangible improvements on others expected before 2015. Maldives itself had achieved five of the eight Millennium Development Goals although, like many developing countries, it faced challenges in maintaining the progress made. Despite the slow decline in the proportion of children who were undernourished, his country still required the support of WHO and other partners.

The high prevalence of substance abuse and the increasing risk of HIV infection due to an increase in risky behaviour among youth seriously threatened to increase the existing low HIV prevalence. Capacity strengthening and empowerment for civil society organizations were needed to ensure effective preventive interventions.

The country's recently enacted Health Protection Act would facilitate the task of reinforcing the control and prevention of diseases, promoting healthy lifestyles and sustaining the gains made towards some Millennium Development Goals.

Dr MENZHI (Morocco) welcomed the progress towards achieving the health-related Millennium Development Goals recorded in the report (document EB132/11) but noted that further financial support and development of technical expertise would be needed to fill existing gaps. He supported the draft resolution on implementation of the recommendations of the Commission on Life-Saving Commodities for Women and Children.

Professor NICKNAM (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that, although significant progress had been made in his Region, countries throughout the world faced challenges in achieving Millennium Development Goals 4 and 5. Countries that were beset by complex emergencies, civil unrest, inadequate political commitment and insufficient resources and capacity required technical and financial resources in order to bolster their efforts. He highlighted the action taken by WHO in partnership with UNICEF and UNFPA to accelerate work on Millennium Development Goals 4 and 5 in the Eastern Mediterranean Region in 2013, and sought the support of Member States, donors and development agencies for that initiative and similar projects in other regions.

Mr LIOW TIONG LAI (Malaysia), referring to the report contained in document EB132/13, supported the 10 recommendations of the Commission on Information and Accountability for Women's and Children's Health. The initiatives described would help countries to evaluate and monitor the progress of women's and children's health through systematic self-assessment, covering important areas such as accountability for results and resources. He urged the Secretariat to continue to monitor national reporting data and to support countries in further national capacity building. The establishment of the independent Expert Review Group would facilitate closer monitoring and analysis of shortcomings in strategies that had not yielded adequate improvements in women's and children's health. Women and children must be at the centre of every country's political vision.

Ms PENEVEYRE (Switzerland) welcomed the draft resolution on implementation of the recommendations of the Commission on Life-Saving Commodities for Women and Children, which underlined that simple and cost-effective solutions existed to meet the major challenges that remained in the field of maternal and child health. The resolution's pragmatic proposals underlined the importance of proven, effective interventions and of WHO working in partnership with other bodies in the United Nations system.

Ms AMMAR (Lebanon), referring to document EB132/13, commended the H4+ interagency mechanism established by WHO and its partners to support countries in implementing the recommendations of the Commission on Information and Accountability for Women's and Children's Health and the establishment of the independent Expert Review Group. It was not acceptable that life-saving commodities were not being made available or used properly, particularly considering their low cost and significant impact on women's and children's health. Lebanon supported and wished to cosponsor the draft resolution.

Dr SARMENTO P. DA COSTA (Timor-Leste) expressed appreciation for the report on follow-up actions to recommendations of the high-level commissions convened to advance women's and children's health. WHO was the lead partner responsible for implementation of the recommendations to strengthen the quality of products, ensure the effectiveness of regulations and extend access to reproductive health services. Timor-Leste fully supported the work of the Regional Office for South-East Asia, in particular with regard to the implementation of the recommendations of the Commission on Information and Accountability for Women's Health.

Timor-Leste was firmly committed to achieving the Millennium Development Goals, in particular the goals to reduce the child mortality rate (currently 64 per 1000 live births) and the maternal mortality ratio (557 per 100 000 live births). She called on the Regional Office with its partners to provide technical support in order to guarantee the quality of essential medicines and basic products and to ensure their availability. She further called on WHO to help to improve the quality of neonatal and maternity care since quality of care was also an important aspect of accountability. Quality of information was also an area in which support was required.

She aligned herself with the recommendations of the Commission on Life-Saving Commodities for Women and Children and supported the draft resolution on the subject.

Professor HALTON (Australia) welcomed the progress recorded in the report on monitoring the achievement of the health-related Millennium Development Goals, which highlighted the usefulness of having measurable targets, and said that health must continue to be prioritized in the post-2015 development agenda. Focus should continue on areas where progress lagged most behind targets, with a special emphasis on reducing maternal mortality, a subject that was accorded particular priority in the Western Pacific Region. The work of the United Nations Commission on Life-Saving Commodities for Women and Children would be important in further improving performance. She supported the draft resolution but proposed that the words “, as appropriate,” be added after “Member States” in paragraph 2.2, in order to ensure that support targeted those States where it was most needed.

Dr ABDULLAYEV (Azerbaijan) thanked WHO and UNICEF for the global consultations on health, which had stimulated inclusive discussion on progress made and lessons learnt from the present health-related Millennium Development Goals and had provided a platform for a post-2015 development framework. Important work remained in the areas of maternal, child and infant mortality, reproductive health and infectious diseases. Member States in the European Region faced substantial challenges in tackling multidrug-resistant and extensively drug-resistant tuberculosis as well as HIV/AIDS and malaria.

Dr BAYE LUKONG (Cameroon) welcomed the draft resolution on implementation of the recommendations of the Commission on Life-Saving Commodities for Women and Children and agreed with the member for Switzerland that progress could be made if practical steps were taken. Although Cameroon was beginning to witness a decline in the mortality rates for infants and under-five children, it still experienced significant problems in relation to maternal mortality. For that reason, Cameroon strongly supported the draft resolution.

Dr VALVERDE (Panama) said that she had taken note of the work done by the Secretariat in relation to the recommendations and implementation plan of the United Nations Commission on Life-Saving Commodities for Women and Children. Panama continued to be committed to the achievement of the health-related Millennium Development Goals; it paid special attention to situations in rural and indigenous areas and worked with an intercultural approach. Panama had made significant progress through the creation of institutions and its strategic programmes had yielded concrete results. More efforts were required in order to obtain data that would allow the Government to take timely action and to improve the availability of life-saving commodities for women and children. She supported both the draft resolution on that theme and the inclusion of universal access to health as one of the Millennium Development Goals.

Dr ALIMOV (Uzbekistan) said that work in his country towards the Millennium Development Goals had reduced poverty and undernutrition among children under five years of age had fallen, with a fourfold decrease in the number of underweight children since 2000. Between 1991 and 2010, child mortality had decreased by a factor of three. Maternal health and universal access to reproductive health had improved and government programmes had led to a threefold decrease in the number of maternal deaths. Concerning Goal 6, the number of deaths from tuberculosis had been halved, but HIV/AIDS remained a concern; no case of malaria had been observed recently.

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

Health in the post-2015 development agenda: Item 7.1 of the Agenda (Document EB132/12)

Professor COLL SECK (Senegal), speaking on behalf of the Member States of the African Region, said that discussions on the post-2015 development agenda had thus far indicated the need to reformulate the Millennium Development Goals in order to reflect current and emerging issues. Goals that had not been achieved by 2015 should be maintained in order to avoid any loss of momentum and emerging issues should be considered against the backdrop of equal access to health care.

Dr GRABAUSKAS (Lithuania), speaking on behalf of the European Union and its Member States, said that Croatia, the former Yugoslav Republic of Macedonia, Montenegro, Iceland, Serbia, Albania, Ukraine, the Republic of Moldova, Armenia and Georgia aligned themselves with his statement. Health should be one of the post-2015 cornerstones, clearly based on equity and human rights and framed in terms of country-specific social, economic and environmental challenges, with continued focus on measurable and qualitative results.

Dr ÁLVAREZ LUCAS (Mexico) said that the post-2015 goals should correspond to the global problems faced by society; they should also continue to be simple, easy to understand and measurable. Health should be made a cornerstone of sustainable development and poverty reduction. Universal health coverage should be a development goal in the post-2015 agenda, which should include diseases of concern to each region and to the international community as a whole.

Professor OSTOJIĆ (Croatia) recognized the importance of the health-related Millennium Development Goals and endorsed the view that health was a precondition and an outcome of sustainable development. Health should be a prominent part of the sustainable development goals and of the post-2015 agenda, as highlighted at the United Nations High-level Meeting on the Prevention and Control of Non-communicable Diseases and the World Conference on the Social Determinants of Health. He emphasized the need for further international collaboration and political commitment in the area of global health.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) agreed that the Millennium Development Goals had been a powerful force in maintaining support for health as a crucial element of development. The simplicity of the framework, the readily understandable objectives and the focus on quantitative monitoring had proved durably engaging. WHO should secure the place of health in the post-2015 agenda. It would be more difficult to define the post-2015 goals given the complexity of the present political and institutional situations but they should take into account current and emerging priorities and embody a common objective that would ensure public acceptance worldwide.

Dr JAMSHEED MOHAMED (Maldives) supported the inclusion of universal health coverage through primary health care and strengthened health systems in the post-Millennium Development Goal agenda; that was a way not only to address health priorities but also to bring about equity and poverty reduction.

Dr MENZHI (Morocco) said that further reflection would be needed on the post-2015 agenda: in addition to health, consideration should be given to poverty, unhealthy living conditions, illiteracy, social injustice and inequality in vulnerable populations. In addition, the current focus on noncommunicable diseases should not exclude communicable and emerging diseases which remained a burden for developing countries.

Mr LIOW TIONG LAI (Malaysia) supported the analysis and recommendations in the report on health in the post-2015 development agenda and the affirmation that health was central to development. He agreed with the three sets of issues outlined in the report, namely: the need to sustain current gains; consideration of other aspects of determinants of health and the links between sustainable development and poverty reduction; and the need for universal coverage. It would be particularly important to include the unfinished agenda in relation to the current health-related Millennium Development Goals in the new agenda.

Dr ABDULLAYEV (Azerbaijan) agreed that health was central to development and strongly supported the view that it should occupy a prominent place in the post 2015-development agenda. In the future, WHO should focus on sustaining gains and protecting investments made to achieve the health-related Millennium Development Goals. New challenges to health should also be considered, including the increasing burden of noncommunicable diseases, mental health and ageing populations. The global monitoring framework on noncommunicable diseases could be used in formulating the post-2015 agenda. A strong health system that provided for universal coverage, health promotion and prevention and a multisectoral approach to address root causes, and that incorporated the social determinants of health, would be required. Other important elements would be universal health coverage that took into account not only financing but also the disease burden of communicable and noncommunicable diseases, and quality of care.

Healthy people contributed to economic and social development, and health policies contributed to poverty reduction. Health was also the potential beneficiary of policies in a wide range of other sectors.

Dr AZODOH (Nigeria) commended the report on monitoring the achievement of the health-related Millennium Development Goals. Despite the achievements, challenges remained and the Goals would still be important after 2015. She called on the Board to ensure that Millennium Development Goals 4, 5 and 6 were incorporated into the sustainable development goals in the post-2015 agenda so that the gains of recent decades were not lost.

Dr VALVERDE (Panama) said that, because the Millennium Development Goals were a powerful force for sustainable development, they should be continued in the post-2015 agenda with indicators that reflected the current situations faced by countries.

Dr ALIMOV (Uzbekistan) said that the three priorities to be considered after 2015 were: to ensure that the results were sustainable, to protect investments and to improve maternal and child health; to tackle infectious diseases, particularly HIV/AIDS and tuberculosis; and to set noncommunicable diseases and environmental health as priority agenda items. Universal health coverage could help to resolve those and other health-related issues.

(For continuation of the discussion, see the summary record of the eighth meeting, section 3.)

The meeting rose at 17:45.

FIFTH MEETING

Wednesday, 23 January 2013, at 09:10

Chairman: Dr J. ST. JOHN (Barbados)
later: Dr A. JAMSHEED MOHAMED (Maldives)
later: Dr J. ST. JOHN (Barbados)

WHO REFORM: Item 5 of the Agenda

- **WHO's arrangements for hosting health partnerships and proposals for harmonizing WHO's work with hosted partnerships** (Documents EB132/5 Add.1, EB132/5 Add.9 and EB132/INF./2)
- **WHO's engagement with nongovernmental organizations** (Document EB132/5 Add.2)

Dr REN Minghui (China) said that hosted partnerships were beneficial, but the problems associated with their governance should be resolved. Management of hosted partnerships by the governing bodies should extend beyond regular review by the Programme, Budget and Administration Committee to include consideration of potential hosted partnerships for approval. The substance and periodicity of any review of hosted partnerships by the Executive Board should be specified, as should the responsibilities of the Secretariat and the partnerships' governing bodies, in order to ensure consistency, facilitate coordination and avoid duplication of effort. He endorsed the suggested courses of action set out in paragraph 16 of document EB132/5 Add.1; the use of clear language was particularly important in order to ensure consistent views were expressed by Member States within the governing bodies and in their capacity as members of hosted partnership boards. The allocation for hosted partnerships should be set out in the programme budget.

He endorsed the guiding principles governing relations between WHO and nongovernmental organizations as well as the three proposed mechanisms for consultation with nongovernmental organizations (document EB132/5 Add.2); consultation on the question of partnerships with private commercial entities was of particular importance. The proposal to de-link consultation from a period of working relations would enable nongovernmental organizations, regardless of their status vis-à-vis the Organization, to contribute their expertise to technical discussions. Detailed plans regarding accreditation procedures were also needed, and should be reviewed by the Standing Committee on Nongovernmental Organizations.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the number of partnerships hosted by WHO should be kept to a minimum in order to ensure proper harmonization. It was not clear why WHO entered into contracts on the partnerships' behalf when they transacted with third parties. A partnership's secretariat should not become part of WHO's administrative, fiduciary and legal framework. He agreed that partnerships should be reviewed on a case-by-case basis every five years and a joint committee established, combining the secretariats of both WHO and the partnership concerned, provided that no staffing implication for WHO was entailed. The regional activities of WHO representatives in countries with hosted partnerships should be brought to the attention of the Secretariat and duly coordinated, and a decision by WHO to host a new partnership should be taken only after a thorough cost-benefit analysis.

The development of a policy on engagement with nongovernmental organizations would be welcome. Accreditation procedures should be revised and updated, and it might be useful to review relations with nongovernmental organizations every five years.

Dr GRABAUSKAS (Lithuania), speaking on behalf of the European Union and its Member States, called for a clear and permanent definition of hosted partnerships. The proposed courses of action to harmonize the programmatic, governance and administrative aspects were commendable. The added value of partnerships must be maintained, and the status of WHO's engagement with each hosted partnership should be reviewed periodically by the appropriate oversight body at global or regional level. Greater consistency and coherence were needed between the governing bodies of WHO and the boards of hosted partnerships.

He sought confirmation that the eight hosted partnerships listed in document EB132/5 Add.1 were not included in the proposed programme budget 2014–2015. Appropriate accountability mechanisms were nonetheless required in order to monitor potential financial liabilities.

A set of core principles must be drawn up to guide WHO's engagement with non-State actors and manage any conflicts that might arise. Further information on how mechanisms such as declaration of interests and a transparency register might work in the WHO context would be welcome.

Dr LARSEN (Norway) recognized the shared interest of maximizing synergies between WHO and its hosted partnerships. The technical challenges involved could be seen as an investment in improved health outcomes and more effective handling of problems too difficult for a single institution to manage. The idea of drawing up and implementing a set of guiding principles for WHO-hosted partnerships was worthy of support.

The reform process provided a good opportunity to review WHO's interaction with nongovernmental organizations and other stakeholders in general. He welcomed the list of proposed consultation methods, to which web-based consultation should be added. Any comments submitted should be open for review by all stakeholders.

WHO must find its place in the modern global health framework. It must remain inclusive, engaging in dialogue with stakeholders, in particular civil society, while ensuring that its decisions were democratic and free from commercial influence. Policies relating to its engagement with nongovernmental organizations and with private commercial entities should be developed in parallel.

Dr LOUME (Senegal), speaking on behalf of the Member States of the African Region, commended the remarkable work done by hosted partnerships. Their effectiveness would grow, however, only when the public health objectives they pursued were convergent with and complementary to those of the Organization. To that end, he endorsed the suggested courses of action outlined in document EB132/5 Add.1 (paragraph 16). Furthermore, hosted partnerships should be required to set aside financial reserves to avoid burdening WHO with unexpected liabilities.

Greater collaboration between WHO and nongovernmental organizations would be welcome as long as it was anchored in clear and transparent procedures designed to prevent conflicts of interest. Each type of nongovernmental organization should be handled separately. Formal consultation mechanisms, such as that used by FAO, might be useful in that regard. A flexible procedure for accreditation of nongovernmental organizations, such as that put forward in document EB132/5 Add.2 (paragraph 22), would be welcome.

Mr REINA (Mexico) commended all efforts to increase transparency and improve harmonization between WHO and hosted partnerships. The courses of action recommended in document EB132/5 Add.1 (paragraph 16) were worthy of consideration, in particular a case-by-case review by the Programme, Budget and Administration Committee, and the incorporation of independent performance evaluations into the Secretariat's report on such partnerships. It was to be hoped that the study being done by the General Management Group within the Secretariat would yield results that would generate cost savings for the Organization. The new tasks assigned to the Programme, Budget and Administration Committee and the establishment of an internal joint committee should be carried out rapidly to avoid delays in reporting.

Better communication with nongovernmental organizations was certainly desirable but the use of technology to that end had not yielded the desired results. He favoured the exploration of open-ended

consultation processes in which all parties could express their views. A distinction should be made between nongovernmental organizations and private interest organizations. The preparation of a policy paper on WHO's relations with private commercial entities would be welcome.

Dr AMMAR (Lebanon) affirmed that hosted partnerships added value to WHO's work, but also posed problems. Dual governance was a concern, as was the need to protect partnerships from any form of vested interest, especially when commercial entities were involved in partnerships' governance and financing. In addition, hosted partnerships might compete with WHO for resources and sometimes failed to cover their administrative costs, even transferring liabilities to the Organization in some cases. The vertical approach often sought by hosted partnerships raised questions about the actual contribution they made to strengthening countries' health systems sustainably. The Organization needed a new partnership policy that would give it greater oversight over partnerships, with particular regard to accountability and performance evaluation.

Ms PENEVEYRE (Switzerland) supported broader collaboration with nongovernmental organizations. The current practice of basing that collaboration on a three-year workplan was an effective management tool. The mechanisms for consultation with nongovernmental organizations must be such that no additional burden was placed on the governing bodies. Furthermore, decision-making within the Organization must remain the prerogative of Member States.

She endorsed the suggestion that the development of WHO's policy on engagement with nongovernmental organizations should parallel the development of its policy on relationships with private commercial entities. Managing conflicts of interest was crucial but it was best not to increase the number of policy-making mechanisms in that area. WHO should apply the same principles in all its relations with non-State actors; those principles should be elaborated according to the schedule for drafting the policy on WHO's relationship with private commercial entities, and be considered by the Board at its 133rd session.

With regard to hosted partnerships, she welcomed the reference in document EB132/5 Add.1 to coverage of administrative costs and encouraged the Secretariat to introduce a more realistic costing framework. The proposal to mandate the Programme, Budget and Administration Committee to review case by case the Organization's relation with each partnership was welcome and a mechanism for selecting candidates for review should be defined.

Dr DAULAIRE (United States of America) said that, as a general principle, WHO should have full voting rights on the board of each hosted partnership. The Programme, Budget and Administration Committee should, on the basis of its reviews of the hosting relationship, provide guidance to the Secretariat in that regard. The hosting arrangement must provide a net gain for both parties. Internal joint committees, which should be phased in gradually, could help to mediate discrepancies between the positions taken by WHO governing bodies and the boards of hosted partnerships. Coordination guidelines would help to limit overlap as well as to provide flexibility.

WHO should draft a set of hosting guidelines, subject to review by the governing bodies, that included "firewalls" to protect both parties and should stipulate, *inter alia*, the conditions of recruitment and partnership obligations in respect of WHO staff members. WHO must limit its liability in all cases and the proposed rule requiring hosted partnerships to set aside reserves was welcome. A risk matrix and a new costing framework for hosted partnerships were also needed.

In terms of WHO's engagement with nongovernmental organizations, the establishment of a transparency register would be helpful. A single, transparent policy should be drawn up and applied consistently to all non-State actors. His Government was not in favour of bringing Member States and nongovernmental organizations together to discuss relations with commercial entities; that was a matter to be considered by the Board at its 133rd session. The idea of setting up a formal working group mechanism for engaging nongovernmental organizations and other non-State actors merited further consideration.

A review of the procedures for accreditation of nongovernmental organizations was needed, and particular attention must be paid to ensuring that groups fronting for others did not take advantage of lax

rules. Nongovernmental organizations authorized to participate in governing body meetings should not be limited to those currently in official relations with WHO; nongovernmental organizations with a wide diversity of experience and needs must be given a voice.

Professor NICKNAM (Islamic Republic of Iran) endorsed most of the courses of action set out in paragraph 16 of document EB132/5 Add.1 but requested more information on the requirement that hosted partnerships set aside reserves to meet potential liabilities, and the development of a risk matrix.

With regard to the Organization's engagement with nongovernmental organizations, he favoured the expansion of web-based or electronic platforms and the holding of structured, inclusive and transparent public hearings; clarification regarding the suggested mechanism of a satellite forum for nongovernmental organizations would be welcome. Further study of ways to strengthen the engagement between WHO and nongovernmental organizations was needed, bearing in mind the specific technical context involved in each case. Mechanisms to ensure full and public disclosure of WHO's interaction with nongovernmental organizations, such as a declaration of interest or a list of potential conflicts of interest, should be applied. The implications of making a distinction between not-for-profit organizations and commercial entities should also be examined. The accreditation procedure for nongovernmental organizations needed revision, and Member States should be involved in the process. He was uncertain about the benefits of inviting the same participants to two different policy consultations, one on engagement with nongovernmental organizations and the other on engagement with private commercial entities.

Mr HAZIM (Morocco) applauded the proposals set out in paragraph 16 of document EB132/5 Add.1, in particular those relating to coordination of the Organization's activities with those of hosted partnerships and to strengthening the Organization's role therein. He endorsed the study being conducted on the costs and risks of hosting partnerships, the aim of which was to ensure that such partnerships were striving to reach clear global-health enhancing goals. Responsibility for assessing hosted partnerships should not lie solely with the Programme, Budget and Administration Committee, but also be entrusted to all WHO bodies within their respective areas of competence.

Dr VALLEJO (Ecuador) said that the current policy governing hosted partnerships should be revised to include administrative and programmatic guidelines, and strategies should be developed to meet the challenges identified in document EB132/5 Add.1. The Organization should not only review the criteria for entering into partnerships but also draw up a policy for coordination and oversight of partnerships in order to ensure their transparency and accountability and to establish rational limits in terms of their number. Considering the broad responsibilities it already had, the Programme, Budget and Administration Committee should not be tasked with carrying out periodic reviews of hosted partnerships.

The process of drafting a policy on the key issue of engagement with nongovernmental organizations was taking too long. Transparency and accountability should be among the main pillars of the policy and, in that regard, an electronic platform providing information on all nongovernmental organizations collaborating with WHO was needed, as was a mechanism for periodic review of the relationship, with a special focus on funding to ensure that transparency was maintained and conflicts of interest were avoided. Potential difficulties, criteria to be met, and management strategies should also be included in the policy.

He was in favour of putting nongovernmental organizations into different categories, each with its own specific policy, but did not support the inclusion of commercially-linked nongovernmental organizations in the Organization's policy on relationships with private commercial entities.

Dr BABB-SCHAEFER (Barbados) favoured joint consultations with Member States and nongovernmental organizations for the purpose of drafting a policy on engagement with nongovernmental organizations. Those organizations should not, however, be included in consultations for policy development in the area of engagement with private commercial enterprises. She agreed with the member for the United States that there should be a single policy for all non-State actors.

Professor HALTON (Australia) said that WHO should focus on the development of a properly articulated policy on all aspects involved in hosting partnerships; whether administration of partnerships should be assigned to the Programme, Budget and Administration Committee was of secondary concern. Partnerships should be properly costed and transparent; the applicable governance arrangements and risk criteria should be consistent with the principles that applied to WHO as a whole.

She agreed with the views of the member for the United States about engagement with nongovernmental organizations, in particular, the need for a single policy applicable to all non-State actors. Engagement should be meaningful, based on a clear rationale, and, above all, consistent with the Organization's interests. Avoiding conflicts of interest was crucial and she called on the Organization to make greater efforts to promote transparency, equity and accountability within the engagement framework. The proposed consultation mechanisms were acceptable, but she did not favour holding another nongovernmental organization forum.

Dr AL-MARRI (Qatar) suggested that a joint committee composed of representatives of WHO and nongovernmental organizations, as mentioned by the member for the United States, should include a neutral and independent member to ensure the most favourable outcomes and avoid duplication of the points covered in document EB132/5 Add.1.

Dr SARETZKI (Colombia)¹ said that, as it could be costly for WHO to maintain the hybrid governance and administrative arrangements that characterized hosted partnerships, steps should be taken to ensure that partnerships had as much administrative, legal and financial independence from WHO as possible, without which accountability and transparency would be compromised. He therefore urged the Programme, Budget and Administration Committee and the Secretariat to examine jointly ways of harmonizing and giving administrative independence to hosted partnerships, and to compare the work done by partnerships with that carried out by WHO in order to avoid duplication of effort and bureaucratic overload and to justify the continued existence of the partnerships. There was no need to set up an internal joint committee combining the secretariats of WHO and a partnership as that might simply create an additional burden. Any concerns could be addressed to the governing bodies of the partnerships or of WHO.

He endorsed the Secretariat's suggestion that specific issues calling for consultation with nongovernmental organizations could be identified and then included in an annual plan for endorsement by the Board at its 133rd session. WHO's collaboration with nongovernmental organizations could, as suggested by the Secretariat, take new directions and further consideration should be given to that idea.

Mr KÜMMEL (Germany)¹ endorsed the courses of action suggested in paragraph 16 of document EB132/5 Add.1 and agreed that the Programme, Budget and Administration Committee was the appropriate body to review hosted partnerships, since many of the challenges they faced were budgetary, programmatic or administrative. WHO had devoted considerable resources to supporting hosted partnerships; such arrangements were even cross-subsidized, a matter of concern to both the Secretariat and Member States. It was therefore a source of satisfaction that such partnerships would no longer be included in the programme budget, which meant that they would henceforth have to cover all services provided to them by the Organization. An explanation of how partnership financing arrangements would be handled in the future would be welcome.

Mr TOBAR (Argentina)² said that a mechanism should exist to inform Member States of the programmatic activities and budgets of hosted partnerships. Information on partnerships' transactions with third parties, for which WHO was liable, would also be welcome. He recalled the partnerships

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

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

policy endorsed in resolution WHA63.10, in particular, the 10 criteria for assessing WHO's engagement in future partnerships and guiding its relations with existing ones. One concern was that tensions resulting from dual governance might increase the risk of conflict and blur the lines of accountability. WHO's dual role as host and technical partner required it to support partnerships in meeting programmatic, governance and administrative challenges. There could, then, be no difference of opinion between the Organization and its partnerships with regard to the normative and technical aspects of their joint work.

He endorsed the proposal that the Programme, Budget and Administration Committee should periodically review hosted partnerships on a case-by-case basis. He favoured the establishment of an internal joint committee combining the secretariats of both WHO and the partnership to consider programmatic and administrative issues. Independent evaluations on the performance and activities of hosted partnerships would be very useful and would help to ensure reporting transparency.

Dr HARVEY (United Kingdom of Great Britain and Northern Ireland),¹ acknowledging the governance and administrative challenges arising from the hosting structure, commended the excellent work done by the partnerships. She was in favour of partnership reviews with fixed dates and targets and, when necessary, of helping partnerships to develop a forward-looking vision, based on an objective assessment of how they could best perform, add value and deliver value for money. There was also a need for proper risk assessment.

With regard to engagement with nongovernmental organizations, she endorsed the views expressed by the member for the United States. Negotiations subsequent to the adoption of the Pandemic Influenza Preparedness Framework had highlighted the pressing need for an agreed and common set of principles governing how WHO would engage with non-State actors, regardless of the sector to which they belonged. To that end, the policy paper on nongovernmental organizations and that regarding the private sector should be combined into a single policy that would apply equally to all.

Dr Jamsheed Mohamed took the Chair.

Mr BLAIS (Canada)¹ endorsed the suggestions regarding WHO's engagement with nongovernmental organizations, in particular improving technological consultation methods, strengthening collaboration with nongovernmental organizations at all levels of the Organization and improving transparency and accountability. Differentiation was one way of increasing transparency, but should not lead to the exclusion of private or civil sector entities that could provide valuable input. Steps to de-link accreditation from a period of working relations with WHO were welcome but would have to be taken in conjunction with revisions to criteria for the admission of nongovernmental organizations to governing body meetings, in order to ensure that only appropriate nongovernmental organizations were admitted.

He endorsed the recommendation in document EB132/5 Add.1 that hosted partnerships should be required to accrue and set aside reserves to meet potential liabilities, thereby removing one unpredictable financial burden on the Organization. Furthermore, partnerships should submit to the Secretariat full financial reports rather than simple income statements in order to provide the governing bodies with a complete picture of their liabilities. To improve hosted partnership arrangements, there was a need for greater Organization-wide harmonization as well as for guidelines for coordinating regional and country activities, and generic terms of reference.

Mr KLEIMAN (Brazil)¹ said that hosting arrangements should be based on the partnerships policy endorsed by the Sixty-third World Health Assembly in order to avoid inconsistencies and conflicts of interest. Detailed, accessible information and transparent cost reporting with regard to

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

partnerships should be provided, and to that end, he endorsed the proposal for periodic review of partnerships by the Programme, Budget and Administration Committee.

In respect of WHO's engagement with nongovernmental organizations, clear and established criteria were essential so that nongovernmental organizations knew exactly what policies to apply and thus avoid any conflicts of interest. Differentiation between commercial and non-commercial entities was also essential.

Ms RUNDALL (Consumers International), speaking at the invitation of the CHAIRMAN, commended the Organization's focus on the need to protect its integrity and public interest mandate from vested interests. The proposal to combine WHO's policy on nongovernmental organizations with that on private commercial entities was welcome. Transparency and public disclosure of WHO's engagement with nongovernmental organizations and the private sector were crucial but not sufficient safeguards. WHO needed a comprehensive policy on conflict of interest that set out criteria, including the objectives and decision-making structure of the organization under scrutiny, for distinguishing clearly between bodies with and without a commercial interest in WHO's areas of competence. The same criteria should also inform the Organization's consultation, collaboration and accreditation procedures. The process of differentiation would provide the private sector with an opportunity to express its views, in the framework of a clear policy designed to safeguard WHO's norms and standards.

Dr St. John resumed the Chair.

Mrs DENTICO (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN and on behalf of the Democratising Global Health Coalition, asked why references to policies aimed at dealing with the private, not-for-profit sector were not reflected any more in documents dealing with WHO reform. The mounting influence, through financial contributions, of philanthropic foundations on the Organization's priority-setting was undeniable and needed to be regulated through an effective policy. The same loss of interest had affected the proposed conflict of interest policy, despite the negative influence such conflicts had on health policy. She urged that those two items be reintegrated into the reform programme.

Mrs GROVES (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, stressed greater involvement of civil society, and in particular patients' organizations, in shaping the Organization's reform, given its implications for global health-care governance. She endorsed WHO's efforts to draft a policy to define more precisely and formalize the active engagement of nongovernmental organizations, which must be allowed to contribute regardless of their financial resources or political affiliations. The criteria for collaboration, consultation and accreditation must allow for the broad range of stakeholders involved in health care and encourage more rather than fewer voices to be heard. The Organization's efforts to improve transparency and accountability and promote full disclosure were to be commended.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that the new policy on engagement with nongovernmental organizations should stress accountability as a means of assessing their tangible contributions to the Organization's work. As a means of increasing transparency, he favoured the establishment of a platform to make publicly available information on all nongovernmental organizations collaborating with WHO, as well as on the current three-year collaboration plan. A requirement of full disclosure by means of a declaration of interests would provide solid ground on which to build future partnerships. Differentiation should not mean discrimination and, in that regard, he encouraged Member States to be pragmatic in their approach to collaboration with nongovernmental organizations, taking into account the value added by each nongovernmental organizations and non-State actor.

Dr TROEDSSON (Executive Director, Office of the Director-General) said that he appreciated the support expressed for the suggested actions to improve hosting arrangements and welcomed the comment on the importance of recognizing the excellent contributions made by hosted partnerships to public health. He had noted some outstanding issues, such as the need to harmonize the technical work done by the partnerships with that of the Secretariat, and to reconsider the financial and management aspects of partnerships. Member States agreed on the need for the governing bodies to undertake a periodic review of hosted partnerships, which would, *inter alia*, analyse the added value and risk factors of the partnership, and take into account the dynamic nature of the relationships, recommending options for action, such as renewal or termination. Nevertheless, speakers diverged on whether the review should be performed by the Executive Board or the Programme, Budget and Administration Committee. The Secretariat would set in place a review mechanism, which would analyse partnerships in a holistic manner.

The recommendation in document EB132/5 Add.1 that hosted partnerships be required to set aside reserves to meet potential liabilities meant that a partnership must have sound finances and be able to cover the relevant costs, in particular staffing costs. Moreover, in view of the danger of WHO subsidizing hosted partnerships, the costing framework of each partnership would be reviewed in order to show a precise breakdown of how partnerships were funded. Cost recovery mechanisms could also be used, when appropriate.

With regard to WHO's engagement with nongovernmental organizations, he welcomed the proposals in favour of various consultation mechanisms, including an electronic platform or web site. Member States had diverged in their views on whether to engage nongovernmental organizations and private entities in single or separate consultations, and whether a separate engagement policy should be drafted for each category. He clarified that the documentation to be produced on a private sector engagement policy would be submitted to the Board at its 133rd session, not to the Health Assembly.

The DIRECTOR-GENERAL, acknowledging the concentrated focus of the foregoing discussion, said that the debate on the structure of hosted partnerships was part of the effort to make the Organization stronger, more credible, more inclusive and more responsive; to do so, it needed partners. As many speakers had said, the complexity of the global health landscape made it difficult for the Secretariat to distinguish between the different types of actors, especially because they were sporting all sorts of new labels. The best solution was to have a comprehensive policy for engagement with all non-State actors. That would additionally make it easier for WHO to decide whether to host certain partners if and when their status changed. Three overriding principles governed the Organization's interactions with all its partners: transparency, accountability and disclosure of interests. In addition, WHO would engage in partnerships only with actors that could contribute to the health of the population they served. In view of the enormous number of requests for partnerships received by the Organization, it was vital to be focused and selective in making a choice.

She strongly emphasized two red lines that must never be crossed: the supremacy of Member States in decision-making and the role of the Secretariat in setting standards and norms. There could be no outside influence in either case. Disclosure of interests by experts nominated to expert committees, and how to ensure it, were also matters that merited consideration. The Institute of Medicine in the United States of America had a system whereby names of potential members of expert panels were posted on the Internet for a short period and comments invited. If no objection was heard, then the expert could be appointed. Once appointed, experts were independent; Member States and non-State actors should not then attempt to influence them in any way. She had not yet made a firm decision and welcomed Member States' views.

Dr VALLEJO (Ecuador) expressed strong concern that the comments made by his country and other members of the Union of South American Nations had not been fully considered. As WHO was a membership organization, it was vital that the concerns expressed and the recommendations made by Member States be taken into account.

The DIRECTOR-GENERAL said that the Secretariat existed to serve Member States. However, without consensus, the Secretariat could not act. The Secretariat must have a clear understanding of what was being asked of it. If that was not the case, the Secretariat would come back to the Member States for clarification and advice.

During the debate that had just taken place, agreement had been reached on the importance of seeking actors that had no conflict of interests and the need for a solid engagement policy for all actors. At the same time, Member States had failed to reach consensus on several key issues: how to classify non-State actors, whether there should be a single procedure for declarations of interests or more than one, depending on the type of actor involved, and what form consultations should take. With regard to the last matter, she assured Member States that separate consultations would be held for nongovernmental organizations and the private sector. The information collected would be analysed and a report combining the two consultations would be drafted, although, if the Member States so desired, two separate reports could be prepared.

Dr VALLEJO (Ecuador) said that he had made it clear that a distinction must be made between hosted partnerships and engagements with nongovernmental organizations, and between non-State actors and private sector actors with commercial interests. Furthermore, at the second extraordinary meeting of the Programme, Budget and Administration Committee in December 2012, his country's delegation had clearly stated that the Organization had to be extremely cautious about the sources from which it accepted funding. He asked only that his comments be taken into consideration and that, at future meeting, reference should be made to what countries had actually said.

- **Work of the governing bodies** (Documents EB132/5 Add.3, EB132/5 Add.4, EB132/5 Add.5 and EB132/43)

Dr THABET NASHER (Yemen), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, summarized the discussions on reform at the Committee's previous meeting, the full details of which were presented in document EB132/43.

Dr REN Minghui (China) reiterated his earlier request for information regarding the funding of hosted partnerships and, in particular, the share contributed by WHO. He endorsed nearly all the recommendations contained in document EB132/5 Add.3. With regard to amending the Rules of Procedure of the Executive Board, Member States should reduce to the extent possible the number of new proposals they submitted for the Board's consideration, with the exception of matters of urgency. From the point of view of timing, all draft resolutions must be submitted to Member States before the session to enable effective consultation at the government level. Fewer new proposals would reduce the number of draft resolutions and consequently increase the Board's efficiency. Before amending the Rules of Procedure of the World Health Assembly, the Board should agree on the prioritizing criteria to be used. The Secretariat should provide support to Member States in evaluating the financial implications of new draft resolutions submitted to the Health Assembly and assess the added value they would provide. New draft resolutions should be compared with previous resolutions and decisions in the same area in order to avoid duplication of effort.

Rather than submitting a large number of progress reports to the Health Assembly, the Board could submit them in the form of a consolidated document. Full advantage should be taken of available technology to provide Member States with greater flexibility in submitting comments and written reports. He welcomed the proposals designed to streamline reporting by Member States, particularly the proposed mechanism to monitor States' implementation of the Board's decisions; that would offer a clear view of individual countries' progress and facilitate the sharing of experience. A database for information sharing should be set up as soon as possible; with more information, Member States would be motivated to produce better reports.

The Organization was entering into an increasing number of health partnerships and it was important for the Secretariat to avoid becoming merely an active member of a partnership; rather, it should take the lead in global health governance.

Dr GRABAUSKAS (Lithuania), speaking on behalf of the European Union and its Member States, said that, in view of the need to improve reporting quality and adjust reporting cycles, the proposal to hold the sessions of the Board and the meetings of the Programme, Budget and Administration Committee in February was welcome. At the same time, he sought assurance that changing the schedule would yield benefits, and that it would not interfere with the quality or timely availability of documents for the Health Assembly.

A new sentence should be added following paragraph 3 of Rule 5 of the Rules of Procedure of the Executive Board that read "If documents for the session are not dispatched three weeks before the commencement of a regular session, the agenda item point to which they refer shall be deferred to the next session, subject to the discretion of the Officers of the Board, which shall include exceptional circumstances."

He supported the proposals for improved management of agenda items and draft resolutions as well as assessment of the financial and administrative implications of the latter. The proposal to limit the requirements for reporting to the Health Assembly to a set number was acceptable but might benefit from a study of similar practices within the United Nations system. All reports should include information on expenditures. The analysis of the current practice of health reporting due to be submitted to the Board at its 134th session would be valuable and he welcomed the proposal to undertake a pilot study on an extranet web site for formal communication between the Secretariat and Member States. The general programme of work should place greater emphasis on WHO's unique role in global health governance.

Ms PENEVEYRE (Switzerland) fully endorsed the observations made in document EB132/5 Add.4 on the lack of coordination and the excessive number of requests and questionnaires sent to Member States from the Organization at all levels. The Secretariat must start using more modern management tools in order to improve coherence. Making the reporting of the implementation of the Health Assembly's decisions by Member States more systematic could perversely make national reports more difficult to obtain and digest. Therefore she emphasized that options for improving reporting must be realistic.

Professor NICKNAM (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, endorsed the recommendations to retain the current financial year format and to hold the meetings of the Programme, Budget and Administration Committee and the Board's sessions in February.

Some of the proposed amendments to the Rules of Procedure of the Executive Board and the World Health Assembly required more scrutiny. Deleting subparagraph (d) of Rule 5 of the Rules of Procedure of the World Health Assembly would, for example, discriminate against Member States by preventing them from directly including items on the Health Assembly's provisional agenda while that possibility would remain open to any organization in the United Nations system. The proposed addition to Rule 8 of the Rules of Procedure of the Executive Board should include a list of the criteria against which proposed agenda items would be matched.

He endorsed the general principles on how to streamline reporting by Member States (document EB132/5 Add.4, paragraphs 18 and 19), but said that one further general principle should be added: the need for capacity building in developing countries in order to bolster their reporting capacities. He strongly supported the proposal to establish an extranet web site for communication between the Secretariat and Member States.

A detailed analysis of current reporting practices was indicated and should be done before the Secretariat started to define a minimum set of health data and indicators. If WHO wished to take the lead in global health governance, both the Secretariat and the Member States needed more technical, diplomatic and administrative capacity.

Dr LOUME (Senegal), speaking on behalf of the Member States of the African Region, commended the positive outcomes arising from implementation of decisions pertaining to harmonization and alignment of the work of regional committees and urged those committees that had

not yet done so to harmonize their practices in respect of examination of delegates' credentials and observer participation. He supported limits on both the length of the provisional agenda and the number of draft resolutions submitted. He endorsed the proposals, also contained in document EB132/5 Add.3, to insert new Rules 28*bis* and 28*ter* into the Rules of Procedure of the Executive Board and, in the Rules of Procedure of the World Health Assembly, to replace Rules 48 and 49 with a new Rule and add additional language to Rule 8. The proposal to amend Rule 5 of the Rules of Procedure of the World Health Assembly should be weighed against the need to ensure respect for the sovereign rights of Member States to propose agenda items. He favoured the proposals to hold the meetings of the Board and the Programme, Budget and Administration Committee in February and to retain the current financial year format. He also supported the five proposals on reporting by Member States and the proposed platform for communication with Member States (document EB132/5 Add.4, paragraphs 21 and 23 respectively). Training in health diplomacy should be provided to all heads of country offices to increase their effectiveness.

Dr VALVERDE (Panama) said that the calendar of meetings of the governing bodies should be synchronized with the overall governance cycle of WHO and the measures proposed in that regard were welcome. The financial and administrative consequences of draft resolutions should always be taken into account by the governing bodies and the Secretariat should not be requested to undertake activities that could not be funded. The proposal to limit the number of items on the provisional agenda of the Health Assembly required further consultation among Member States before a decision could be made.

The Secretariat might consider holding training sessions for new members of the Board to enable them to participate more fully in the debates.

Dr AMMAR (Lebanon) said that scheduling the meetings of the Programme, Budget and Administration Committee and the Board's sessions in February would give the Secretariat enough time to prepare the necessary documents within the deadline set and would mean that management reports could encompass an entire year. The proposed amendments to the Rules of Procedure of the Executive Board and the World Health Assembly were a positive step that would help to reduce the excessive size of the agendas and limit the number of draft resolutions without undermining the sovereign right of Member States to pursue their policy objectives. Selection of agenda items had to be done with an eye to efficient time management. He endorsed the suggestion made by the member for Lithuania that agenda items for which documentation had arrived late should be considered at a later time.

Dr THABET NASHER (Yemen) said that the Board should take additional time to consider the views of Member States with regard to the reform proposals before it took up the next agenda item. That debate could be held after consideration of each area of reform or at the end of the reform discussion as a whole.

The DIRECTOR-GENERAL said that, rather than actually making decisions on the reform proposals, Member States should advise the Secretariat on changes that should be made to them so that the documents could be modified accordingly before being considered by the Health Assembly. Clear guidance was lacking with regard to several issues because of divergences of opinion.

Professor HALTON (Australia) suggested that the Secretariat should produce a summary of the decision points that would clearly indicate where agreement had not been reached.

Professor NICKNAM (Islamic Republic of Iran) and Dr DAULAIRE (United States America) endorsed the suggestion made by the member for Australia.

The DIRECTOR-GENERAL said that the Secretariat would compile a list of both the agreed decision points and those upon which agreement had not been reached for circulation later in the session. She sought guidance from Member States.

Professor HALTON (Australia) asked that time be set aside for informal consultations once the list had been distributed to the Member States. That would increase the likelihood of consensus when discussion on those issues was resumed.

The CHAIRMAN said that, if she heard no objection, she would take it that the Board wished the Secretariat to produce a list that clearly indicated whether or not consensus had been reached on each reform proposal under consideration. The Board's programme of work would then be modified in order to allow time for additional debate on items on which consensus had not been reached.

It was so agreed.

The meeting rose at 12:35 p.m.

SIXTH MEETING

Wednesday, 23 January 2013, at 14:35

Chairman: Dr J. ST. JOHN (Barbados)

1. WHO REFORM: Item 5 of the Agenda (Document EB132/5) (continued)

- **Work of the governing bodies** (Documents EB132/5 Add.3, EB132/5 Add.4, EB132/5 Add.5 and EB132/43) (continued)

Mr HAZIM (Morocco) expressed support for the recommendation to maintain the current schedule of the sessions of the regional committees and the Health Assembly; the recommendations concerning amendments to the Rules of Procedure of the Executive Board and the World Health Assembly; and the recommendation to entrust to the Programme, Budget and Administrative Committee the role of assessing the financial implications of resolutions. He also supported the view that more high-priority items should be included on the agendas of the governing bodies and the number of time-consuming progress reports decreased. The proposals for scheduling, harmonization, alignment, priority-setting and decision-making were aimed at streamlining and enhancing the efficiency of the meetings and work of the governing bodies, speeding up decision-making and rationalizing the use of time and money and, as such, they were worthy of consideration.

He supported the comments made by the member for Lithuania during the previous meeting on communication with Member States and had no objection to the establishment of an extranet platform, although its management would inevitably be costly. In the interests of equitable and timely access to information, the site should be available in all official languages. Other communication options could be considered, including adapting the Organization's current web site or relying on briefings of Member States with permanent missions in Geneva.

Member States had repeatedly said that they wanted to see WHO play an enhanced role in global health governance, both politically and technically, and to be a true leader in the global health environment. The role of the governing bodies in that regard was very important, at both the regional and international levels. Health diplomacy was essential for progress to be made, and for WHO to play its rightful role in the global health landscape.

Ms HERNÁNDEZ NARVAEZ (Mexico) said that any measure aimed at streamlining the work of the governing bodies should be welcomed. She supported rescheduling the sessions of the Programme, Budget and Administration Committee and the Executive Board to February in order to allow more time for analysis of the pre-session documents. However, it would do no good to hold the sessions later in the year if documents were still not available. In general, documents should be issued at least five working days before a meeting. She supported the other reforms and proposed changes to the Rules of Procedure contained in document EB132/5 Add.3.

She commended the idea proposed in document EB132/5 Add.4 of a harmonized platform for health statistics and information, which would make it possible to eliminate certain reports that were of no practical use for decision-making. More details would be welcome on the proposal to create an extranet platform for formal communication between all three levels of the Secretariat and Member States, in particular regarding countries chosen for the pilot test and the expected outcome in the long term.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that, if the reform process were to achieve its goal of strengthening the Organization and making it more efficient, it should not be executed in haste. Streamlining the work of the governing bodies and harmonizing and aligning that of the regional committees required much thought and attention. The Secretariat should continue systematically presenting its global strategies, policies and legal instruments to the regional committees. The latter could then adapt global strategies to suit local needs instead of developing separate regional strategies. Governing body documents should be more succinct, which would reduce production costs and enable members to analyse them with due care. The number of agenda items should be reduced; Member States had a right to propose resolutions and agenda items, but they should strive to limit the number so that matters could be discussed in depth. With regard to the rescheduling of governing body sessions, it appeared that the only viable option would be to move the Programme, Budget and Administration Committee session to December and the Board to February.

He pointed out that in the Spanish version of document EB132/5 Add.3, the term “órganos deliberantes” (governing bodies) had been used. Was the meaning the same as that of “cuerpos directivos”?

Mr BURCI (Legal Counsel) explained that the term “governing bodies” as used in the English version of EB132/5 Add.3 referred broadly to both the global governing bodies, namely the World Health Assembly and the Executive Board, and to the regional committees. The translation services would take note of the comments of the member for Cuba.

Mr KASE (Papua New Guinea), expressing support for the reform process, said that he would prefer the Board to continue to meet in January. Changing the date as proposed in document EB132/5 Add.3 would create scheduling conflicts for national officials in his country and others.

Dr MYINT HTWE (Myanmar), referring to paragraphs 16 and 17 of document EB132/5 Add.4, said that poor communication between the Secretariat and Member States could have serious repercussions. It was not necessary for all three levels of the Organization to communicate with Member States or receive reports from them. WHO country offices were the appropriate gatekeepers for communications to headquarters and regional offices simultaneously where necessary. Clear guidelines on how to communicate with Member States for specific purposes were needed. At present newly recruited WHO staff members were not properly briefed, in particular about communication. For reform to be successful, an updated staff briefing package should be produced and distributed to all new staff. If a joint communications platform for the Secretariat and Member States were to be established, it should be accompanied by clear and simple guidelines and should be reviewed and updated as necessary.

Professor HALTON (Australia) noted the tension between Member States wanting to contribute agenda items and the burden arising from timing and volume of agenda items. She supported the proposals for streamlining and moving towards a modern management approach, in particular the use of electronic platforms, streamlining of reporting, and harmonization of data standards and reporting timetables. She also supported the delegation of responsibility, provided that it was transparent. She agreed that limits should be set on the number of items on governing body agendas, although safeguards were needed to ensure that urgent issues could be tabled.

She could not support the proposed rescheduling of the Board’s sessions because it would pose difficulties for her country and other parliamentary democracies in the southern hemisphere, which began their government year in February. Such a change would also make it hard to complete the necessary intersessional work before the Health Assembly.

Dr DAULAIRE (United States of America), welcoming the proposals for streamlining the work of WHO’s governing bodies, said that he was gratified that the Organization was taking steps to ensure that regions were adapting global strategies rather than developing their own regional strategies.

The financial year should remain unaltered. The marginal benefit of changing it would be far outweighed by the cost and complications. Rescheduling the Board sessions to early February would mean a shorter intersessional period; the tighter schedule before the Health Assembly would make it difficult for the Secretariat to produce timely documentation. In view of the concerns voiced by the member for Australia, he recommended holding further informal consultations on the matter, with maximum participation by southern hemisphere countries.

The proposed role of the Programme, Budget and Administration Committee in considering the financial implications of draft Health Assembly resolutions needed further elaboration. He supported the earlier submission of resolutions, decisions and reports in accordance with the proposed changes to the Rules of Procedure of the Executive Board and World Health Assembly so as to enable a more substantive and less rushed consideration of global health issues before the governing body sessions. He endorsed the proposed amendments to Rules 5 and 12 of the Rules of Procedure of the World Health Assembly, provided that Member States retained the right to propose the inclusion of additional agenda items in extraordinary circumstances, such as a public health emergency of international concern. He also supported the addition of a new Rule 11*bis* to the Board's Rules of Procedure. In order to limit the number of progress reports, he proposed that the Director-General, at the May session of the Board, be able to recommend referral or discontinuation of any of progress reports scheduled for the year.

He agreed with the principles for streamlining and strengthening reporting and communication between Member States. He supported efforts to standardize reporting and improve data collection, although those goals required more thought and a longer perspective. He looked forward to the outcome of the study mentioned in paragraph 13 of document EB132/5 Add.4 and encouraged the Secretariat to explore simplified means of tracking Member States' progress in respect of commitments made in governing body resolutions. Doing so could also serve to strengthen the results chain between outputs, which were the responsibility of the Secretariat, and outcomes, which represented a shared responsibility with Member States. He supported the proposal to establish an extranet platform to coordinate and streamline communication with Member States across the three levels of the Organization. The platform should be a cost-saving measure.

Dr LARSEN (Norway) expressed support for the efforts to streamline the work of the governing bodies and the proposals on reporting by and communication with Member States. Regarding the latter, the Secretariat should carefully consider the potential added value of any new measure and ensure that it would simplify reporting and improve collaboration between the Secretariat and Member States. He concurred with the suggestion made by the member for Panama during the previous meeting that new Board members should be briefed on its workings.

Dr VALLEJO (Ecuador) expressed concern over the late publication of the documents on reform, which had made it difficult for members to study them carefully and for the Board to discuss thoroughly the proposals for streamlining the work of the governing bodies and enhancing the participation of Member States. Those proposals included important constitutional reforms that would affect the future work of the governing bodies, and no decision should be made on them until the proposals had been studied and discussed more fully. Rescheduling Board sessions to February might be a good idea if it would ensure timely publication of documents. He favoured deferring the discussion of items for which documents were received late.

The paramount factor to be borne in mind when considering the proposals in document EB132/5 Add.3 was WHO's intergovernmental nature. If limitations were to be imposed on the number of items and resolutions that Member States could submit for inclusion in the provisional agenda, clear criteria and procedures must be established and transparency must be ensured. The criteria in resolution EB121.R1 should be re-examined and a procedure put in place for accepting or rejecting proposed agenda items and draft resolutions, including a submission deadline, and Member States should be disciplined about submitting only items that represented global priorities. Coordination between the three levels of the Organization was the key to allowing the needs of countries and regions to be dealt with at the correct level. He supported the recommendation

concerning prior assessment of the financial implications of resolutions. He also endorsed the suggestion put forward by the member for Australia that a list of decision points should be produced, but wished to emphasize that the selection of points should be inclusive and that points should be chosen on the basis of whether or not they were ready to be discussed.

Dr JAMSHEED MOHAMED (Maldives) endorsed the suggestion put forward by the member for Panama on training and orienting new Board members on their roles and responsibilities and on the workings of the Board. Such guidance would be especially helpful to smaller countries with limited numbers and high turnover of health officials.

Professor SHIRALIYEV (Azerbaijan), acknowledging the preparation of the documents, said that the proposals put forward in document EB132/5 Add.3 were sensible, clearly argued and practical. He agreed with the proposals to shift the financial year and move the Board sessions to February; although he understood the objections of the member for Australia, he thought that a consensus could be reached. The continual increase in the length of the agenda decreased the likelihood that issues would be resolved. Items should be ranked by priority and considered in order of that priority. With regard to reporting, WHO's authority meant that its statistical data were accepted the world over. Problems had arisen the previous year, requiring the intervention of the Director-General herself, which highlighted the importance of statistical data reporting.

He pointed out the contradiction between, on the one hand, Member States asking and expecting much of the Director-General and her staff while, on the other hand, constantly seeming to try to limit her powers.

Dr WARIDA (Egypt)¹ expressed appreciation for the progress made on WHO reform. Regarding the recommendation on managing new items on the Board's agenda, it was important to include the five criteria in paragraph 23 of document EB132/5 Add.3 in the proposed wording for Rule 8 of the Rules of Procedure of the Executive Board. The recommendation to delete paragraph (d) of Rule 5 of the Rules of Procedure of the World Health Assembly was worrisome because it could deprive Member States of the right to propose items for the Health Assembly agenda; the rationale given (paragraph 27) was that it was not applied in practice, but if that were so it was difficult to understand the assertion in paragraph 26 about "increas[ing] the crowding of the Health Assembly's agenda without an evident benefit". Under the suggested amendment to Rule 5, all proposals for the Health Assembly's provisional agenda submitted by Member States would be considered by the Board. It should be recalled that some proposals could be put forward by Member States that did not designate Board members. In any case, all proposals should be considered by the full Health Assembly before the agenda was adopted.

Mr KLEIMAN (Brazil)¹ said that, like previous speakers, he regretted the late arrival of the documents and the consequent difficulty of studying them and reaching decisions. The complex issues raised in document EB132/5 Add.3 should not be dealt with hastily, and the Board would need another opportunity to discuss them fully.

Just as the global and regional health agendas reflected priorities identified by Member States at the three levels of the Organization, so the different global and regional priorities could be reflected in the agendas of the WHO governing bodies and the regional committees. That would allow the best use of time and facilitate implementation of the resolutions adopted at each organizational level. The study of commitments undertaken by Member States through Health Assembly resolutions, mentioned in paragraph 13 of document EB132/5 Add.4, would provide an important basis for more efficient work in the future, including better mechanisms for communication and monitoring the implementation of Health Assembly decisions, as well as better reporting strategies. The establishment of a new platform

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

for disseminating health information and the proposed extranet were interesting ideas. However, use should be made of existing tools before developing new ones.

The proposed rescheduling of the Programme, Budget and Administration Committee meetings and Board sessions to February was acceptable. Although he recognized the need to streamline working methods, it should not be forgotten that WHO was a Member-driven organization. Opportunities for discussion and exchange of ideas were essential in order to preserve its democratic nature, and therefore no restriction should be placed on the submission of proposed resolutions, amendments and new agenda items by Member States.

Mr KOÇAK (Turkey)¹ commended the quality of the reform-related documents, which provided a good basis for discussion. Document EB132/5 Add.3 clearly outlined the challenges involved in scheduling governing body meetings. The added value of moving the Programme, Budget and Administration Committee meetings and Board sessions to February was obvious. However, an equally important consideration was the need to allow a sufficient interval before the Board's session for the Secretariat to prepare documents requested by the Committee for submission to the Board. In turn the Board would be able to provide clearer guidance for the Committee's meeting in May.

The idea of introducing clear time limits and procedures for the submission of draft resolutions and agenda items was acceptable in principle, but a balance must be maintained between disciplined governing body working methods and the sovereign rights of Member States. Application of the criteria for priority setting contained in the draft twelfth general programme of work might be practical, provided that balance was maintained. The Secretariat should design a mechanism to facilitate Member States' access to resolutions and decisions. Member States could then be asked to indicate how their proposals were linked to the general programme of work and, to the extent possible, their cost implications.

Ms POLACH (Argentina)¹ said that she shared the concerns expressed by the member for Ecuador during the previous meeting regarding the inclusion of Member States' views in Secretariat reports and had therefore submitted her statement in writing. She also shared the concerns voiced by previous speakers about late publication of the reform-related documents and the need for more time to study them. The subject of reform should not be dealt with in haste, as the member for Cuba had noted. She saw advantages to rescheduling the Board's sessions to February, as it would improve the quality of documentation and allow Member States more preparation time, provided documents were issued on schedule. However, the interval between the Programme, Budget and Administration Committee meetings and Board sessions should be extended in order to address the problems outlined in document EB132/5 Add.3. She supported the establishment of a web-based platform as proposed in paragraph 16 of that document in order to provide real-time financial information.

With a view to striking a balance between, on the one hand, the rights of Member States and, on the other, the need to avoid overloading the agenda, she supported the recommendation to add a new Rule 28*bis* to the Board's Rules of Procedure regarding the deadline for submission of proposed agenda items. The proposed new Rule 28*ter* was also acceptable, as was the proposed new wording of Rules 48 and 49 of the Rules of Procedure of the World Health Assembly.

With regard to managing the number of new agenda items under Rule 8 of the Board's Rules of Procedure, she supported the recommendation that the Director-General and the Officers of the Board should apply the criteria for priority setting in the draft twelfth general programme of work. However, she proposed that the proposed new wording to be added to Rule 8 be modified to read: "The Director-General and the Officers of the Board will use criteria adopted by the Health Assembly ...", rather than "by the Board or the Health Assembly" in order to make it clear that the body that set the Organization's priorities was the Health Assembly, in which all Member States were represented. She had no objection to agenda items being first submitted to the Officers of the Board instead of directly

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to the Health Assembly, as long as the matter was not urgent or had not arisen too late for the Officers to be consulted; that proviso should be stated explicitly. She shared other members' concern about the number of progress reports, but urged that a happy medium be sought between a rigid solution and a flexible, discretionary reporting requirement.

Mr LEE KYONG-YUL (Republic of Korea)¹ fully supported the work done to advance the reform process. He did not object to moving Programme, Budget and Administration Committee meetings and Board sessions to February and supported the Director-General's recommendation to maintain the existing financial year.

Referring to the earlier discussion on arrangements for hosting health partnerships, he welcomed the proposed course of action to improve the harmonization between WHO and its hosted partnerships. In the interests of improving collaboration with partners, he would welcome the establishment of an internal joint committee, as proposed in paragraph 16 of document EB132/5 Add.1. It would be appropriate for the Programme, Budget and Administration Committee to conduct periodic reviews of WHO's interactions with partners.

Ms TYSON (United Kingdom of Great Britain and Northern Ireland)¹ said that the work of oversight bodies, such as the Independent Expert Oversight Advisory Committee, helped to enhance the credibility and effectiveness of governance. On occasion political imperatives might dictate a particular course of action, but the norm should be adherence to agreed rules. Improvement on the part of Member States, as well as the Secretariat and its executive management, was needed in order to secure genuine reform in the area of governance. She was encouraged by the way in which the current session had been managed. As governing body sessions became more complex, training and support for the Board's officers and members would be important.

She supported rescheduling Programme, Budget and Administration Committee meetings and Board sessions to early February, which should allow participants to be better prepared. She could accept the changes to the Rules of Procedure as outlined in paragraph 20 of document EB132/5 Add.3, but the Rules must then be rigorously applied if greater efficiencies were to be realized. She also supported the proposed changes to Rules 5, 8 and 11, but with the proviso articulated by the member for Iran in the previous meeting that there should be clear criteria for any decisions taken under Rule 8. In that connection, she supported a greater role for Officers of the Board and the Health Assembly. It would be acceptable for the Director-General to determine when a report should be prepared for the Board, but it had to be recognized that a Member State placing an item on the agenda could reasonably expect a Secretariat report in order to facilitate the discussion. If the changes adopted failed to improve the internal governance of the Organization, they should be reviewed without delay. It was incumbent on all concerned to be responsible and disciplined in exercising their governance responsibilities.

Dr JESSE (Estonia)¹ suggested that the Board should consider allowing the proceedings of the meetings of the Programme, Budget and Administration Committee and Board sessions to be transmitted over Internet-based conferencing tools, such as WebEx or webinar systems already being used by WHO. She was not suggesting that those meetings be made publicly available, but that restricted access to the webcast be allowed to authorized individuals who had registered in advance. Such an approach would provide officials in Member States a way of following the debate and being better prepared for the Health Assembly and enable governments to reduce the size of delegations travelling to Geneva. She advocated making all documents, including conference papers and draft resolutions, available electronically during governing body sessions.

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

Ms EPHREM (Canada),¹ endorsed the comments made by previous speakers on the establishment of formal criteria for determining which governing body should deal with particular agenda items. She also agreed that new draft resolutions should be assessed in the light of previous resolutions. It would be critical to streamline reporting requirements as the Organization began implementing and monitoring action plans and strategies. With regard to WHO's role in global health governance, in accordance with its Constitution, the Organization was the directing and coordinating authority on international health work, and it should therefore play a leadership role, while also working with key partners in other sectors, in monitoring and assessing health risks and trends and taking action on global health. She supported the proposed measures to simplify and improve the effectiveness and efficiency of reporting and communication systems, including the establishment of an extranet platform.

Dr REYNDERS (Belgium)¹ endorsed the comments made by the member for Lithuania and the proposal made by the representative of Estonia.

Mr KÜMMEL (Germany)¹ also endorsed the suggestions put forward by the representative of Estonia. The overall goal of the reform process was to strengthen WHO's role in global health governance, but that goal had more or less disappeared from recent reform-related documents, hence the request to the Secretariat to prepare a report on the topic for submission to the current session of the Board. Strengthening WHO's role vis-à-vis other key actors in global health governance was a priority. Germany took its governance responsibilities as a Member State seriously and endeavoured to provide guidance and oversight to the Secretariat on that and other important issues. He appreciated that the late publication of document EB132/5 Add.5 had been the result of the many requests made of the Secretariat by Member States, and acknowledged that he had not had time to study it thoroughly. Given the importance of the subject, the work that had gone into preparing the report and the desirability of keeping WHO's role in global health high on the agenda, he suggested that the matter should be deferred to May 2013, when it could be further discussed.

The CHAIRMAN agreed that the issue of WHO's role in global health governance was crucial and required careful consideration with proper preparation. Member States had perhaps asked the Secretariat to do too much in too little time. She invited the Director-General to respond to the comments made.

The DIRECTOR-GENERAL, emphasizing that WHO belonged to its Member States and that the reform process was Member State-driven, recalled that she had initiated reform precisely because it had been needed in order to enable WHO to exercise its global health governance role properly. In keeping with the intergovernmental nature of the Organization, Member States had wished to drive the process, and since its launch had identified 40 reform measures. The Secretariat had endeavoured to prioritize those measures, and, on that basis, had produced 10 reports thus far. She had been asked to provide specific advice on possible reform actions, which she had done on the basis of the input – sometimes conflicting – that she had received from Member States in the previous two years.

Of the four reform issues addressed in document EB132/5 Add.3, consensus seemed to have been reached on the first one: retention of the current financial year. Opinion was still divided on the advisability of rescheduling Programme, Budget and Administration Committee meetings and Board sessions to February. Although such a change would allow more financial information from the previous year to be made available, the period covered would be extended only from September to November. The Secretariat would still not be able to provide full-year data. Moreover, rescheduling the sessions to February would shorten the interval before the Health Assembly, in which numerous intergovernmental meetings took place and numerous documents had to be produced. Mindful of those

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considerations and the challenges that such a change would pose for southern hemisphere countries, she therefore proposed that the current meeting schedule be maintained at least until 2014.

Concerning the method of work of the governing bodies, there was indeed an underlying tension between the prerogative of Member States to propose agenda items and resolutions and the need for WHO's internal governance to be focused and strategic and the agenda manageable. She noted that support had been expressed for some of the proposed amendments to the Rules of Procedure, but she would not recommend any immediate change. The best approach might be to "learn by doing" during forthcoming governing body meetings, to identify best practices and then to decide what changes would be most appropriate. Meanwhile, she undertook to provide training for all new Board members and, especially, Officers of the Board with a view to ensuring that they could exercise their authority effectively.

She assured Member States that they could always refer urgent matters directly to the Health Assembly, as had occurred, for example, in the case of pandemic (H1N1) 2009. The Secretariat did not have the authority to prevent Member States from tabling urgent agenda items. She had reservations about the suggestion by the member for Lithuania that items on the provisional agenda of the Health Assembly should be deferred if the relevant reports were not distributed at least four weeks before the opening of the session, as such a move could have serious political implications.

She had noted strong support for the notion of streamlining communications and would explore ways of doing so, particularly between Member States and the three levels of the Organization. One possibility might be for all parties to appoint focal points for communication. That might bring an improvement over the current situation, in which Member States were sometimes inundated with communications from numerous WHO offices, while the Secretariat and the regional offices sometimes received separate communications about the same issue from different ministries in the same Member State. She would welcome guidance on how to deal with that situation, but, in the meantime, she assured Member States, that her primary interlocutor would always be the health minister.

She expressed the hope that she had summarized the debate correctly and reflected Member States' views on the various reform matters discussed.

The CHAIRMAN said that, hearing no objection, she took it that the Board agreed with the Director-General's assessment of the conclusions that had emerged from the debate and with the courses of action she had outlined.

It was so agreed.

• Review of management, administration, and decentralization in the World Health Organization, report by the Joint Inspection Unit (Document EB132/5 Add.6)

Mr POSTA (Joint Inspection Unit of the United Nations system), recalling that the Executive Board had asked the Joint Inspection Unit to update its two previous reports,¹ said that, in view of the time elapsed since the publication of those reports, the Unit had decided instead to carry out a full-scale review, resulting in the report contained in document EB132/5 Add.6. In addition, it had conducted a survey of WHO staff, the results of which were available on the Unit's web site.² The Unit had made two types of recommendations, both of which should serve as useful inputs for decision-making about WHO reform. The first set consisted of "soft" recommendations, which suggested desirable courses of action; the second set consisted of concrete, actionable recommendations. The recommendations were wide-ranging in scope and would affect the Organization's activities to varying degrees. They had been made with the aim of strengthening

¹ See decision EBSS2(3), paragraph 7.

² See document JIU/Supplementary_Paper_2 (JIU/REP/2012/6&7).

Organization-wide coherence and improving efficiency and effectiveness. It was recognized, however, that some might be overridden by financial, political, regional or priority-related considerations.

The report highlighted some positive developments, including the results achieved by the Global Policy Group, improved coordination mechanisms, the introduction of the Global Management System, and the strengthened network for Directors of Administration and Finance. Areas requiring further improvement included strengthening the institutional framework of the Global Policy Group; improving horizontal coordination across clusters at headquarters and in the regional offices; refining certain top-level management functions and organizational structures; increasing the transparency of executive management; and improving training in managerial competences and responsibilities. The Unit had not made any concrete recommendations on governance or the financial framework, as those areas were the focus of intense intergovernmental discussions currently under way. However, its “soft” recommendations might provide useful guidance for Member States. The report also highlighted the major challenges faced by WHO with regard to decentralization, including problems relating to clear and transparent resource allocation among the various levels of the Organization, inconsistent implementation of corporate-level policies in the administrative area and ambiguity or inadequacy of the chain of command and accountability in practice. Although the Unit had been mindful of the need to avoid duplication of effort, some of its findings were similar to those already identified or addressed by the Secretariat as part of the reform process.

The Joint Inspection Unit had prepared its report without any direct instructions or expectations from the Organization’s senior management, and had received constructive support from staff at headquarters and in the regional and country offices. He thanked the Board for entrusting the Unit with the task of carrying out the review and urged Member States and the Secretariat to act on the report’s recommendations, whether that meant accepting or rejecting them, partially accepting them or deciding that further analysis was needed.

Mr HAZIM (Morocco) said that the Joint Inspection Unit’s report provided a comprehensive view of the Organization’s administrative reform and that the Secretariat should carefully consider all the comments on the implementation of reform. The recommendations concerning the predictability of financing (recommendation 11 in part I of the report) and the long-term policy on building management (recommendation 15, part I) should be discussed as part of the financing dialogue proposed by the Programme, Budget and Administration Committee at its extraordinary meeting in December 2012.

As to the recommendation that the Executive Board should put forward concrete proposals for improving the functioning of the regional committees (recommendation 1, part II), various proposals along those lines had been made by the Regional Committee of the Eastern Mediterranean at its fifty-ninth session. With regard to the recommendation concerning revision of existing staff categories and grades in order to bring them into line with operational needs (recommendation 5, part II), the first step should be to ensure that country offices had the human resources needed to enhance their performance.

Dr MYINT HTWE (Myanmar) said that the Secretariat and the regional and country offices should give serious consideration to the many valuable and high-impact recommendations contained in the report and, bearing in mind the ongoing nature of the reform process, implement them as required. Referring to the recommendation on promotion of intercountry and interregional cooperation (recommendation 6, part II), he noted with appreciation that the Regional Office for South-East Asia had allocated adequate funding to each country office in order to facilitate horizontal collaboration, including joint capacity-building and border health activities – an innovative approach that might be replicated by other regional offices.

Mr TOSCANO VELASCO (Mexico) said that the valuable work conducted by the Joint Inspection Unit as an independent, external oversight body complemented and contributed to the oversight work being undertaken internally at the three levels of the Organization. He welcomed the Secretariat’s efforts to address the recommendations put forward by the Unit. He supported the

recommendation for an external evaluation of the preparation of publications in WHO (recommendation 5, part I) with a view to improving efficiency and reducing costs. However, while cost-effectiveness was an important consideration, the technical quality of the Organization's publications must not be compromised. He endorsed all the recommendations, but considered the recommendation on predictability of funding (recommendation 11, part I) particularly important.

Dr DAULAIRE (United States of America) welcomed WHO's proactive approach in pursuing many of the recommendations contained in the report. He supported the implementation of most of them and looked forward to follow-up by the Secretariat, including the use of an implementation plan. He viewed the recommendations on human resources (recommendations 1, 2, 7, 8, 9 and 10, part I) as especially important. In discussions at the regional level, his Government had emphasized the need for long-term compatibility of PAHO's enterprise resource planning system with the Global Management System, and he supported an Organization-wide review of that System, as outlined in recommendation 3, part I, in order to examine compatibility, transparency, efficiency and potential cost savings with the aim of bringing the two systems together.

He supported the evaluation of WHO publications (recommendation 5, part I), but suggested that the exercise be conducted by the internal auditor in order to reduce the cost. He welcomed recommendations 11 and 12 in part I, both of which would help to enhance transparency in resource allocation. Concerning the recommendations on building management (recommendations 14 and 15, part I), he regarded the Working Capital Master Plan as an important long-term tool and would remain attentive to the issue.

The review of decentralization (part II) provided welcome insights into WHO's structure and drew attention to the need for reform and greater alignment at all levels of the Organization. He would welcome more information from the Secretariat – possibly in the form of a future report – about the way in which the three levels of the Organization operated and coordinated internally during times of major humanitarian crises or public health emergencies. He welcomed section V and said that his delegation would raise the matter of an evaluation of the subregional portion of the PAHO budget at the regional level.

Professor NICKNAM (Islamic Republic of Iran) endorsed all the recommendations regarding the management, administration and decentralization of WHO and urged the Secretariat to implement them. The recommendations addressed to the governing bodies merited immediate attention and subsequent implementation, in particular recommendation 11, part I, which sought to increase the predictability of financing – one of the core objectives of WHO reform. With regard to part II of the report, there was room for improvement in the functioning of the regional committees, but their independence should not be compromised. He commended the work of the Regional Director for the Eastern Mediterranean on harmonizing the Rules of Procedure of the Regional Committee, which had been finalized during the Regional Committee session in October 2012.

Ms LIU Yue (China), expressing support for recommendations 11 and 15 in part I of the report, noted that some of the recommendations had already been implemented by the Secretariat as part of the continuing process of WHO reform. Referring to the recommendation for an evaluation of the preparation of publications in WHO (recommendation 5, part I), she pointed out that progress in enhancing multilingualism in WHO publications had been limited, despite the expenditure of considerable resources. The external evaluation would be valuable in elucidating that situation. Concerning recommendation 9, part I, she observed that, although a staff mobility policy had been advocated for years, progress had been slow. She urged the Director-General to implement an Organization-wide mobility policy and to adopt global recruitment for all WHO regional office staff.

With regard to part II of the report, she supported the recommendation concerning strengthening of the alignment of WHO regions and harmonizing their rules of procedure (recommendation 1). The reform process should focus on increasing the efficiency, effectiveness and consistency of the activities of the regional offices and headquarters. The unique nature of WHO's regional structure posed some challenges, for example in relation to cross-border disease control. She was therefore of

the view that the recommendation in paragraph 7 of part II concerning redefinition of the current regional design was worthy of study.

Dr GRABAUSKAS (Lithuania), speaking on behalf of the European Union and its Member States, said that the report would provide a robust framework within which to address managerial challenges. The European Union fully supported all measures aimed at enhancing coherence, transparency and accountability across the Organization and recognized the work undertaken by the Secretariat thus far. The recommendations relating to human resources policy, including mobility and appointment of Assistant Directors-General, were especially important. He sought clarification about the way in which the recommendations, particularly those accepted without comment, would be reflected in the WHO reform implementation plan and asked for more information on the status of implementation of the recommendations already being put into practice by the Secretariat. The Joint Inspection Unit's recommendations and findings should be referenced in the appropriate sections of the WHO reform implementation plan in order to provide a clear overview of how they related to the reform process.

In view of the finding that the current evaluation policy did not meet the requisite standards and best practices, he supported the recommendation that the Director-General should initiate a United Nations Evaluation Group peer review on the evaluation function of WHO (recommendation 17, part I). With regard to building management, he welcomed the Secretariat's work in relation to the long-term policy on the matter in the context of the Capital Master Plan. Recommendation 1, part II, should be implemented with a view to improving the functioning of the governance and organizational processes across all levels of the Organization.

Ms SUNDREHAGEN (Norway) welcomed WHO's use of existing evaluation instruments within the United Nations system for the review of management, administration and decentralization. The resulting report provided useful insights into WHO's operational practices, drawing attention to both well-functioning aspects and areas requiring reform, and confirming that the reform process was headed in the right direction. Future reform activities should take account of the Joint Inspection Unit's recommendations.

Professor HALTON (Australia) said that the report would serve as a useful tool in the WHO reform process. She noted with appreciation the work already undertaken by the Director-General and the regional directors in response to some of the issues and recommendations in the report, especially the recommendation concerning a long-term strategy for the Global Service Centre (recommendation 4, part I), and she encouraged them to continue those efforts. As suggested by the member for Lithuania, it would be useful to cross-reference the recommendations in the WHO reform implementation plan online browser so that stakeholders could more easily identify how they fit within the broader reform agenda and track their implementation. She endorsed the suggestion made by the member for Morocco that the Capital Master Plan should be examined as part of the financing dialogue proposed at the extraordinary meeting of the Programme, Budget and Administration Committee.

Dr LOUME (Senegal) noted with satisfaction that the Secretariat had accepted most of the recommendations in the report. He particularly welcomed recommendations 14 and 15 in part I and recommendations 1 and 6 in part II. The implementation of recommendation 1, part II, would be especially important, as it would improve governance at the regional level and enhance the effectiveness of the regional committees and subcommittees. The Secretariat should ensure that adequate funding was made available in order to fully implement the recommendation on promotion of intercountry and interregional cooperation (recommendation 6, part II).

Dr NOOR HISHAM ABDULLAH (Malaysia) said that his country was pleased to host the Global Service Centre, the capacity of which had grown steadily since its establishment in 2008. He welcomed the recommendation regarding the development of a long-term strategy for the functions and operation of the Global Service Centre, including its governance and financing (recommendation 4,

part I), as well as the proposal in paragraph 68 of part I to transform the Centre into a global administrative hub. Malaysia would continue to support decentralization and reform.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the report was a timely and useful tool in the reform process, and all its recommendations should be implemented. With regard to increasing the predictability of financing (recommendation 11, part I), he affirmed the need to examine the methods used to mobilize additional voluntary contributions from Member States and to encourage un-earmarked contributions. A coordinated, well-managed approach to the mobilization of resources was crucial to improving financing for WHO and to the ongoing reform process. Referring to the recommendation concerning the review of the long-term policy on building management (recommendation 15, part I), he proposed a detailed analysis of the policy, especially in relation to its financial and management aspects, for subsequent consideration by the Health Assembly. He supported the implementation of recommendation 1, part II, which would improve governance and operational effectiveness at all levels of the Organization.

Ms PENEVEYRE (Switzerland), confirming that the report would provide useful guidance for the reform process, said that she shared the Joint Inspection Unit's concerns about the state of the Organization's buildings and supported the implementation of the pertinent recommendations (recommendations 14 and 15, part I).

Mr SARETZKI FORERO (Colombia),¹ expressing broad support for the Unit's recommendations, emphasized that Member States' views should be taken into consideration in the preparation of the programme budget. As the report affirmed, the budget allocation process should be more transparent and inclusive at both global and regional levels. The views of the Programme, Budget and Administration Committee expressed at its seventeenth meeting, particularly regarding lack of alignment between the general programme of work and the programme budget and between the latter and agreed priorities, should also be borne in mind. In that regard, he recalled that Colombia and other countries had repeatedly drawn attention to the need to incorporate a social determinants of health approach in all categories of work.

In view of the Organization's current financial circumstances, it was important to strengthen the institutional capacity of Member States. He supported the implementation of the recommendation regarding predictability of financing (recommendation 11, part I), but observed that WHO's financial situation could be improved by strengthening coordination among the three levels and within headquarters, avoiding duplication of effort and increasing overall effectiveness. The Secretariat should implement the recommendations regarding human resources (recommendations 7 to 10, part I) and a review of the governance process at regional level (recommendation 1, part II), which would help to enhance efficiency. He congratulated the Secretariat for the progress made in the reform process and expressed the hope that similar progress would be made in harmonizing governance practices.

Mr SEN (Turkey)¹ affirmed that the report provided a good understanding of the structure and functioning of WHO. Implementation of the recommendations would considerably improve the functioning of the Organization and he urged the Secretariat to do that fully. He welcomed the recommendations addressed to the governing bodies, particularly the one concerning comprehensive review of the governance process at regional level (recommendation 1, part II). As the report noted, cooperation between regions, subregions and Member States should be promoted and strengthened.

Mr KÜMMEL (Germany),¹ referring to the staff survey conducted by the Joint Inspection Unit, said that staff members were a valuable source of information on the workings of the Organization and

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

should be consulted more frequently. Commenting on the review of decentralization in part II of the report, he stressed the importance of corporate alignment as a key goal of the reform process and expressed the hope that the report's recommendation would stimulate debate on how to strengthen alignment within WHO and manage the challenges posed by its decentralized structure. He strongly supported the recommendation on monitoring the establishment and functioning of networks and annual meetings by technical and administrative areas of work at the three levels of the Organization (recommendation 2, part II). Although the work of the Global Policy Group was heading in the right direction, the Group's institutional framework should be strengthened, as noted in the report. He would appreciate information on what steps were being taken to ensure that the decisions of the Global Policy Group were communicated to and followed up and implemented by the entire Organization, and would welcome the formulation of an implementation plan, as suggested by the member for the United States of America.

Mr LEE Kyong-Yul (Republic of Korea),¹ referring to the recommendations of both the Joint Inspection Unit and the Programme, Budget and Administration Committee for improving the transparency, predictability and flexibility of WHO's financing, expressed support for the Committee's five proposals.² He particularly welcomed the proposal for a financing dialogue. The Organization was performing well with a technical expertise that was unparalleled. If WHO needed more money in order to do what its Member States expected of it, then its Member States should give it more money. His Government had increased its voluntary contributions by 20% for 2013 and would endeavour to continue increasing them over the coming three years.

Dr PHUSIT PRAKONGSAI (Thailand),¹ voicing support for all 17 recommendations contained in part I of the report, said that, in addition to the review of Assistant Director-General positions under recommendation 2, the Director-General should take steps to improve the selection and appointment of regional directors, a process that was often politically motivated, which gave rise to political patronage and the selection of candidates who were not always adequately qualified. He supported recommendation 7, part I, on human resources management. Staff had a vital role to play in strengthening the Organization and achieving the goals and targets of WHO reform, and recruiting and retaining staff with the requisite skills and capacities was essential.

The DIRECTOR-GENERAL thanked the Joint Inspection Unit for its excellent work and the overview presented to the Board. She was reassured that Member States appeared generally to agree that the WHO reform process was moving in the right direction. Member States had considered the Unit's report excellent and timely and the recommendations valuable. They had acknowledged that, because the Unit's review had been conducted while reform measures were being implemented, some of the recommendations contained in the report had already been addressed by the Secretariat.

She had heard no objection to any recommendation, but had gained the impression that there were some recommendations that Member States were not keen to see implemented without further study, such as that concerning redesign of WHO's regional structure, as mentioned by the member for China. She assumed that, given the highly political nature of that recommendation, Member States would not want to rush to implement it, but she stood ready to carry out the decisions of the governing bodies. Concerning the recommendation for a review of WHO's evaluation function (recommendation 17, in part I), she was uncertain whether the Unit was recommending that the WHO evaluation policy approved by Member States in May 2012³ should be revisited. Noting that the Secretariat continued to study documents and best practices with a view to enhancing the culture of evaluation within the

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² See document EB132/3.

³ Decision EB131(1).

Organization, she suggested that, before undertaking a review of the policy, the Secretariat should first proceed to implement it and then apply the lessons learnt in order to improve the evaluation function.

The Joint Inspection Unit's recommendations, which she had studied carefully and would implement fully, would be incorporated into the WHO reform implementation plan.¹ They would be cross-referenced with similar reform-related recommendations and activities, and Member States would be kept informed of how they were being implemented. Information concerning implementation costs would also be provided. Together with the Global Policy Group, she would examine all the findings of the Unit's report, including the "soft" recommendations, and take appropriate action on those, as well. Referring to the comments made by the representative of Germany, she affirmed that the institutional framework of the Global Policy Group would be strengthened. Further information would be made available to Member States to enable them to understand how the Group's decisions were made and followed up.

The CHAIRMAN said that, hearing no further comment, she would take it that the Board wished to note the report and the recommendations of the Joint Inspection Unit.

The Board noted the report.

- **Modalities for the independent evaluation of the WHO reform: stage two, and implementation of WHO reform, 2012 – progress report and high-level implementation plan** (Documents EB132/5 Add.7, EB132/5 Add.8, EB132/43 and EB132/INF./3)

The CHAIRMAN drew attention to several corrections to the printed version of document EB132/INF./3, noting that the electronic version had already been amended. In the table entitled "Budget for WHO reform: 2012–2013 and 2014–2015, the figure 3730 on line 3.4 (Accountability) should be replaced by the figure 5126 in both the "2012–2013" and the "Total" columns. In the "Total" row at the bottom, the figure 18 502 in the "2012–2013 column" should be replaced by 19 898 and 23 242 should be replaced by 24 638. In the section entitled "Managerial reform: accountability and transparency", the figure 3730 should be changed to 5126 in the "Total" line of the table entitled "Outputs" on page 19 of the English version of the document. In the table entitled "Outputs" on page 20, the figure 1649 in the "Total" line should be replaced with 1579 in both columns.

Dr THABET NASHER (Yemen), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee and referring to the report contained in document EB132/5 Add.7, said that the Committee had expressed support for the modalities of the second-stage evaluation, in particular the focus on change to ensure WHO's preparedness to implement the reform process, and had emphasized that the complementary work done by the Joint Inspection Unit should be taken into account in the formulation and finalization of the terms of reference for the second stage of the evaluation. With regard to the reports contained in documents EB132/5 Add.8 and EB132/INF./3, the Director-General had noted that, in view of the significant shortfall in the reform implementation budget, she had shifted resources internally in order to proceed with the implementation plan and that further progress in the implementation of reform would depend on the availability of sufficient resources. She had thanked those Member States that had made contributions for that purpose.

Dr GRABAUSKAS (Lithuania), speaking on behalf of the European Union and its Member States, said that reform was needed in order to ensure that WHO was fit for purpose and had a transparent budgetary process and robust governance structures. The Secretariat was to be commended for developing the reform implementation plan online browser, which would be a useful tool in

¹ See document EB132/INF./3.

monitoring the implementation of reform. Its submission of progress reports to the Independent Expert Oversight Advisory Committee was also praiseworthy. He sought further information on the independent validation role to be played by the Committee. He also sought clarification of the substantial costs associated with some items included in the estimated budget for the high-level implementation plan, particularly the proposed human resource and governance reforms. Discussions on funding should not impede progress in implementing less costly reforms. He supported the proposals for the establishment of an evaluation management group that would approve the terms of reference for the second stage of the independent evaluation of WHO reform, and asked how Member States could provide input to that group on the terms of reference.

Recalling the Board's earlier discussion of the methods of work of the governing bodies, he requested that the proposed changes to the Rules of Procedure of the Executive Board, including the proposal made on behalf of the European Union during the previous meeting to amend Rule 5, paragraph 3, of those Rules be included in the list of reform-related matters requiring further discussion by Member States.

Dr LOUME (Senegal), requesting clarification on certain aspects of the modalities for the independent evaluation of WHO reform, enquired which Secretariat staff would be supporting the evaluation management group, how the criteria for selection of the evaluators would be established, what criteria and principles would guide the evaluation process, and what role Member States would play in the evaluation process. He would also like to know when the Secretariat intended to begin implementing the reform plan and how it proposed to address the problem of late submission of working documents.

Professor NICKNAM (Islamic Republic of Iran) said that he could endorse the modalities for stage two of the independent evaluation of WHO reform and the establishment of the evaluation management group. However, he sought clarification about the scope of the evaluation, which according to document EB132/5 Add.7 would seek to prioritize various components of the reform proposal. It had been his understanding that the second stage of the evaluation would assess the Secretariat's preparedness to implement fully the reform proposals, not its preparedness to prioritize certain components of the reform proposals. He viewed reform as a package that should be implemented in its totality and not on the basis of any prioritization.

It was clear from the report contained in document EB132/5 Add. 8 that significant progress had been made in the three broad areas of WHO reform but further efforts were needed in order to identify mechanisms to increase the flexibility of financing and ensure that all programmes were fully financed and supported and to revitalize the core responsibilities and roles of the Organization.

Mr KOÇAK (Turkey)¹ said that the high-level implementation plan provided a good overview of how WHO reform was being implemented. He welcomed the availability of regular progress reports, including financial information, on a dedicated web page. Financing was, however, the central aspect of WHO reform. Improving the predictability and sustainability of financing would require more realistic results-based planning, as well as increased transparency and accountability. The financing dialogue would play a crucial role in that respect. As had been emphasized during recent meetings of the Programme, Budget and Administration Committee, greater clarity was needed on all aspects of that dialogue, but particularly on the rules and responsibilities of the governing bodies. Their involvement in the financing dialogue would be indispensable given that they made the final decision on the composition of the Organization's budget.

He welcomed the proposal on modalities for the second stage of the independent evaluation of WHO reform, which would provide better insight into the process. The identification of barriers to change was crucial to the successful implementation of the reform process. That component should

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

also include proposals for refining the change management strategy, as well as preparation of an adequate communication strategy in order to convey the right messages to the relevant actors. Member States should have the opportunity to comment on the terms of reference for the evaluation before they were finalized.

Ms HALÉN (Sweden),¹ welcoming the establishment of the implementation plan for the reform process and the related online browser, asked whether the term “key deliverables” referred to “output indicators”. Noting the large number of key deliverables, she called for focused efforts and a realistic division of activities over the years. The implementation plan was a tool for ensuring that the Organization was making steady progress towards the ultimate goal of reform: achieving improved global health outcomes. Reform would, of course, carry costs, which was acceptable as long as Member States could see that concrete results and efficiency gains were being made at all levels of the Organization. She wondered how the estimated costs shown in the implementation plan related to the draft programme budget and suggested that all reform-related costs should be included in the next draft of the budget. The implications of the reform proposals must be coherently and consistently communicated across all levels of the Organization in order to ensure that staff were aware of and understood them.

Ms TYSON (United Kingdom of Great Britain and Northern Ireland)¹ concurred with the comments made by the previous speaker. It was crucial for implementation to be well planned and progress clearly communicated. She urged the Secretariat to maintain the momentum of the reform process and to continue to be realistic.

Mrs FABBRI (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN and also on behalf of the Democratising Global Health Coalition, recalled that the Board had decided² that the first stage of the two-stage independent evaluation should consist of a review of existing information, focusing on financing challenges for the Organization, staffing issues and internal governance, and should provide a roadmap for the second stage. The decision to allow the evaluation process to run in parallel with other aspects of reform ran counter to common sense, as did the fact that governments were deciding on the future of the Organization before the evaluators had presented their recommendations.

In the first stage of the evaluation, the External Auditor had failed to meet the terms of reference, focusing instead on reforms that had been implemented up to that point, a failure that might affect the second stage of the evaluation. Focusing the second stage on the Organization’s readiness to take the reform forward would fail to produce information crucial for developing a Constitution-based vision of the Organization’s future role. The independent evaluation should yield a comprehensive and strategic situation analysis of the Organization’s current positioning on the overcrowded stage of actors influencing global health.

The DIRECTOR-GENERAL, recalling the exhortation of the representative of the United Kingdom to be realistic and responding to the question raised by the representative of Sweden with respect to the costs associated with the high-level implementation plan, said that additional resources were needed to cover costs of reform implementation that had not been budgeted for when the Programme budget 2012–2013 had been approved – for example, the creation of the Ethics Office and the Compliance and Risk Management Unit, the commissioning of two reports from the Joint Inspection Unit and both the first and second stages of the evaluation. The total cost of the reform package was estimated at US\$ 19.898 million, of which US\$ 5.615 million had been contributed to date by Canada, Germany, Monaco, Norway, Sweden, Switzerland and the United States of America.

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

² Decision EBSS2(3).

Another US\$ 5 million had been obtained, with great difficulty, by mobilizing internal resources. The resulting US\$ 10.6 million would help to ensure that the reforms did not stop for lack of money. However, a funding shortfall of US\$ 9 million remained for 2013.

The cost of the Ethics Office and other new reform-related functions and offices would continue to be incurred and would be included in the programme budgets for 2014–2015 and beyond. Although the Secretariat would seek to make savings and absorb costs, additional resources would be needed for some areas, including transparency and accountability. Those costs would be shown under the category “Enabling functions/corporate services” and financial data would be provided in the next draft of the proposed programme budget 2014–2015.

The Secretariat would keep Member States apprised of progress under the implementation plan. She would be pleased to present a demonstration of web-based implementation plan tracking tool if the Board so wished. Responding to questions raised by the member for Senegal, she noted that paragraph 11 of document EB132/5 Add.7 showed the timeline for the second stage of the evaluation. The evaluation management group would consist of the Officers of the Executive Board and be led by the Chairman. In order to preserve the independent nature of the evaluation, the Board’s Officers would be supported by the Office of Internal Oversight Services. Member States were welcome to provide input to the Chairman of the Board on the terms of reference and the criteria for selecting the evaluators, which would be finalized by the Board acting as the evaluation management group.

With respect to late submission of documents, the growing trend in the number of documents requested by Member States helped to explain document delays. The scheduling and structuring of meetings also had an impact on the timing of document production. For example, if Member States scheduled an intergovernmental working group meeting in December, it was impossible for the Secretariat to produce a report on the meeting for submission within the time prescribed in the Rules of Procedure to the Board in January. The Secretariat always sought to avoid delays, but sometimes the demand for documents exceeded the working capacity of its staff. When that occurred, the Secretariat needed a way to notify Member States that delays were likely unless additional resources were provided to allow the outsourcing of some of the work, such as translation.

She asked the member for Lithuania to clarify his request about the methods of work of the governing bodies.

Dr GRABAUSKAS (Lithuania) explained that he simply wished to ensure that the proposal he had made on behalf of the European Union with regard to Rule 5 of the Board’s Rules of Procedure was reflected in the list of decision points that the Director-General intended to draw up.

Following a procedural discussion in which Mr KÜMMEL (Germany),¹ Mr CORRALES HIDALGO (Panama), Professor HALTON (Australia), the CHAIRMAN and the DIRECTOR-GENERAL took part, the CHAIRMAN suggested that interested delegations should hold informal consultations to discuss the draft list of decision points to be produced by the Secretariat. As agreed during the previous meeting, the list would indicate areas in which consensus had and had not been reached. Professor Halton (Australia) had agreed to lead the informal consultations. The Secretariat would provide logistic support, including interpretation.

It was so agreed.

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

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

2. PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 7 of the Agenda (continued)

Follow-up actions to recommendations of the high-level commissions convened to advance women's and children's health: Item 7.2 of the Agenda (Document EB132/13) (continued from the fourth meeting, section 3)

The CHAIRMAN recalled the draft resolution on implementation of the recommendations of the Commission on Life-Saving Commodities for Women and Children, proposed by Libya, Nigeria, Norway and the United States of America, noting that the only proposed amendment had been the addition of the words “as appropriate” in subparagraph 2(2), as proposed by the member for Australia. The financial and administrative implications for the Secretariat remained unchanged. The amended subparagraph would thus read:

2. REQUESTS the Director General:

...

(2) to work with and support Member States **as appropriate** in improving regulatory efficiency, standardizing and harmonizing registration requirements and streamlining assessment processes including granting priority review to the products belonging to the life-saving commodities;

...

Dr REN Minghui (China) said that his delegation had questioned the practicality of requesting Member States to introduce standardized registration requirements, but the amendment proposed by the member for Australia had allayed those concerns, and he was therefore prepared to adopt the resolution as amended.

Dr LAHTINEN (Finland),¹ Ms van GULIK (Netherlands),¹ Ms FERENIUS (Sweden),¹ Mr LANE (United Kingdom of Great Britain and Northern Ireland),¹ Ms LINDGAARD (Denmark)¹ and Ms BRANCHI (France)¹ stated that their countries wished to cosponsor the draft resolution.

The draft resolution, as amended, was adopted.²

Dr REN Minghui (China), welcoming the adoption of the draft resolution, reiterated his delegation's question posed in the fourth meeting as to whether the recommendations of the Commission on Life-Saving Commodities for Women's and Children's Health had been implemented and were reflected in the proposed programme budget 2014–2015.

Dr BUSTREO (Assistant Director-General) said that the Commission's recommendations and the significant work undertaken over the previous year in relation to the recommendations of the Commission on Information and Accountability for Women's and Children's Health had indeed been taken into account in the proposed programme budget 2014–2015 and incorporated into the programmes of work of headquarters and the regional and country offices. Member States had made commendable progress in reducing child and maternal mortality and in respect of other health-related Millennium Development Goals. The Secretariat and the regional offices would do their utmost in the

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

² Resolution EB132.R4.

coming three years to provide support to countries in achieving the Goals. A high-level meeting would be held to that end the following week in the Eastern Mediterranean Region.

Mgr VITILLO (Holy See), speaking at the invitation of the CHAIRMAN, observed that medical care associated with the Catholic Church and other major faith traditions greatly reduced morbidity and mortality among mothers, neonates and children, particularly in developing countries and marginalized populations. Faith-based organizations agreed on the need to achieve further reductions in loss of life and to prevent illness through increased access to affordable interventions that were respectful of the life and dignity of all mothers and children, from conception to natural death. He expressed grave concern at the consideration being given by the Board to affirming and promoting “emergency contraception”, a strategy recommended by the Commission on Life-Saving Commodities for Women and Children. It was totally unacceptable to refer to medical products that constituted a direct attack on the life of the child in utero as “life-saving commodities” and, worse, to encourage an increase in their use. The Holy See did not consider abortion and abortion-related services as a dimension of reproductive health or reproductive health services.

The meeting rose at 18:00.

SEVENTH MEETING

Thursday, 24 January 2013, at 09:10

Chairman: Dr J. ST. JOHN (Barbados)

PROGRAMME AND BUDGET MATTERS: Item 11 of the Agenda

Implementation of Programme budget 2012–2013: update: Item 11.1 of the Agenda (Documents EB132/25 and EB132/43)

Dr THABET NASHER (Yemen), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, reported that the Committee had considered the update on implementation of the Programme budget 2012–2013 at its seventeenth meeting (document EB132/43). It had appreciated the progress made towards greater transparency and accountability; noted gaps in key programmatic areas across several WHO regions, especially the continued funding shortfalls in the African Region; and welcomed the establishment of the Resource Mobilization Task Force and its work in identifying resources to resolve the shortfalls. Responding to the various comments, the Secretariat had attributed the misalignment of funds for priorities to highly earmarked funding, and the Director-General had said that part of the shortfall in the Programme budget was being covered through the allocation of flexible funding to areas of strategic need across the Organization.

Dr MYINT HTWE (Myanmar), drawing attention to the observation (document EB132/25, paragraph 11) that the pace of programme budget implementation traditionally accelerated in the second year of a biennium, stressed that ways needed to be found of ensuring that the quality of implementation in WHO's collaborative activities on the ground would not suffer as a result of the imbalance.

Mr HAZIM (Morocco) welcomed the clear sets of data contained in the Secretariat's report and was pleased to note the expectation that the Programme budget 2012–2013 would be fully financed. He had expected, however, to receive information on the situation as at the end of December 2012, rather than as at 30 September 2012, and on the rate of funding and implementation of the Programme budget at the regional office level by strategic objective.

Concerning implementation and with particular reference to expenditure, the Organization had begun to introduce measures aimed at cutting travel costs, at the regional level especially, such as requesting Member States to shoulder a percentage of the budget allocated to participation in regional meetings. Member States should ideally be involved in any discussion of that issue in order to ensure that none was precluded from participating in important meetings. They should also limit their annual programme to meetings scheduled by the Organization or at the regional level. Moreover, they should be told how much they were expected to contribute to the travel budget so that they could more easily weigh up the importance of their participation in any given meeting and either budget for it accordingly or decide to be represented by their permanent mission or ambassador.

Concurring with the analysis indicating that some strategic objectives were underfunded, he welcomed the establishment of the Resource Mobilization Task Force to alleviate the misalignment of funding across WHO, and the planned introduction of a resource management policy. Those measures represented a first step in the implementation of system reforms, which would assist in the preparation of a programme budget 2014–2015 that was broken down among categories in line with country specificities and priorities.

Dr JAMA (Assistant Director-General), in response, explained that 30 September 2012 had been the cut-off point for the analysis in order to meet the deadline for translation and publication. Data received for the period up to 30 November showed a reduction in the financing shortfall from US\$ 547 million to US\$ 300 million. The Secretariat had taken note of the suggestions that the next report should contain a breakdown of implementation rates by regional office and that the continuing misalignment of funding should be dealt with by the Resource Mobilization Task Force. On the matter of cutting travel costs, specific rules and regulations applied to participation in sessions of the governing bodies that ensured that the costs of representatives from lower-income countries would continue to be covered by the Organization.

Dr VALVERDE (Panama) noted with satisfaction the expectation that the Programme budget 2012–2013 would be fully financed, but expressed concern about the continuing differences in the level of financing and the fact that some strategic objectives were still underfunded in certain regions, which attested to the problems arising from high levels of earmarked funding and low levels of flexible funding. In particular, the figures presented in document EB132/25 (Fig. 3) showed that the Regional Office for the Americas had the lowest individual rate of available funding: just 6.15% of the total budget compared with 24.4% for the Regional Office for Africa and 34.3% for headquarters. Furthermore, there had been an unprecedented increase in the percentage of the budget allocated to headquarters and the Regional Office for Africa compared with the biennium 2006–2007. Questions had been raised on the matter on several occasions but they had remained unanswered. She therefore requested the Secretariat to prepare a detailed explanatory document.

Dr JAMA (Assistant Director-General), recalling that the report in document EB132/25 covered only the period up to 30 September 2012, said that the Director-General had since allocated additional resources from core voluntary contributions to all the regional offices. Furthermore, as far as the Regional Office for the Americas was concerned, the Secretariat had only had access to the figures pertaining to the assessed contributions appropriated through the Health Assembly and the voluntary contributions raised by WHO, and had been unable to take into account the extra assessed contributions and voluntary contributions that the Regional Office for the Americas/PAHO had received as PAHO was not in the Global Management System. The update therefore provided only a partial analysis. The Secretariat was currently working with PAHO colleagues to obtain the relevant figures, which would be incorporated into an updated report to be submitted to the Programme, Budget and Administration Committee for consideration at its eighteenth meeting in May 2013.

The Board noted the report.

Draft twelfth general programme of work: Item 11.2 of the Agenda (Documents EB132/26 and EB132/43)

Proposed programme budget 2014–2015: Item 11.3 of the Agenda (Documents EB132/27, EB132/43 and EB132/INF./4)

The CHAIRMAN recalled the agreement to consider the two items together.

Dr THABET NASHER (Yemen), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, reported that the Committee had welcomed the progress made in developing the draft twelfth general programme of work and the proposed programme budget 2014–2015.¹ The Secretariat's two reports would serve as the key instruments for implementing programmatic reform, setting the direction for the coming six years. The Committee had suggested that the eight

¹ Document EB132/43.

strategic priorities be labelled as “leadership priorities” for the Organization and that the governance and management priorities should be treated differently from the public-health priorities. Clarity had been sought on the basis of allocation of financial and human resources to programme areas and major offices, with some members of the Committee expressing concern about the level of allocations to the Regional Office for the Americas and the Regional Office for South-East Asia. The revised documents for the Health Assembly should provide more information on staffing levels and the availability and sources of funding for the programme budget, which would be useful in the financing dialogue. Furthermore, the priorities and terminology should be refined; the articulation between the six categories and the eight strategic priorities in the draft twelfth general programme of work must be made clearer and greater accountability should be ensured, especially in terms of the linkages between outputs and outcomes.

In response, the Director-General had explained that the eight strategic priorities had been based on the application of criteria discussed by Member States during previous consultations and on feedback from regional committees. More work would be done in all the areas highlighted by the Committee, and the presentation of the results chain would be improved by clarifying the linkages between the impacts, outcomes and outputs, and by providing a clear definition of the joint responsibility of Member States and the Secretariat. In order to ensure that the finalized programme budget served as a tool to review progress and longer-term impacts, the Secretariat had set up working groups whose results would be presented to the governing bodies. In the meantime, Member States would have an opportunity to comment on both documents in various forums and were invited to submit written contributions by 15 February 2013. Those contributions would be posted on an access-restricted section of the WHO web site, and the documents would be finalized in time for the Committee’s eighteenth meeting in May 2013.

The DIRECTOR-GENERAL said that the informative and perceptive discussions in the Programme, Budget and Administration Committee had identified some of the weaknesses to be tackled in the next general programme of work and programme budget. It was, indeed, a work in progress. The Secretariat must concentrate on reinforcing the linkage between the two documents and on the financing dialogue, as well as on finalizing the requested draft resolution for the Sixty-sixth World Health Assembly and considering the possible amendments to the Financial Regulations and Financial Rules. She had discussed with the six regional directors and the Deputy Director-General the Committee’s comments but would listen to the views of Board members before sharing their initial thoughts on the matter.

Mr KOLKER (United States of America), recognizing the size of the task requested, applauded the progress made in providing more detailed information on the budget allocation and the effort to connect budgets to goals and outcomes, which would be essential to the reform process and would have major implications for the Organization’s ability to attract additional financing in the long term. He commended the Director-General’s reduction of the number of strategic priorities in the draft twelfth general programme of work to eight, and would welcome their designation as “leadership priorities”. However, they were a mismatched combination of categories of work (e.g. noncommunicable diseases and access to medicines) and cross-cutting approaches (e.g. universal health coverage, determinants of health). In its written contributions to be submitted by 15 February 2013, his Government would propose a fuller, clearer, set of goals and outcomes, including a particular focus on poliomyelitis. In the meantime, he suggested that the Secretariat incorporate the feedback from the Programme, Budget and Administration Committee’s meeting and the current session of the Board into a revised document and that it convene informal briefings for Member States in an online consultation aimed at promoting dialogue and consensus.

The proposed programme budget 2014–2015 would, if adopted in its entirety, serve both to guide the technical programme and to promote transparency, accountability and resource mobilization. He thanked the Secretariat for noting that more work was needed on the results chain, as in the current version of the document it was hard to link the outputs, outcomes and goals with the proposed strategic priorities and categories of work. The Secretariat had undertaken to provide a detailed

breakdown of the budget by source of funding, which would be of great value to the next Health Assembly. Among the specific concerns to be dealt with in finalizing the document was the fact that the section on noncommunicable diseases in category 2 did not include an indicator on harmful alcohol use, in spite of the compromise agreement reached after lengthy negotiations at the formal meeting of Member States on the global monitoring framework in November 2012. Furthermore, the chapter on category 3 included no indicators on healthy ageing, the social, economic and environmental determinants of health, or gender, equity and human rights mainstreaming; and the chapter on category 4 lacked any information on the existing barriers to access to medical products or any mention of substandard, spurious, falsely-labelled, falsified and counterfeit medical products, and lacked an adequate focus on research and development priorities for developing countries.

Dr VALLEJO (Ecuador), speaking on behalf of the Union of South American Nations, acknowledged the proposed programme budget 2014–2015 but drew attention to its shortcomings. Her comments were meant constructively. First, it was impossible to determine the prioritization of programme areas or the articulation between the six categories and the eight strategic priorities in the draft twelfth general programme of work, which were crucial to promoting results-based management and accountability. Secondly, the overall quality of the indicators needed to be improved, as some of them were unclear or insufficiently detailed and others had no baseline or targets, thereby rendering the monitoring of progress difficult for Member States, especially smaller countries with limited resources. The way in which the outputs and deliverables were presented did not show how they would contribute directly to meeting those objectives. Thirdly, the document did not clearly define roles and responsibilities for the implementation of the programme budget at the various levels of the Organization. The quality of indicators related to the social determinants of health should be improved, and the associated funding should be increased.

She expressed concern about the diminishing share of voluntary contributions being allocated to the Regional Office for the Americas, and considered that an adequate and predictable balance should be maintained between the allocations to regions and to headquarters; WHO's budgetary policy should specify the criteria according to which its resources were allocated.

Dr GRABAUSKAS (Lithuania), speaking on behalf of the European Union and its Member States on agenda item 11.2, recognized that the draft twelfth general programme of work represented a new chapter for WHO and emphasized the importance of enhancing country and regional level involvement in priority-setting and planning over the six-year period. The two reform-related priorities, on governance and management, should be considered as means to an end; they should be dealt with in a separate section on the governance of WHO and the role of WHO in health governance, which could be linked to the high-level implementation plan in the same way that the six programmatic priorities were meant to be linked with the proposed programme budget 2014–2015. He requested clarification of how those priorities had been established in relation to the priority-setting exercise undertaken by Member States in 2012, and how they tied in with the overall work of the Organization.

Recognizing the work done on the results chain and welcoming the efforts to set indicators that were linked to targets, he expressed concern about the framework for regular performance assessment and accountability, which was unwieldy and in need of streamlining across the general programme of work and the proposed programme budget; the former should focus on outcome indicators, while the latter should focus primarily on outputs. The outcomes in the general programme of work should stem from internationally agreed goals and frameworks.

He welcomed the opportunity to provide detailed written feedback and stressed the importance of further consultation on the two documents before the Sixty-sixth World Health Assembly.

Dr CUYPERS (Belgium), speaking on behalf of the European Union and its Member States on agenda item 11.3, supported the outcome of the second extraordinary meeting of the Programme, Budget and Administration Committee in December 2012,¹ including the proposal that the draft programme budget be adopted in its entirety, and endorsed the Committee's conclusion that more work was needed on the document. Further clarification was sought on the modalities of the financing dialogue, the allocation of assessed contribution funding, the legal implications of the proposals relating to the draft appropriation resolution, the proposed amendments to the Financial Regulations and cost-recovery measures. He also welcomed the opportunity to provide written comments and further consultation with Member States, and suggested that the Director-General explore options for a clear role for the governing bodies in relation to the outcomes of the financing dialogue and the resource mobilization strategy, which should be submitted to the Committee for consideration at its eighteenth meeting in May 2013.

The European Union remained committed to the principle of results-based budgeting. In order to improve accountability, however, outputs must be measurable, properly costed and differentiated across the three levels of the Organization. The goals, outcomes and indicators should be better defined and the means of verification clarified; clear outputs, indicators and targets for efficiency savings should be provided in each category; and the structure of the programme budget should remain constant in order to allow for comparison over the three bienniums covered by the twelfth general programme of work. He welcomed the efforts to develop indicators linked to targets but stressed that the focus should be on outputs and deliverables rather than on outcomes. He furthermore stressed the need for compliance mechanisms and requested further information on the mechanism for reporting progress.

Mr ROMERO PUENTES (Cuba) expressed appreciation of the draft twelfth programme of work, which should be further refined, and which would prove highly useful. He concurred with the emphasis placed on multisectoral action, but advised caution in relation to the proposal on private-sector participation, as it was hard to imagine the private sector not working in its own interest. Only non-earmarked contributions from charitable foundations should be accepted, and the organizations concerned should not be allowed a role in the governance of the Organization.

The proposed strategic priorities were satisfactory and capable of being adapted to the specificities and needs of the settings to which they would apply, although the impact goals and outcomes would need reformulating to bring them into line with those priorities. However, the group of indicators pertaining to noncommunicable diseases did not tally with the agreement reached after lengthy negotiation at the formal meeting of Member States in November 2012 with respect to indicators and age groups not only for alcohol use but also for tobacco use and salt consumption; they should be amended accordingly.

Dr REN Minghui (China) said that the eight strategic priorities in the draft twelfth general programme of work fully reflected the health challenges to be met in the next six years, and their links with the six categories in the proposed programme budget 2014–2015 would enable steady and effective progress to be made. He welcomed the emphasis on health system strengthening and the focus on access to essential medicines, good governance and health information, people-centred services and a well-trained, motivated workforce. However, the general programme of work should take account of the fact that country-level experience had shown the process of health system strengthening to be more effective when it was community-based. He asked the Secretariat why many of the impact goals and outcomes in the draft programme budget, intended to be achieved by 2015, were the same as those in the draft general programme of work, intended to be achieved by 2019. Quantitative indicators should be provided to measure progress in category 3 (Promoting health throughout the life course) with respect to healthy ageing, gender, equity and human rights mainstreaming and the social determinants of health.

¹ Document EB132/3.

Ms VUKOVIĆ (Croatia) said that the draft twelfth general programme of work captured the challenges facing WHO over the coming years. However, more work was needed to streamline its strategic priorities, to improve its linkages with the programme budget and to clarify and strengthen the results chain, which would serve to enhance the Organization's accountability in delivering outputs. Regarding the proposed programme budget 2014–2015, which would be a transitional budget, she supported the pragmatic approach of basing the financial envelope on previous expenditure patterns and the resulting budgetary allocations. The proposed programme budget, too, required more work before submission to the Sixty-sixth World Health Assembly. In particular, it needed to reflect regional specificities better and to give a clearer idea of what was to be done in the regions under the various programmes. As for the draft programme budget resolution presented in document EB132/INF./4, which would give the Director-General full flexibility in allocating assessed contributions to major offices and categories of activity, she preferred to maintain the current system, with the regional directors being given the flexibility to allocate funds within their respective regions in line with the outcome of the financing dialogue.

Mr HAZIM (Morocco) concurred with the analysis of the political, economic and institutional context set out in Chapter 1 of the draft twelfth general programme of work and the priorities identified in Chapters 2 and 3, but said that human rights must be emphasized as one of the enduring principles, values and approaches referred to in Chapter 2. He commended the proposals for organizational alignment, which would unquestionably help to define responsibilities at each level of the Organization and ensure that all parts of WHO worked in concert to frame new development goals and develop strategies in various spheres. The strengthening of country offices was, however, crucial to the success of such reform.

Chapter 4 envisaged transfers of resources between the various categories of work. Country specificities and priorities must be taken into account, however, and the flexibility of financing should be enhanced by increasing to 10% the amount of any budget transfer from one category to another, as had been the case with such shifts between strategic objectives under the Eleventh General Programme of Work.

He applauded the effort that had gone into preparing the proposed programme budget, but the fact that it covered a total of 25 programme areas, excluding those in category 6, raised several questions. Would it be possible to assess the results? Was every country required to have a programme in every one of those areas? How would countries incorporate their priorities, bearing in mind that the budget was divided up among those areas? Was there a mechanism for indicating the amount of flexibility available in terms of resource shifts between categories and also between programme areas? He proposed that the matter be dealt with by way of an amendment to the Financial Regulations and Financial Rules, which were due to be discussed later. He noted that the overall priorities, in particular social determinants of health, were confined exclusively to category 3 (Promoting health through the life course). No explanation of the links between categories was provided and no consideration was given to the financing method.

Ms PENEVEYRE (Switzerland) commended the streamlining of the number of strategic priorities in the draft general programme of work and agreed that more must be done to render that document consistent with the proposed programme budget. As the latter would be the first such budget to implement the new financing mechanisms envisaged in the reform, some uncertainty was inevitable; but she was keen to see Organization-wide involvement and the establishment of a genuinely bottom-up budgeting process. For the moment, every effort must be made to ensure that the adopted programme budget provided a reliable basis for the financing dialogue to take place after the Health Assembly. The role of the governing bodies after the adoption of the programme budget remained to be clarified. A balance must be found between the Director-General's flexibility to allocate funds and the involvement of the governing bodies in the process, particularly in respect of assessed contributions, reallocation of resources and adjustments to the programme budget during the biennium.

She welcomed the opportunity of a web-based consultation for Member States, which should provide the Secretariat with the input to finalize the document. She also supported the proposed authorization in the draft programme budget resolution (document EB132/INF./4, operative paragraph 6) of the Director-General to make transfers between categories of up to 5% of the amount allocated to each category; that would give her the flexibility to reallocate resources without undermining the role of the governing bodies and provide a financial management tool capable of preventing overfunding or underfunding of the various categories.

Dr BAYE LUKONG (Cameroon), speaking on behalf of the Member States of the African Region, commended the work to update the draft general programme of work and the proposed programme budget. In the context of a widening equity gap, the Organization urgently needed to change its ways in order to ensure that all people, especially the poor, had access to high-quality health care, which was a prerequisite for poverty reduction and sustainable development. Much progress had been made over the course of the current Eleventh General Programme of Work, such as the establishment of global partnerships facilitating access to life-saving commodities in Africa's meningitis belt, but much more remained to be done to protect people's health. Achievement of the health-related Millennium Development Goals, maternal and child health, progress against communicable, noncommunicable and neglected tropical diseases, access to medicines and vaccines, responding to epidemics and disasters, and the governance of WHO remained priorities for the Region.

The Region had noted the allocations in the proposed programme budget 2014–2015. It had been especially pleased to note the output under category 3 (Promoting health throughout the life course) concerning the generation of evidence for key interventions, including those for the control of sexually transmitted infections, which would be crucial for tackling the emergence of antibiotic resistance. In view of the international agenda to eliminate mother-to-child transmission of HIV by 2015, it might be useful to include an additional indicator on the number of pregnant women receiving antiretroviral therapy. The biggest challenge in her Region was to build robust health systems, and its Member States looked forward to providing more input on the subject in the period before 15 February 2013.

Dr UDVAL NATSAG (Mongolia) acknowledged the comprehensive and informative reports and expressed full support for WHO's reform process, its strategic response to new political, economic, social, demographic and environmental realities, and its approach to introducing effective health governance and best practices, such as results-based performance management, which could become a model for national governments. She proposed that the draft general programme of work be amended to include a focus on: human health security and patient safety, which would contribute to WHO's efforts to increase healthy life expectancy and improve quality of life; behavioural health programmes; and neglected zoonoses, which accounted for some 75% of newly emerging infectious diseases and had become more prevalent because of climate change and global warming.

Ms SUNDREHAGEN (Norway) welcomed the revised version of the draft twelfth general programme of work, commended the Secretariat's efforts to provide strategic direction through priority-setting, in spite of the lack of information on how it had arrived at the eight strategic priorities, and expressed appreciation for the increased focus on noncommunicable diseases, an area of WHO's work to which her Government had just decided to allocate additional funding.

In the proposed programme budget, she welcomed the fact that the Secretariat had responded to the request from Member States to provide more information on the suggested priorities. She accepted the figure of US\$ 4000 million to be budgeted for each biennium of the period covered by the general programme of work, provided that it was not altered by changes in the practice of carry-forward, but asked that future reports include more details on the economic situation in order to enable informed and responsible decision-making. She also agreed that the programme budget should serve as the main tool for priority-setting and accountability, and the basis for the financing dialogue. The accountability dimension would be weakened, however, without a costing for outputs, the division of labour and the entire results chain in the final version of the document. She welcomed the opportunity to provide written input by 15 February 2013 and the Secretariat's proposal to hold regular briefings before the

final draft was completed. She acknowledged the progress made in the area of programmatic reform; the Organization was heading in the right direction.

Dr JAMSHEED MOHAMED (Maldives), speaking on behalf of the Member States of the South-East Asia Region, noted with satisfaction that the proposed programme budget had clarified important elements of WHO reform, including organizational priorities and full costing. However, a clearer link should be established between the outcomes and outputs described in the proposed programme budget and the impacts and outcomes in the draft twelfth general programme of work. WHO must meet public expectations not only by addressing global health challenges but also by achieving more accountability, transparency, coherence and organizational effectiveness.

He expressed serious concern about the proposed 11.5% reduction in the budget allocation for the Regional Office for South-East Asia in the next biennium, especially as increases were proposed for other regional offices and headquarters. He acknowledged that changes were inevitable in the reform process and agreed with the underlying assumption that assessed contributions would remain stable while development partners were unlikely, in the current economic climate, to increase their voluntary contributions. However, any changes in resource allocation should not be allowed to undermine a regional office's work or to affect one office disproportionately compared with the others; they should be based on fair and transparent criteria, solid scientific evidence and, above all, real needs. That was not the case with the proposed cuts for the South-East Asia Region, which was home to more than one quarter of the world's population; it consisted mostly of low-income and lower-middle income countries, many of them struggling with high levels of poverty; it faced a high burden of life-threatening communicable diseases and an increasing prevalence of noncommunicable diseases; it had no major donors among its Member States; and it could not count on the continuation of the current trend of increasing partnership. Hence, it must be provided with a more realistic budget, with a fair and equitable allocation of resources across all regions. The current version of the proposed programme budget 2014–2015 had been described as a "work in progress", and he looked forward to continuing the discussion until the adoption of the proposed programme budget by the Sixty-sixth World Health Assembly.

Dr AMMAR (Lebanon), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the adoption of the proposed programme budget in its entirety would reaffirm the responsibility of Member States to make available the financial resources for the proper implementation of governing body decisions and resolutions. The ensuing financing dialogue would serve to improve the alignment of funding with the agreed priorities. He commended the efforts made in costing outputs, in defining roles and responsibilities across the three levels of the Organization and in improving results-based management, which would enhance accountability. The allocation of resources in the proposed programme budget, however, should be better attuned to the needs and priorities of Member States, which varied among and within the regions, and countries should have a greater say in the preparation of future programme budgets and more flexibility in reallocating resources. Turning to the current draft, he said that two particular concerns had to be taken into account. First, adequate funding must be made available for the first year of the biennium to offset the unpredictability of financing, as WHO would not have received in full the voluntary contributions that constituted its main source of income; the Region's programme budget relied more than any other on voluntary contributions. Secondly, as humanitarian emergencies in his Region accounted for 52% of budget expenditure, in contrast to the WHO average of 23%, support for such emergencies should be separated from the rest of category 5 (Preparedness, surveillance and response) in order to safeguard the funding of other activities in the Region.

Ms PATTERSON (Australia) welcomed the overall structure and content of the current version of the draft twelfth general programme of work but said that some refining of the text was still necessary. The strategic priorities should be linked with the categories listed in the proposed programme budget 2014–2015, and there should be references to the links between noncommunicable disease, disability and blindness. The section of the draft twelfth general programme of work on the International Health Regulations (2005) should include a reference to the Pandemic Influenza Preparedness Framework; likewise, the section on increasing access to essential, high-quality, effective and affordable medical products should include a reference to substandard/spurious/falsely-labelled/counterfeit medical products. In Chapter 4, on results and resources, she supported the definition of impact goals and outcomes, but acknowledged that more work was needed. The chapter should reflect the conclusions of the recent Formal Meeting of Member States to conclude the work on the comprehensive global monitoring framework for noncommunicable diseases. The outcome indicators should place more emphasis on prevention. As for shifting resources in order to reflect priorities, it was important to do so sensibly and in such a way that none of the outcomes on communicable diseases were compromised.

Regarding the proposed programme budget, she underscored the importance of the results chain but noted that the document needed refinement. In particular, the discrepancies in the length of time for which the indicators and targets were set needed to be resolved.

Both documents needed to place a greater emphasis on disease prevention with more clarity on outputs and key deliverables, given their importance in underpinning WHO's work. Member States should receive updates on the two documents before the Sixty-sixth World Health Assembly and information would also be useful on what would happen after the Health Assembly to determine the balance between the roles of the governing bodies and the flexibility that the Director-General needed to run the Organization effectively.

Dr SARMENTO P. DA COSTA (Timor-Leste), referring to the proposed programme budget 2014–2015, commended, in particular, the setting of priorities in six categories and its compliance with the WHO reform process.

However, she also stated concern over the proposed reduction of more than 11% in the funds allocated to the Region, given that its countries faced a range of global health challenges and that no other region was due to see a reduction in its budget. The high level of seismic activity in the Region meant that it could be struck by natural disasters or emergency health situations at any moment. It was essential to maintain current levels of WHO's technical support and funding if health systems were to cope with such situations and if the Millennium Development Goals were to be achieved in the Region. She therefore urged that the proposed figures be reconsidered.

Ms DÁVILA CHÁVEZ (Mexico) said that the continued work on the draft twelfth general programme of work, especially elements relating to budget calculations, should be founded on the overarching principles of transparency, synergy between operational units, regions, headquarters and other actors, and linkages between actions and expected outcomes. Noting that the draft general programme of work set eight strategic priorities, while the allocation of resources in the proposed programme budget was based on six categories, she queried how overall performance and progress would be monitored. She also sought confirmation that the draft programme budget resolution contained in document EB132/INF./4 would be amended to reflect the discussions of the Programme, Budget and Administration Committee at its last meeting and would include, in particular, the level of Member States' assessed contributions.

Professor NICKNAM (Islamic Republic of Iran) welcomed the draft twelfth general programme of work and, in particular, the emphasis on surveillance. However, more attention should be given under the International Health Regulations (2005) to zoonoses and to management of emergencies and disasters beyond the initial critical phase. Further, as only the priorities of setting national health policies, strategies and plans were mentioned, he recommended that WHO be more active in drafting regulations in areas such as medicines quality and distribution, vaccines, noncommunicable diseases,

rehabilitation and health standards. Social protection mechanisms should also be included alongside health coverage, owing to the important role they played in helping people with poor health or disabilities to attain health equity and equality.

Dr ABDULLAYEV (Azerbaijan) said that the draft general programme of work successfully captured many of the challenges that WHO would face in the coming years, but more work was needed to streamline the priorities and to provide better links with the proposed programme budget 2014–2015. The results chain should be further strengthened and clarified in the interests of WHO's accountability in delivering outputs.

As the proposed programme budget was seen as a transitional budget, it was impossible to reflect all aspects of WHO reform in it. He thus welcomed the use of the figures for projected expenditure in 2012–2013 to calculate the budgets of major offices and programmatic areas. However, more work was needed before the proposed programme budget could be submitted to the Health Assembly for consideration; in particular, regional specificities and deliverables should be better reflected to aid comprehension of the activities carried out in each region under the various programmatic areas.

He welcomed the proposal in the draft programme budget resolution to give greater flexibility to the Director-General in the allocation of resources from assessed contributions, but said that the current allocation formula for apportioning resources to the major offices should be maintained, so that regional directors had the flexibility to allocate those funds at the regional level.

Dr SANGA (United Republic of Tanzania)¹ said that, more than ever, WHO's work must be based on scientific evidence so that it could promote the health-in-all-policies approach, continue to take the lead among the many different health actors and continue to provide technical guidance to Member States across all areas of health. The draft twelfth general programme of work should extend its focus on simplified treatment regimens for HIV/AIDS to include the promotion of strategies and the generation of new evidence for the prevention of infection, especially in areas of generalized epidemic.

One output listed under category 3 of the proposed programme budget 2014–2015 was the provision of support to Member States to prevent unsafe abortions, but there was no indication of relevant activities to be undertaken. The issue of abortion, whether safe or unsafe, was sensitive in many countries as it was often linked to cultural and religious beliefs. WHO should seek to act in that area through the provision of technical guidance to determine the moment when life was deemed to begin, based on the latest scientific evidence. In countries with restrictive abortion laws, WHO should provide support through investment in family planning services to help to address the large unmet need for contraception.

Ms ANDERSSON (Sweden)¹ thanked the Secretariat for providing answers and clarification on the complex process and acknowledged that producing a programme budget in line with reform was a learning process for all involved. As the draft twelfth general programme of work should help to define the impact that Member States wanted WHO to have on people's health, the next draft of the document should focus on results, clarifying WHO's expected achievements in the following six years and WHO's role and functions, with WHO's core functions as the point of departure.

The reduced number of strategic priorities was an improvement on previous drafts, but she asked how those strategic priorities had been selected. She emphasized the need to separate the governance and reform priorities from the programmatic priorities, as reform was not an end in itself but something that would help to achieve the programmatic priorities. An illustration of how the various parts of the draft general programme of work were related would be useful.

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

The proposed programme budget was the primary tool for planning, financing and resource mobilization, and follow-up, evaluation and accountability. It should focus on analysing WHO's role in achieving the listed outcomes, linking the six core functions to expected outputs, and the results chain, identifying appropriate indicators, the cost of outputs, and the level at which those outputs were to be delivered. In addition to a formal consultation process, there should be continued close cooperation between the Secretariat and Member States on the two documents under discussion in the period before the next Health Assembly.

Ms KUIVASNIEMI (Finland)¹ said that the goal of reforming WHO was a challenge, but one that all Member States had accepted. Reform was not easy, but within that process the issues of the draft general programme of work, the proposed programme budget and the financing dialogue were all interconnected and it was important to understand the implications of any changes to those key aspects of WHO reform before the documents were sent for consideration and adoption by the Health Assembly. To that end, she requested continued engagement between the Secretariat and Member States before the meetings of the Programme, Budget and Administration Committee and Health Assembly in May 2013.

Dr PHUSIT PRAKONGSAI (Thailand)¹ welcomed the two documents and, in particular, the six priority categories in the draft general programme of work, and the targets and indicators that had been set. There were challenges ahead in global health, however, and he requested clarification on how the draft general programme of work would be reoriented to guide the programme budget in the light of the changes coming with the post-2015 development agenda.

He welcomed the link between resources and results set out transparently in the results chain of the proposed programme budget. The clear and measurable outcomes listed under the six categories would also facilitate monitoring of progress. He supported the calls for the proposed reduction in the budget allocated to the South-East Asia Region to be reconsidered.

Mr PUSP (India)¹ expressed grave concern at the major impact that the potential reduction in the budget allocated to the South-East Asia Region could have on the ability to respond to its health needs. Cuts should not be made to any region's budget and he warned that doing so in his Region would have a serious impact on, among other things, India's ability to achieve poliomyelitis-free status. India was aiming to achieve universal health coverage over the next five years: a reduction in the Region's budget would risk decreasing the effectiveness of WHO's support for the Government, which was particularly undesirable given the positive impact that changes in India and the other countries of the Region might have on global health indicators.

Mr ALIMUZZAMAN (Bangladesh)¹ said that Bangladesh was, like other Member States of the South-East Asia Region, deeply concerned by the proposed 11.5% reduction in the budget allocated to the Region. As the proposed programme budget was to be further revised before its submission to the Health Assembly, it was to be hoped that an appropriate review would be undertaken in the meantime on the regional budget allocations to ensure that they were based on rationality, equity and regional needs.

Dr JAYANTHA (Sri Lanka)¹ added his serious concern to comments already made about the proposed reduction to the budget allocated to the South-East Asia Region. Such a reduction would harm the progress being made towards achieving the Millennium Development Goals and poverty alleviation. The proposed programme budget should be reconsidered, bearing in mind the need to support programmes in that Region and to promote social justice.

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

Ms WIDIYARTI (Indonesia)¹ backed the calls made by other Member States of the South-East Asia Region for reconsideration of the proposed reduction in the Region's budget. The assistance currently provided by various partnerships in the Region was not sustainable in the long term, and Member States should therefore be able to rely on continued and predictable support from WHO.

Mr KÜMMEL (Germany)¹ said that, although the new way of financing, including the financing dialogue and the new programme budget preparation process, offered great potential for improvement in the future, it would not be achieved overnight. There was a limit to what the Secretariat could do in the short period before the next Health Assembly and the financing dialogue meetings, and he therefore asked which changes and amendments to the draft twelfth general programme of work and the proposed programme budget could realistically be made in that time. He commended the Secretariat's approach of basing the proposal for allocating funds to the major offices on the current implementation capacity of those offices, which was both reasonable and realistic.

The programme budget was the Organization's primary steering mechanism for prioritization, programming, financing, accountability and resource mobilization, and should provide Member States with an understanding of WHO's activities to be undertaken during the biennium; on that basis, there was still more work to be done on the proposed programme budget 2014–2015. He considered the current draft programme budget to be a transitional one: it did not yet allocate potential donor funding to specific areas in a satisfactory manner, and it was difficult to see how it could serve as the basis for the financing dialogue in its current form.

He welcomed the change from the current practice whereby the Health Assembly would be asked to adopt the entire programme budget in May 2013 before the allocation of assessed contributions was complete, as the inclusion of the assessed and voluntary contributions would only be useful after the financing dialogue had taken place. He requested a further explanation of the role of the governing bodies, which he understood would be strengthened under the reform process, especially following the financing dialogue. Their role would be particularly important in regard of the allocation of assessed contributions, which were given by Member States, and should be allocated by Member States.

Ms WISEMAN (Canada)¹ emphasized the importance of setting clear priorities and establishing a sound framework for performance evaluation and resource allocation, which were provided by the draft twelfth general programme of work and the proposed programme budget 2014–2015.

She supported many of the priorities laid down in the two documents. There was, however, considerable variation in their scope, and some required further refinement, for instance in the areas of noncommunicable diseases and the social, economic and environmental determinants of health, if WHO were not to face continued challenges in deploying its resources in a focused manner. Consistency between the general programme of work and the targets and indicators that had been agreed by Member States was essential. The links between impact goals and expected outcomes were not always clear; for example, though there was an impact goal to eradicate poliomyelitis, there was no corresponding outcome or indicator. One problematic indicator for her country was "the proportion of countries that have a national health sector strategy that conduct a regular review and evaluation of its implementation." As a federated State, Canada did not have a single national health sector strategy, and such national contexts should be reflected in the documents.

Supporting the new approach to financing the work of WHO including the approval of the budget in its entirety, she said that any new financing model had to provide a mechanism for establishing a realistic budget aligned with identified priorities. Clarity should be provided on how and when assessment of financing, resources and WHO's activities would be undertaken, and it was important to determine the role of the governing bodies in that regard.

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

The clear structure of the current draft of the proposed programme budget was a significant improvement, but she urged the Secretariat to ensure that a fully costed budget was presented in advance of the next Health Assembly.

Mr SEN (Turkey)¹ welcomed the current versions of the draft twelfth general programme of work and the proposed programme budget and the strategic priorities that had been set, as they would provide an appropriate framework for addressing Member States' needs. Certain refinements were still needed, however, particularly in the results chain, indicators, evaluation and performance assessment, timelines, costing of activities and allocation of funds and work across the different levels of the Organization.

The governing bodies must play an active role in the programme budget preparations and the financing dialogue. He supported the proposals to enable Member States to provide further input on the documents before their submission to the Health Assembly.

Ms GROVES (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, commended the work done on the draft twelfth general programme of work and the proposed programme budget. The focus, however, on only four primary noncommunicable diseases and their common risk factors should be widened to include mental, neuromuscular, immunological and developmental disorders, which often did not receive enough attention at the national level precisely because they did not get enough at the global level. The draft twelfth general programme of work would also benefit from a greater focus on patient-centred health care and patient involvement, which was necessary in order to address the political, economic and social contexts that underpinned global public health.

The Alliance looked forward to continued work with WHO on facilitating engagement between patients' organizations, civil society organizations, communities and country authorities to ensure that policies reflected patients' and carers' needs; developing standards, guidelines and indicators; collecting case-studies of best practice; and monitoring effective patient participation and engagement.

Mr EISELE (FDI World Dental Federation), speaking at the invitation of the CHAIRMAN, welcomed the emphasis in the draft twelfth general programme of work on social determinants of health, nutrition, noncommunicable diseases, shared risk factors and the promotion of health throughout the life course. He acknowledged the financial constraints facing the Organization and the difficulty of identifying priorities, but expressed regret at the omission of oral health from the current draft of the general programme of work. In resolution WHA60.17 on oral health, the Health Assembly had acknowledged the public health impact of oral disease and noted that the greatest burden fell on disadvantaged and poor populations. The WHO Global Oral Health Programme had a major impact in many countries, as illustrated at the recent negotiations held under the auspices of UNEP to finalize the Minamata Convention on Mercury, which included provisions for the phase-down in the dental use of mercury amalgam. The Convention explicitly mentioned WHO's recommendations on the importance of prevention and restorative materials in the treatment of caries. Without the inclusion of oral health in the twelfth general programme of work, it was likely that countries would not benefit from WHO's support. He therefore urged WHO to revise the draft general programme of work to include oral health before it was submitted to the next Health Assembly.

Ms FABBRI (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, welcomed the inclusion of the social determinants of health in the strategic priorities, but said that the exercise of priority-setting alone was not sufficient to overcome issues of budget allocation if there was not also a bold discussion on sustainable financing mechanisms. Success would depend on overcoming the distortions arising from

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

earmarked donor funding but, in the current drafts, there was no clear explanation of how the financial gaps could be filled. There was still a risk that key areas of WHO's work would remain underfinanced.

She expressed concern at the absence of details on specific allocations of resources under the six categories listed in the proposed programme budget and also on the proposed allocations from assessed and voluntary contributions. It was a striking change from previous budgets where such allocations had been clearly itemized. She was also worried by the fact that many of the baselines, targets and indicators were yet to be finalized.

She recalled that several Member States had asked for assessed contributions to be increased, an issue extensively discussed by the Programme, Budget and Administration Committee but not mentioned in the two documents. Without a commitment to a real increase in assessed contributions, any proposal for reform would remain ineffective. Member States should insist upon sustainable financing mechanisms to ensure that WHO received adequate untied funding.

The DIRECTOR-GENERAL thanked all speakers for their constructive comments and guidance on refining the draft twelfth general programme of work and the proposed programme budget 2014–2015. She said that she had observed the convergence of the various comments. She also acknowledged the broader remarks on progress made and the changes that were being implemented within WHO, and strongly affirmed the Secretariat's commitment to that process.

Responding to the comments made, she focused her remarks on five areas: the draft twelfth general programme of work; the proposed programme budget 2014–2015; the draft programme budget resolution and related Financial Regulations; the process between the current session of the Executive Board and the next World Health Assembly; and the financing dialogue (regarding logistics and participation).

On the draft twelfth general programme of work, she recalled the criteria that Member States had agreed upon in an intergovernmental process and had asked to be applied in order to identify priorities within the five programmatic categories and one corporate function category. That process had led to the identification of 26 priorities which were, at the request of Member States, then subjected to further analysis and streamlining, resulting in the eight priorities – six programmatic and two on WHO's governance and reform – listed in the current draft. As a result of the comments made at the current session of the Board, she confirmed that the Secretariat would work to refine the document, improving the language and explanations given in some sections, ensuring, for example, that the outcome of the Consultative Expert Working Group on Research and Development: Financing and Coordination was appropriately reflected, and moving the governance and reform priorities into a new, separate chapter.

The proposed programme budget 2014–2015 differed from the Programme budget 2012–2013 because of the desire for increased budget discipline, with a realistic budget based on expected income and expenditure. After tracking WHO's income in recent years, the Secretariat had identified that it ranged between US\$ 3.7 billion and US\$ 3.9 billion per biennium and, as such, the projection in the proposed programme budget was for a stable budget of no more than US\$ 4 billion for the two-year period. Given the current global austerity, that trend was expected to continue for some time. Member States would not be asked to contribute more than their own financial situations would allow, but the intention was to maintain a stable budget for the six-year lifespan of the twelfth general programme of work.

In the light of other comments that had been made, the proposed programme budget would be improved through better articulation of the results chain with the proposed impacts and outcomes described in the general programme of work. It would include additional output indicators that Member States felt were important, for instance in the areas of social determinants of health and noncommunicable diseases, but would not include any that had not been agreed.

The document would be further recast to show outputs at country, regional and headquarters levels, reflecting regional specificities. The Regional Director for the Eastern Mediterranean and the Regional Director for the Western Pacific would be leading the work to review the division of labour and clarity of roles and functions among the three levels of the Organization and would provide input for the adjustments to be made to the programme budget in due course.

The costing of outputs would also be improved in the proposed programme budget, with more information on expenditure patterns and the cost of staff and activities per programme. However, it would not yet be possible to determine optimum costings as, without a benchmark, efficiency savings could not be identified. She would report back to the Board when that information was available.

She acknowledged the concerns raised about allocation of resources, particularly those of the South-East Asia Region, and said that the exercise to be undertaken by the two regional directors should provide useful, evidence-based information on that matter. The budget allocations would be linked to a monitoring and evaluation framework in order to evaluate results and ensure accountability and transparency.

Turning to the proposed programme budget resolution, she said that if Member States had concerns to raise or comments to make on the first draft that had been presented to them, they should provide those to the Secretariat so that the necessary changes could be made.

Regarding the process between the current session of the Board and the Sixty-sixth World Health Assembly, she said that consultations with Member States would continue and all the comments that had been made on the draft twelfth general programme of work and proposed programme budget would be posted online, and the necessary changes would be made to the texts. Member States were requested to submit their comments by 15 February, and the new versions of the two documents would be supplied in as timely a manner as the iterative process of development permitted. Mission briefings and informal discussions would be held so that countries could provide feedback on subsequent drafts of the documents before the submission of the final versions to the Health Assembly.

Moving on to the financing dialogue, she made a presentation to the Board, illustrated by slides, about the meetings proposed for the financing dialogue, which would also deal with logistics and participation. The presentation had been prepared in response to a request by the Programme, Budget and Administration Committee at its second extraordinary meeting. Two meetings were proposed, the first in June or early July 2013 and the second in October or November 2013. The purpose of the first would be to provide information on resource requirements based on the programme budget 2014–2015, assuming that it was adopted by the Sixty-sixth World Health Assembly, on the levels of funding that had already been secured, the programmes or offices to which they would be allocated, and what funding gaps there were and where. A one-day meeting in headquarters was envisaged, which Member States – including representatives of ministries of health, foreign affairs and development, as Member States wished – and current major financial contributors to WHO (such as United Nations organizations and philanthropic foundations) could attend. The Secretariat proposed that that meeting should be chaired by the Chairman or Vice-Chairman of the Programme, Budget and Administration Committee, who would report back to the Executive Board, and that it should take the form of an informal consultation. The expected outcome was a full assessment of the current status of funding for the programme budget 2014–2015 and the resource requirements. It was likely that the first meeting would cost around US\$ 300 000, including travel support for least-developed-country participants.

The purpose of the second proposed meeting would be to hold a structured dialogue with Member States and major contributors in order to identify appropriate ways to fill remaining funding gaps. That meeting, in Geneva possibly in October or November 2013, would last two days and would again be chaired by the Chairman or Vice-Chairman of the Programme, Budget and Administration Committee. It would probably cost slightly more than the first meeting, closer to US\$ 350 000, again including travel support for least-developed-country participants. The expected outcomes would be a comprehensive update on the status of financing of the programme budget 2014–2015; the identification of funding gaps; proposals for action and ways to mobilize resources to reduce those gaps; and the provision of information on the proposed allocation of assessed contributions.

She affirmed her commitment to providing the governing bodies with regular updates on income, expenditure, funding shortfalls and ways to fill those gaps. However, she questioned the value of early reporting: was the May session of the Board in the first year of the cycle too early to be providing an update? Might the May session of the Board in the second year of the biennium be a better point from which to assess the need for reprogramming of funds? She would welcome comments and suggestions from Member States on the proposed meetings.

The CHAIRMAN asked the Secretariat to provide information on the potential for virtual attendance at the financing dialogue.

The meeting rose at 12:40.

EIGHTH MEETING

Thursday, 24 January 2013, at 14:40

Chairman: Dr J. ST. JOHN (Barbados)

1. PROGRAMME AND BUDGET MATTERS: Item 11 of the Agenda (continued)

Implementation of Programme budget 2012–2013: update: Item 11.1 of the Agenda (Documents EB132/25 and EB132/43)

Draft twelfth general programme of work: Item 11.2 of the Agenda (Document EB132/26) (continued)

Proposed programme budget 2014–2015: Item 11.3 of the Agenda (Documents EB132/27 and EB132/INF./4) (continued)

Dr DAULAIRE (United States of America) noted that the Global Fund to Fight AIDS, Tuberculosis and Malaria was holding a Board meeting from 17 to 20 June 2013 in Sri Lanka; he therefore asked that the first meeting of the financing dialogue be moved to the first week in July.

The CHAIRMAN recalled that a question had been raised at the previous meeting as to whether some form of online participation would be possible for Member States that were unable to attend the first meeting.

Dr GRABAUSKAS (Lithuania), speaking on behalf of the European Union and its Member States and supporting the outcomes of the second extraordinary meeting of the Programme, Budget and Administration Committee held in December 2012, noted that the cost of holding a meeting in June was estimated at US\$ 300 000. Could the meeting be held during or immediately after the governing body meetings, particularly as up-to-date financial information would be available during the Health Assembly? He reiterated his proposal that the Director-General should explore ways in which the governing bodies could perform their clear governance role in relation to the outcome of the financing dialogue and the coordinated resource mobilization strategy, and present them for consideration to the Programme, Budget and Administration Committee at its eighteenth meeting in May 2013. He suggested that the mission briefings be held before the Health Assembly, be thematic and include the draft twelfth general programme of work and proposed programme budget, details of the financing dialogue, allocation of assessed contributions, the proposed draft resolution for approval of the entire programme budget, and the proposed amendments to the Financial Regulations and Financial Rules.

Mr KÜMMEL (Germany),¹ agreeing that the financing dialogue meetings were important, noted the cost implications of holding an additional meeting in June 2013 and recalled that the Programme, Budget and Administration Committee, at its extraordinary meeting in December 2012, had decided that financial information on income and funding shortfalls should be provided to the Health Assembly at the time of approval of the programme budget. That meant that an additional

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

meeting would not be necessary. He agreed with the proposal by the member for Lithuania that, if a meeting were to be held, it could take place immediately after the governing body meetings.

The DIRECTOR-GENERAL said that a webcast or podcast could be organized to enable those who were unable to attend the first meeting of the financing dialogue to follow the discussion online and participate by electronic means.

Mission briefings could be organized thematically, but the most important documents would be those on the draft twelfth general programme of work and the proposed programme budget 2014–2015. She also needed Member States' input on the draft resolution and the possible amendments to the Financial Regulations and Financial Rules. The relevant information would be placed on the WHO web site as soon as possible to enable Member States to begin consideration of the issues. She recognized the practical difficulties for Members with small missions to attend separate briefings on the themes suggested. Rather than any discussion of the use of assessed contributions, the briefings would serve the purpose of information sharing based on the pattern of expenditure. The use of assessed contributions and shortfalls in funding could be the subjects for the second financing meeting.

She confirmed that updated financial information would be made available during the Sixty-sixth World Health Assembly in May, but it would have to be presented orally, as a written document could only contain data up to March 2013.

Turning to the timing of the first meeting of the financing dialogue, if it was necessary to hold that meeting, she recalled the provisional timings for the next governing body meetings: the Programme, Budget and Administration Committee would meet on 16 and 17 May 2013, the Sixty-sixth World Health Assembly from 20 to 28 May and the 133rd session of the Executive Board on 29 and 30 May. She therefore suggested that an informal first meeting for information-sharing purposes could take place on Friday 31 May 2013. It was important that the financing dialogue meeting be held separately from the governing body meetings, as different parts of government (such as ministers of development or foreign affairs), other organizations in the United Nations system, partners and donors would be invited to attend.

The CHAIRMAN said that the question appeared to be whether the first meeting of the financing dialogue was to be held on Friday, 31 May, or in June or July.

Mr LUTNÆS (Norway), recalling that the Programme, Budget and Administration Committee had discussed the subject during its second extraordinary meeting, said that he favoured a longer interval between the Health Assembly and the first meeting of the financing dialogue, particularly if there was an option to participate without travelling to Geneva.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland)¹ asked whether there was agreement on the need to hold the first meeting.

The CHAIRMAN invited comments on whether to hold the proposed first meeting of the financing dialogue.

Dr DAULAIRE (United States of America) considered that, as the purpose of the first meeting was to share information, it could be held electronically on a defined date, saving up to US\$ 300 000.

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

Professor HALTON (Australia), supporting the comment made by the member for the United States of America, said that the first meeting was designed to facilitate understanding and subsequent discussion at country level, and could therefore be held as a webinar, rather than a podcast, so as to ensure an equal information base for the second meeting and enable countries to consider priorities and explore financing options.

Mr CHATELUS (France)¹ agreed with the Director-General's suggestion to provide oral updates to financial information, which would meet the objective of ensuring that correct information was available at the time of decision-making.

Regarding the financing dialogue, as the substantive work would take place at the second meeting in the autumn of 2013, virtual information sharing would be sufficient for the first phase, particularly taking into account the provision of information during the governing body meetings in May 2013 and the availability of information on the WHO web site after those meetings.

Dr HORI (Japan)¹ agreed with the comments made by the members for the United States of America and Australia; the purpose of the first meeting could be served through document sharing on the WHO web site and mission briefings.

Dr VALLEJO (Ecuador) said that, although the financing dialogue was essential to the reform process, the first phase of information or document sharing could be undertaken in the context of a virtual meeting in preparation for a later substantive meeting.

The DIRECTOR-GENERAL agreed that information sharing was essential, and understood that members wanted updates on financial information during the Health Assembly as part of the presentation on the proposed programme budget; that information would subsequently be posted on the WHO web site. Members had also requested the virtual sharing of any further information updates before a substantive meeting in October or November 2013, the date of which would depend on venue availability and other logistical considerations. She drew attention to the fact that any information posted on the WHO web site would be available not only to Member States but to other major donors so that they would be able to identify funding gaps and indicate how they wished to allocate their funding.

Mr LUTNÆS (Norway) asked for clarification: would the information-sharing meeting be a virtual one or would there be a physical meeting with an option to participate electronically? He favoured the latter option, as it would provide an opportunity for donor funding preferences to be expressed.

The DIRECTOR-GENERAL said that most members had expressed a preference for a virtual meeting and expressed the hope that the member for Norway would accept that proposal.

Dr THABET NASHER (Yemen), noting that one reason for the first meeting was formally to launch the financing dialogue, said that there was no value in inviting new donors to a virtual meeting. He agreed with the member for Norway that a first meeting would be a good opportunity for donors to indicate the quantity and allocation of their contribution to WHO.

The DIRECTOR-GENERAL pointed out that the holding of a formal meeting would necessarily have cost implications.

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

Professor NICKNAM (Islamic Republic of Iran) proposed that, in addition to a virtual meeting for information sharing, a mission briefing could be held in Geneva to raise awareness, discuss issues, clarify areas of ambiguity, and secure the engagement of ministers for foreign affairs in the second meeting.

Dr THABET NASHER (Yemen) reiterated the importance of formally launching the financing dialogue, whether by means of a meeting of representatives of permanent missions in Geneva or a formal invitation issued by the Director-General, irrespective of the decision on whether to hold a meeting in June.

Mr CHATELUS (France)¹ said that the oral presentation of information during the Health Assembly's discussions on the proposed programme budget, as suggested by the Director-General, would generate face-to-face interaction in the context of a physical meeting.

As far as information sharing was concerned, he proposed that a side event in the form of a mission briefing should be held during the Health Assembly.

Ms LANTERI (Monaco),¹ endorsing the proposal made by the representative of France, said that the first stage of the financing dialogue could be conducted informally and be followed by a formal meeting in October 2013. A mission briefing could be organized during the Health Assembly, as a side event, or immediately afterwards, supplemented by the bilateral meetings that traditionally took place during the first half of the year.

Mr LUTNÆS (Norway) agreed that the October meeting would constitute the formal phase of the financing dialogue, and supported the proposal by the member for Iran to complement a virtual meeting with a mission briefing for those who wanted to meet face to face.

Dr THABET NASHER (Yemen) stressed his view that the financing dialogue should be launched by means of an invitation issued by the Director-General during the Health Assembly; that should be followed by virtual information sharing before the October or November meeting.

Mr SEN (Turkey)¹ said that the first meeting of the financing dialogue would not be necessary as the information on resource availability that was to be shared at that meeting would have already been provided to the Health Assembly to guide discussion of the proposed programme budget. He agreed that the second meeting would be more formal, that it would need to come to a decision on the next steps, and would necessarily involve the governing bodies.

Mr HAZIM (Morocco) said that participants had spent a great deal of time discussing whether to hold a real or virtual meeting and had forgotten that the objective of the first meeting of the financing dialogue was not only to share information but to facilitate a discussion about stakeholders' roles in the dialogue, with a view to seeking funding from Member States or other donors. The best time for a meeting would be during the Sixty-sixth World Health Assembly, which would be attended by ministers, decision-makers and other stakeholders.

Dr BAYE LUKONG (Cameroon) asked whether non-Member State donors would be invited to the launch of the financing dialogue.

Mr KÜMMEL (Germany)¹ said that the reason for not holding a meeting separate from the Health Assembly was to avoid significant expenditure just for information sharing. The information in question was to be provided by WHO to donors, which could be done virtually. However, he agreed

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

with the member for Norway that an exchange of views with and between donors would be a useful exercise. Such an exchange could take place within the parameters of the Health Assembly as all relevant stakeholders would be present in Geneva. Not to use the Health Assembly for that purpose would be a missed opportunity.

Dr THABET NASHER (Yemen) said that the financing dialogue was an important part of the reform process, and the first meeting would be a milestone. He therefore proposed including the dialogue on the provisional agenda of the Health Assembly and issuing an invitation to countries and donors to a launch.

The DIRECTOR-GENERAL reminded the Board that the Health Assembly had yet to approve the financing dialogue, and any proposal to launch that dialogue during the Health Assembly would depend on obtaining such approval.

Responding to the comments made by the member for Cameroon, she said that when the Health Assembly approved the programme budget or the allocation of assessed contributions, funds were never available at the time of those decisions. Experience indicated that only 30% to 35% of the programme budget became available at the beginning of the financial year, which was why funds were carried forward and a prefinancing mechanism was used.

Seeking a way forward, and subject to agreement by the Health Assembly, she suggested scheduling discussion on the draft general programme of work and proposed programme budget early in the Health Assembly in May 2013 so that the financing dialogue could be launched shortly thereafter. She noted that usually most ministers attended only the first few days of the Health Assembly. If the Health Assembly approved the establishment of the process, she would invite Member States, senior regional officials and representatives of existing donors and other United Nations bodies to its launch. Financial information could then be shared on the WHO web site and through a mission briefing in Geneva in June or July, without incurring additional costs. A meeting for face-to-face dialogue would be held in October or November. Regular financial information updates would be provided on the WHO web site, and at future meetings of the Programme, Budget and Administration Committee and Board sessions until May 2015, at which point consideration could be given to reprogramming, cutting priorities or celebrating the full financing of the programme budget.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) agreed with the line of action suggested by the Director-General and with her observation that the financing dialogue had to be approved by the Health Assembly before it could be implemented.

Dr THABET NASHER (Yemen), taking it that the Health Assembly would approve the financing dialogue, said that one option would be to organize a virtual launch, during which the Director-General could make a statement to Member States, development partners and donors, encouraging them to engage in the dialogue; that could be followed, as suggested by the member for Iran, by a mission briefing.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the proposal to the Health Assembly for the initiation of the financing dialogue should clearly specify who the participants in the dialogue would be and that its main purpose was to seek new donors. However, the search for potential donors should not conflict with the Organization's governance system which remained under the exclusive control of Member States.

The DIRECTOR-GENERAL, in response, said that she operated under precise instructions, including guidance received from the Programme, Budget and Administration Committee at its second extraordinary meeting: only Member States and traditional donors could be invited to participate in the financing dialogue. The traditional donors included bodies such as the Rockefeller Foundation and the Bill & Melinda Gates Foundation, which were contributing to poliomyelitis eradication and immunization, and other United Nations agencies including UNICEF and UNFPA. However, there would be no further opening up to private-sector entities. She reminded the Board that contributors to WHO numbered in the thousands, as many made small contributions to basic operational costs.

Mrs ESCOREL DE MORAES (Brazil)¹ expressed concern at the Director-General's suggestion – which she regarded as part of a growing trend – that the first meeting of the financing dialogue should be held during the Health Assembly. It was fundamentally important that that governing body, which remained the sole universal decision-making forum of the Organization, should give its approval before any such suggestion could be implemented. She agreed that the proposal by the representative of Germany to hold a meeting immediately after the Health Assembly was practical, but it could set a dangerous procedural precedent. Although the Health Assembly often approved the recommendations made by the Executive Board or the Programme, Budget and Administration Committee, which demonstrated that those bodies were doing good work, such approval could not be taken for granted.

The CHAIRMAN recalled that the Director-General had repeatedly affirmed the need for prior approval by the Health Assembly.

The DIRECTOR-GENERAL reiterated that the Programme, Budget and Administration Committee or the Executive Board could make proposals but the ultimate authority rested with the Health Assembly. She had merely suggested submitting a proposal to the Health Assembly in line with the suggestions and comments made by participants during the meeting.

Dr JESSE (Estonia),¹ recognizing the need for endorsement by the Health Assembly before the first meeting of the financing dialogue could be held, asked whether the Director-General had the authority to convene an information meeting as a side event during the Health Assembly, with the participation of Member States and major non-Member State donors, to provide an introduction to, or overview of, the programme budget, on the understanding that such a meeting could not take place unless the programme budget was approved by the Health Assembly.

Mrs ESCOREL DE MORAES (Brazil)¹ said that she did not wish to be misunderstood. She was concerned that a dangerous precedent would be set if the first meeting of the financing dialogue was held immediately after the Health Assembly, which she had understood to be the proposal made by the representative of Germany.

The DIRECTOR-GENERAL said that it was a matter of good governance that no other body could or should pre-empt the decisions of the Health Assembly. However, she would try to meet the expectations of the Board by organizing a launch for the financing dialogue at an appropriate moment, subject to the approval of the Health Assembly. To clarify, she repeated that the Board could recommend that the Health Assembly should approve the establishment of a financing dialogue. If that approval were given, she would facilitate the organization of a virtual meeting and a mission briefing, to be followed by a formal meeting in Geneva in October 2013.

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

2. FINANCIAL MATTERS: Item 12 of the Agenda

Amendments to the Financial Regulations and the Financial Rules: Item 12.2 of the Agenda (Documents EB132/43, EB132/44 and EB132/INF./4)

Dr THABET NASHER (Yemen), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, recalled the Committee's deliberations on the item (document EB132/43, paragraphs 34–42). Having discussed the Secretariat's report on amendments to the Financial Regulations and Financial Rules (document EB132/44) and a mock-up of a draft programme budget resolution (document EB132/INF./4), the Committee had recommended that the Executive Board consider the comments and concerns reflected in its deliberations.

Dr de Assunção Saide took the Chair.

Ms BLACKWOOD (United States of America), supporting the outcome of the second extraordinary meeting of the Programme, Budget and Administration Committee held in December 2012, said that approval of the entire programme budget was an important part of the reform process. The new approach of integrating assessed and expected voluntary contributions was the key to providing a full picture of the work to be completed during the biennium. She supported the proposed amendments to the Financial Regulations and Financial Rules, which addressed that issue and had been clarified during the meeting of the Committee. She welcomed the mock-up of the draft resolution on the approval of the proposed programme budget 2014–2015, but said that further clarification should be provided, by May 2013, of the roles and responsibilities of the governing bodies in relation to the financing dialogue. The Director-General should be given greater flexibility with regard to the transfer of resources, even though most voluntary contributions had specific conditions attached to them.

Professor HALTON (Australia) said that the discussions of the Programme, Budget and Administration Committee on the item under consideration had been very useful and the new approach to drafting had significantly improved the relevant document, in some cases by virtue of felicitous wording rather than intent. She acknowledged the issues raised by the member for the United States of America, but expressed support for the change made in that particular area of the reform process. It was clear, however, that much remained to be done in other areas.

Mr CHATELUS (France)¹ commended the quality of the discussions held in the Programme, Budget and Administration Committee. Noting that the existing Financial Regulations and Financial Rules were out of step with the financing model and the situation of imbalance in the Organization, he said that the discussion of changes should concentrate on updating them and on specific issues relating to approval of the total budget. He emphasized the regulatory and legal requirement that any spending authority or decision on resource allocation should be matched to the availability of resources. Further discussion should be undertaken on the allocation of resources and the practice of carrying forward funds, which was a difficult but important issue and one that required clarification.

The mock-up of a draft programme budget resolution gave a clear picture of the changes envisaged, although there were some problems of terminology, including in particular the use of the phrase "allocate the total effective budget". The wording relating to the approval of the programme budget should be brought into line with that used in other organizations in the United Nations system and at the regional level, and the same applied to the provision on assessed contributions.

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

The reference to the financing dialogue should fully reflect the outcomes of the Board's discussion, with particular regard to the timing of allocations from assessed contributions. Overall, it was a good document, and required only terminological changes.

Mr JEFFREYS (Comptroller) said that he had taken note of the comments made and would revise accordingly the document to be submitted to the Programme, Budget and Administration Committee in May 2013. He invited Member States to make additional written comments if they so wished, including proposed amendments, which would also be taken into account.

The CHAIRMAN took it that the Board agreed with the proposal that the Secretariat should submit a revised version of the two draft resolutions, after the appropriate consultations with Member States, to the next meeting of the Programme, Budget and Administration Committee, with final decisions to be taken by the Health Assembly.

It was so agreed.

3. PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 7 of the Agenda (continued)

Monitoring the achievement of the health-related Millennium Development Goals (continued)

- **Health in the post-2015 development agenda:** Item 7.1 of the Agenda (Document EB132/12) (continued from the fourth meeting, section 3)

Dr BOERMA (Health Statistics and Information Systems), responding to a request from several Member States, gave an illustrated presentation on the consultative process that would lead to formulation of the post-2015 development goals.

The CHAIRMAN said that the presentation would be made available on the WHO SharePoint site.

Dr SHI Guang (China) endorsed the analysis of the post-2015 development agenda. Discussion of the topic in China within governmental, nongovernmental and academic circles had led to the following conclusions. It would be essential to maintain continuity between the health-related Millennium Development Goals and the health goals in the post-2015 agenda. The new goals should incorporate indicators on chronic noncommunicable diseases, taking into account the new public health landscape created by social, economic, demographic and epidemiological changes. The post-2015 health goals should also emphasize the centrality of health in sustainable development and its importance as an indicator of economic, social and environmental development. The goal of universal health coverage could include the concerns of many countries although, by the same token, it risked losing focus unless it was linked to quantifiable objectives that were readily understood and that had been agreed by consensus. In developing the goals, attention should be paid to the disparities between countries' economic, social and health systems; he encouraged WHO to study that area further. It would be necessary to achieve international consensus on how the social determinants of health shaped the health agenda and to include the research findings in the new goals.

WHO should continue to consult with Member States and other stakeholders on the subject of health in the context of the post-2015 agenda; China would continue to take an active part in the consultations.

Dr St. John resumed the Chair.

Dr AMMAR (Lebanon) said that significant progress had been made in nearly all countries in meeting the Millennium Development Goals although the achievements were difficult to sustain in countries enduring complex emergencies. In some countries, armed conflict was hindering the implementation of health programmes, while in others civil unrest had led to a lack of commitment on the part of the authorities and, consequently, to inadequate financial allocations. It was essential that countries with weakened health systems should consolidate existing achievements before undertaking work on new goals.

The resolution on global health and foreign policy adopted by the United Nations General Assembly in December 2012¹ demonstrated the commitment of the international community to achieving universal health coverage under the post-2015 development agenda. The concept of universal health coverage implied ensuring accessibility to promotional, preventive and curative health services and the avoidance of financial risks that would push people below the poverty line because of their spending on health. Consequently, universal health coverage influenced both health and poverty reduction and thus contributed to equity and sustainable development. Noncommunicable diseases, also a global priority, could be included within the accessibility dimension of universal health coverage. Thus, universal health coverage could be considered as an overarching goal in the post-2015 development agenda. WHO should also push for health to be taken into account in measuring economic progress, with healthy life expectancy supplementing gross domestic product to form a composite indicator. However, more simple and direct measures of health systems' achievements, such as out-of-pocket expenditure, were needed.

Dr REYNDERS (Belgium), urging continued efforts and progress towards achieving the current health-related Millennium Development Goals, said that lessons should be drawn from that work and from implementing the health aspects in the other Goals. Health was a fundamental human right and it was essential that future goals were based on equity and the social, economic and environmental determinants of health. Universal health coverage could be a potential health goal for the post-2015 development agenda. Above all, both the Secretariat and Member States should be well prepared to make a convincing case on how health goals should be framed in the different consultation processes that were under way. He requested the Director-General to continue providing regular updates on the ongoing processes to allow the broadest input from all Member States, including civil society, as well as on the progress made on including health in the post-2015 goals. He further requested that a report on the outcome of the high-level meeting to be held in Botswana in March 2013 should be provided to the Sixty-sixth World Health Assembly.

Dr DAULAIRE (United States of America) said that the Millennium Development Goals represented a growing global commitment to ending poverty and extending opportunity to all. His Government was pleased to note that momentum had been growing for the adoption of universal health coverage as an umbrella goal – at the Sixty-fourth World Health Assembly,² the United Nations Conference on Sustainable Development (Rio+20), and the United Nations General Assembly. Universal health coverage served as a powerful, unifying element in the discussion of the post-2015 Millennium Development Goal framework and it was at the heart of the United States reform agenda which had become known as “Obamacare”.

However, the expansion of health coverage was not an end in itself, but a means towards improved health outcomes. The new goals must take forward work done under the existing health framework, building on achievements in reducing maternal, newborn and child deaths as well as deaths from HIV, malaria and other infectious diseases. Consideration should be given to including

¹ United Nations General Assembly resolution 67/81.

² See resolution WHA64.9 entitled “Sustainable health financing structures and universal coverage”.

noncommunicable diseases in the new health architecture as they constituted the fastest growing disease burden. A recent report indicated that the global economic burden of noncommunicable diseases would be more than US\$ 30 trillion over the next 20 years, hampering economic growth and pushing millions of people into poverty.¹

Professor NICKNAM (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that, although significant progress had been made in his Region, countries throughout the world would face challenges in achieving Millennium Development Goals 4 and 5 by 2015. Countries that were hampered by complex emergencies, civil unrest, inadequate political commitment and insufficient resources and capacity required technical and financial resources in order to scale up their efforts. He highlighted the action taken by WHO in partnership with UNICEF and UNFPA to accelerate work on Millennium Development Goals 4 and 5 in the Eastern Mediterranean Region in 2013, and called on Member States, donors and development agencies to support both that initiative and similar projects in other regions.

He underlined the need for both sustained action on the current health-related Millennium Development Goals beyond 2015 and the inclusion of that issue in the discussions on the post-2015 agenda. Countries most in need were lagging behind in progress towards the Millennium Development Goals. Any slippage in international focus, encouragement and support would have a disastrous effect on the targeted vulnerable groups. Partners should be made aware of the urgent need to assist those countries to finish the good work on the Millennium Development Goals while moving ahead with the sustainable development goals.

It was essential that discussion of the future goals should include the significant impact of noncommunicable diseases on socioeconomic development and poverty eradication.

Ms STIRØ (Norway), speaking on behalf of Denmark, Finland, Iceland, the Netherlands, Norway and Sweden, said that WHO had the opportunity to frame a post-2015 development agenda that was global and that built on the Millennium Development Goals. There should be a single set of goals that would bring together the objectives of poverty eradication and sustainable development. In planning for the future agenda, it would be important to build on evidence, on the lessons learnt from the Millennium Development Goals and the outcomes of the Rio+20 Conference. Stakeholders recognized the value of the Millennium Development Goals, which lay in their clarity, concision and measurability. The health-related Millennium Development Goals that had not been achieved should continue to be addressed after 2015. Improving the health of all was vital to the achievement of the social, economic and environmental dimensions of sustainable development, while improved health was also an outcome of investments in other sectors. Resilient health systems that were capable of delivering quality health services would be decisive in tackling current and future health challenges. The post-2015 development agenda should include equity; poverty reduction; human rights; a strong focus on the rights of women and girls; gender equality and women's empowerment; and sexual and reproductive rights for all. That included the rights of women and men, boys and girls to decide freely over their own bodies. Young men and women, especially adolescents, must be at the centre of discussions since an adolescent who entered adulthood in a healthy way was more likely to live a healthy and productive life and make choices conducive to realizing his or her potential.

It would be important to work together to create an inclusive global partnership. She encouraged all development partners, including civil society and the private sector, to take an active part in the important work that lay ahead.

¹ Bloom DE et al. *The global economic burden of noncommunicable disease: a report by the World Economic Forum and the Harvard School of Public Health*. Geneva, World Economic Forum, 2011.

Ms PENEVEYRE (Switzerland) said that considerable progress had been made towards achieving the Millennium Development Goals, although much remained to be done up to and beyond 2015. Health should be central to the post-2015 development agenda and the new framework should reflect the uncompleted work in relation to the Millennium Development Goals as well as the significant changes in the health architecture. As the report pointed out, a piecemeal approach could not cover all the dimensions of health and was unsustainable. The value of a collective approach had been illustrated by the progress made in combating HIV/AIDS. The new framework should emphasize equity and the needs and rights of individuals. The concept of universal health coverage should be discussed in the wider context of the streams of work that would be part of the post-2015 agenda in order to understand the cross-cutting nature of the themes in relation to health. The new goals should be based on the results of the Millennium Development Goals; be universally applicable; contain deadlines; and be clear and quantifiable.

She looked forward to the report synthesizing lessons learnt and recommendations on how health should be reflected in the post-2015 development agenda, which would be submitted to the High-level Panel of Eminent Persons and the Secretary-General after the final high-level meeting in Botswana in March 2013.

Professor HALTON (Australia), while recognizing the significant challenges inherent in the Millennium Development Goals and welcoming the significant – and pleasantly surprising – progress made, emphasized that sight should not be lost of the targets that had yet to be reached, and some were very close, when formulating the new goals. WHO should play a central role in defining the post-2015 agenda, which should include health as a key theme. She acknowledged the importance of the issues that had arisen thus far from the consultations, including noncommunicable diseases, and the need for strong and resilient health systems and equity. The focus on development and poverty reduction should remain. Lessons should be learnt from the current review and the convening power of the goals should be emphasized. The new goals must be measurable, reflect the theme of equity, be easy to communicate, and, most importantly, be inclusive and be developed with input from all players. She had sympathy with the view that the number of goals should be restricted and that health was only part of the agenda. On the other hand, it was clear that universal health coverage had great potential, given its broad reach and convening power, and she was interested in hearing the discussion of the subject.

Dr ÁLVAREZ LUCAS (Mexico) agreed that the next generation of development goals should be based on shared responsibilities in order to confront global problems. Nevertheless, work towards common targets should not obscure the tasks that remain to be accomplished in individual countries. The adoption of universal health coverage as an overall goal in the post-2015 development agenda would meet both of those considerations; in addition, it would enable countries to redouble their efforts to reach any unachieved Millennium Development Goals and would represent the most important step forward in history for the benefit of human health.

Dr VALLEJO (Ecuador), speaking on behalf of the member States of the Union of South American Nations, said that the definition of the post-2015 development agenda would have a substantial impact on the health agenda and WHO should ensure that the widest possible consultations were undertaken in developing the health-related goals. It was essential that the post-2015 goals should incorporate the outcomes of the World Conference on the Social Determinants of Health and of the United Nations Conference on Sustainable Development (Rio+20) and that they should be reflected in national strategies and policies. WHO should promote the inclusion of health in the post-2015 development agenda, emphasizing the link between health and sustainable development.

Although universal coverage was an important concept that could encompass many health priorities, the post-2015 goals should not be limited to health care but should take into account the wider perspective of the social determinants of health and the link between health and development.

Dr AZODOH (Nigeria) welcomed WHO's engagement in the process of preparing the post-2015 development agenda and the assurance that the health-related Millennium Development Goals that had not yet been achieved would be prioritized within that agenda. The health-related Goals had had the effect of focusing attention and resources, and the lessons learnt from them should be incorporated in the post-2015 agenda. She sought confirmation that all health ministries would be fully involved in the forthcoming consultations and that the new goals would not have the effect of further fragmenting achievement of the existing Millennium Development Goals at the country level. The central role of WHO in the process, and hence of the health ministries, would ensure shared responsibility for the outcomes adopted and demonstrate that the principle of equity had been put into practice.

Mr HAZIM (Morocco) agreed with the proposals on health-related goals identified in the consultations thus far, but stressed the issue of health systems financing and the path to universal coverage, which had been highlighted in the debate on *The world health report 2010*.¹ Health-related costs were still high in many countries and expenditure on chronic illness could push households into poverty or destitution. The goal of reducing health costs to a reasonable level could promote universal commitment to a mechanism for health systems financing, especially for the poorest, together with health system strengthening aimed at addressing inequity in health. He proposed the adoption of an overarching goal of universal health coverage to further those aims.

Dr LOUME (Senegal), speaking on behalf of the Member States of the African Region and recalling the statement made by his delegation during a previous meeting,² said that participants in a regional workshop to articulate Africa's position on the post-2015 development agenda (Accra, November 2011) had supported the idea of developing new goals that would reflect current and emerging problems. However, those Millennium Development Goals that had not yet been achieved should also be maintained in order to protect the progress made to date. Emerging problems should be considered against the background of equal access to health services. The proposal contained in the report with respect to the adoption of the goal of universal health coverage was an appropriate way to address inequities in health.

Dr ISHIKAWA (Japan)¹ commended the contribution made by health workers and community volunteers to the remarkable progress that had been made towards achieving the health-related Millennium Development Goals in resource-limited settings. She joined others in emphasizing the importance of continuing to work towards those Goals. She supported WHO's efforts to place health at the centre of the post-2015 development agenda as successful development would be impossible without health. The issue of health was often invisible or overlooked and health professionals were responsible for communicating its importance. She also supported the proposal to include universal health coverage as an overarching goal in the post-2015 agenda.

Mr TOBAR (Argentina)³ said that it would be important to continue working towards the achievement of the health-related Millennium Development Goals and especially those concerned with reducing maternal and child mortality. Health was affected by many social determinants and it would be appropriate to develop a goal that encouraged coordination between professionals in each area, thereby improving efficiency and enhancing progress. Universal coverage was a concept that could bring together related health goals but it should encompass not only health systems but also the

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

² See the summary record of the fourth meeting.

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

determinants identified at the World Conference on the Social Determinants of Health and at the United Nations Conference on Sustainable Development (Rio+20).

The Secretariat should ensure the greatest possible involvement of all Member States in the consultation process, with the participation of WHO regional offices, the Union of South American Nations, the Caribbean Community and other regional groups.

Mr ROSALES LOZADA (Bolivia)¹ shared the view that the Millennium Development Goals had helped to focus the attention of the international community on action to achieve health-related targets. In looking beyond 2015, it was time to consolidate efforts and to find substantive and sustainable solutions to global health problems and their principal causes such as poverty, underdevelopment and health inequity. The post-2015 agenda would require better indicators within the social determinants of health that would include education, employment and the environment, as well as effective services for the prevention and treatment of health problems. The promotion of health equity was vital in order to improve the quality of life and well-being of all and would in turn contribute to peace and security. The social determinants of health should be one of the main elements in the post-2015 agenda.

Ms LANTERI (Monaco)¹ agreed that health was both an indicator of, and a precondition for, sustainable development. Health should be central to the post-2015 development agenda. Monaco supported the concept of universal health coverage and had been a sponsor of the United Nations General Assembly resolution on global health and foreign policy. Indicators and targets that reflected the many health concerns raised by Member States could be encompassed within universal health coverage as an overarching health goal. Those concerns included continued progress in relation to the current Millennium Development Goals, health equity, human rights, noncommunicable diseases and social, economic and environmental determinants. She requested that the outcomes of the March 2013 meeting in Botswana be conveyed to all Member States.

Mr PELLET (France)¹ said that the place of health in the post-2015 development agenda would be the subject of widespread consultations in France. Despite the progress made, it was imperative that work should continue on the health-related Millennium Development Goals and related issues such as access to safer drinking-water, the eradication of hunger and gender equality. However, the post-2015 goals should also include new topics such as climate change and other environmental challenges, the prevention of noncommunicable diseases, and the increased risks of pandemics in the context of globalization. Those health challenges had major economic impacts and required a comprehensive approach that could address both new problems and cross-cutting themes such as the social and environment determinants of health as well as health system strengthening. He therefore associated himself with the many speakers who had identified universal health coverage as the goal that was most likely to contribute to poverty reduction, the promotion of equity, sustainable development and respect for human rights.

Universal health coverage should provide universal access to quality health services while protecting users from being pushed into poverty. It would provide access to health services for all and encompass the fight against pandemics and noncommunicable diseases as well as improving maternal and child health. Furthermore, universal health coverage would contribute to health system strengthening by promoting efficiency, sustainable financing and quality services. It was also a theme that could mobilize universal support, as was illustrated by the recent adoption by the United Nations General Assembly of resolution 67/81 on global health and foreign policy. He fully supported the proposal to adopt universal health coverage as an overarching goal.

Health gains could also be made through the use of health indicators to measure progress in other sectors on the path to sustainable development. It would also be essential to establish a separate health agenda within the post-2015 landscape that would address current and emerging health challenges, a process in which WHO would play a vital role in ensuring an effective flow of information.

Dr PHUSIT PRAKONGSAI (Thailand)¹ agreed with the observation that health equity must be a key feature of sustainable development and poverty reduction. Health was central to development and had a legitimate place within the post-2015 development agenda. Sustainable development should be the foundation for the new goals, and health indicators should be used to measure progress in other areas. Work on the health-related Millennium Development Goals should also continue in the post-2015 era. The United Nations General Assembly resolution on global health and foreign policy had placed universal health coverage at the heart of the new agenda. Universal health coverage implied universal access to essential health care and strong and efficient health systems that could provide a broad range of good-quality services that would enable people to live productive lives. Financial risk protection would also prevent people from being pushed into poverty. Universal health coverage was an essential component of sustainable development and poverty reduction and it would therefore be appropriate to make it a central goal and target in the post-2015 agenda.

Mr SEN (Turkey)¹ recognized that the health-related Millennium Development Goals had enabled countries to improve the health status of their populations although the Goals would not be achieved by all Member States by 2015. Countries should continue to receive support in achieving the health-related Goals and the unattained targets included in the post-2015 agenda. Since it would not be possible to have more than one health goal in the new agenda, it would be important to find a goal that would encompass existing and new challenges and to do so through extensive consultation between the Secretariat and Member States. He supported the proposal to adopt the goal of universal health coverage, provided that it was accompanied by a clear and comprehensive definition and an appropriate set of indicators.

Dr EL OAKLEY (Libya)¹ supported the targets set out in the Secretariat's presentation. Universal health access had a narrow horizon and was open to over-simplistic interpretation. Quoting from *The world health report 2010*, he drew attention to the three fundamental, interrelated problems that restricted countries' moving closer to universal coverage: availability of resources; excessive reliance on direct payments at the time people needed care; and inefficient and inequitable use of resources. Moreover, universal coverage did not guarantee access to high-quality medicine or health care and it did not cover issues such as clinical research, the International Health Regulations (2005) and health services during national and international crises. By contrast, a robust health system would address most if not all of those shortcomings. Universal access to a broken health system would not be an ideal target for the post-2015 era. Health system strengthening, including access to high-standard health care, would be preferable as an overarching goal.

Mr DOETINCHEM (Germany)¹ supported the statement made by the member for Belgium.

Dr CHU Chae-Shin (Republic of Korea)¹ agreed that health should be an essential part of the post-2015 development goals. Heavy investment in health and education had been the secret of his country's rapid economic growth. Relevant and realistic health goals should be carefully selected and accompanied with persuasive narratives for individual State donors and international economic institutions.

It would not be advisable to replace the present three health-related Goals because not all targets had yet been reached and further action might be needed after 2015 in order to improve outcomes. However, new health goals must be developed on the basis of fresh thinking; they could include universal health coverage, healthy life expectancy and water-related goals. Noncommunicable diseases were also important because they were a strategic priority and posed a threat in both developing and developed countries.

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

WHO should continue to work with international economic institutions and strengthen the role of global health governance since that would greatly support Member States in their implementation of the goals. WTO was another important partner, given the overlap between health and trade.

Mr KLEIMAN (Brazil)¹ said that the central role of health in the post-2015 development agenda was of international significance. Recent international conferences had underlined that action on the social and environmental determinants of health was essential to the achievement of inclusive, equitable, economically productive and healthy societies. Health was a fundamental right, which it was the duty of the State to provide. Health was part of a wide-ranging process that included the promotion of health and well-being, and for that reason it should be viewed within the context of universal health coverage. Universal health systems should ensure equitable, integrated and quality services and recognize the links with the social, economic and environmental determinants of health. Universal health coverage also required clear goals and a recognition of the asymmetries between systems in different countries. In developing the new goals, the current health-related Goals should not be overlooked and work on those that had not yet been achieved should continue under the post-2015 agenda, especially in relation to reducing maternal and infant mortality. Increased life expectancy could also be a tangible post-2015 goal.

Ms WEBER (Luxembourg)¹ said that the inclusion of health in the next generation of global development goals was a priority; she endorsed the commitment of the Director-General to achieve that aim. It was essential that progress towards achievement of the health-related Millennium Development Goals should be sustained and that there should be maximum coherence between them and the new sustainable development goals. The Secretariat and Member States would play a crucial role in maintaining national awareness-raising to ensure continuity of the political and financial commitment.

She endorsed the concept of universal health coverage as a priority and as an integral component of the social pillar of sustainable development, but it would be useful to provide a definition that would assist all stakeholders to work within a common framework on the basis of clear and measurable indicators. The post-2015 development agenda would also need a cross-cutting approach in order to achieve the ultimate goal of poverty reduction.

Ms BERMUDEZ ARCINIEGAS (Colombia)¹ said that it was essential that work should continue on the Millennium Development Goals that had yet to be reached. The health agenda in the post-2015 goals would be most effectively realized through the adoption of social determinants of health since the capacities of countries and institutions would be strengthened by taking into account the economic, social and environmental factors that influenced the health of the individual and the impact that health could have in improving social, economic and environmental well-being. An approach that included the social determinants of health would assist in the introduction of systematic, multisectoral and interrelated proposals that would be necessary in order to tackle post-2015 challenges.

Mr BERTONI (Italy)¹ echoed the request by the representative of Monaco for the organization of a briefing before the Sixty-sixth World Health Assembly on the outcomes of the meeting to be held in Botswana. He, too, wished to underline the link between the item under consideration and the United Nations General Assembly resolution on global health and foreign policy. Health should retain a central role in the post-2015 agenda and he agreed with previous speakers that work should continue on the so-called “unfinished business”, namely the full achievement of existing health-related Millennium Development Goals. The post-2015 goals should take into account human rights and gender equity. Health and sustainable development were closely connected and Italy attached great importance to the place of health in all policies and to the interrelationship between health and social,

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

economic and environmental considerations, given that health policy contributed to poverty reduction. For those reasons, Italy supported the adoption of universal health coverage as an overarching goal, although it would need to be better defined and to include clear subgoals or indicators that were clearly understandable and easy to communicate. There was also a need to strengthen national health systems in order to provide quality health care.

The meeting rose at 17:30.

NINTH MEETING

Thursday, 24 January 2013, at 18:30

Chairman: Dr J. ST. JOHN (Barbados)

later: Dr M.O. DE ASSUNÇÃO SAÍDE (Mozambique)

later: Dr J. ST. JOHN (Barbados)

1. PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 7 of the Agenda (continued)

Monitoring the achievement of the health-related Millennium Development Goals (continued)

- **Health in the post-2015 development agenda:** Item 7.1 of the Agenda (Document EB132/12) (continued)

Ms RUNDALL (Consumers International), speaking at the invitation of the CHAIRMAN, expressed concern that the report on health in the post-2015 development agenda failed to emphasize nutrition, particularly infant and young child feeding. A recent WHO/UNICEF report had revealed that coverage of effective maternal, newborn and child interventions was inadequate and that the take-up of such evidence-based policies as the International Code of Marketing of Breast-milk Substitutes was poor.¹ A 51-country assessment of the Global Strategy for Infant and Young Child Feeding had also revealed that policies and programmes for all 10 infant and young child feeding indicators were generally inadequate.² Thus in the efforts to attain the Millennium Development Goals the attention devoted to the highly cost-effective interventions of breastfeeding and infant and young child feeding was unsatisfactory; instead they needed full attention and funding, notwithstanding the difficulties in that area of work, particularly the risk of conflicts of interest in public-private partnerships. It was time to use the tools available for implementing the Global Strategy, to which end she urged full integration of the protection, promotion and support of adequate infant and young child feeding into the post-2015 process, together with progress indicators, in order to bring about the change needed.

Ms GROVES (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, said that the post-2015 development agenda provided an opportunity to build on the recent major achievements in global development, encouraged by the powerful influence of the Millennium Development Goals in maintaining support for health. Ambitious targets should be set for sustaining the progress achieved, ensuring health for all, tackling poverty and integrating the economic, social and environment pillars of sustainable development. The attention being directed to the socioeconomic impact of noncommunicable diseases and to their holistic prevention and management was welcome. Nonetheless, the post-2015 agenda must be driven by the needs and experiences of persons affected by ill health, and success must be defined in their terms. WHO's focus

¹ WHO, UNICEF. *Countdown to 2015: maternal, newborn and child survival – building a future for women and children: the 2012 report*. Geneva, World Health Organization, 2012.

² Gupta A, Holla R, Dadhich JP, Bhatt B. *Are our babies falling through the gaps? The state of policies and programme implementation of the Global Strategy for Infant and Young Child Feeding in 51 countries*. Delhi, Breastfeeding Promotion Network of India/International Baby Food Action Asia, 2012.

on health as a human right and the growing international support for universal health coverage were therefore positive steps towards such patient-centred health care and sustainable development. Also welcome was the global consultation on health; patients' organizations had an important role and undertook vital work, improving health outcomes and preventing poverty as a result. Her organization would continue to support WHO and other stakeholders in their efforts to ensure that health was a focus of the post-2015 agenda.

Ms BELL (International Council of Nurses), speaking at the invitation of the CHAIRMAN and on behalf of the World Health Professions Alliance, agreed that the Millennium Development Goals were a powerful force for maintaining support for health as a crucial element of development. Securing the place of health in the post-2015 development agenda and, in particular, the definition of person-centred and population-focused indicators should be a priority for WHO. Post-2015 development priorities must likewise reflect current and emerging disease burdens and threats, avoiding a focus on single diseases that could distort health system priorities and resource allocations. The themes to be emphasized in mapping the future agenda included equitable and universal access to health services as a human right; the holistic and people-centred approaches to health; strengthening of health systems at the point of service delivery; and the link between noncommunicable diseases, communicable diseases and the social determinants of health. Health and well-being were an outcome of coherent policies and broader societal and environmental forces, and a holistic and multisectoral approach was therefore crucial to the post-2015 development framework.

Miss DHATT (International Federation of Medical Students Associations), speaking at the invitation of the CHAIRMAN, said that, commendable as they were, the achievements outlined in the report must be accelerated if the Millennium Development Goals were to be attained by 2015. Populations not reached by the Goals should be targeted by the post-2015 development agenda, which should ideally: promote health as a concept that cut across the entire sustainable development agenda; adopt human rights and human security as the approach for the health component; and prioritize reproductive, maternal, child and newborn health. Another crucial item on the agenda was gender equality and women's empowerment, including legislation, health education, basic health care and economic opportunities. To that end, her organization supported the United Nations Commission on Life-Saving Commodities for Women and Children and its young members remained eager to highlight and promote issues of importance for the future. She urged Member States to play an active role in shaping the next phase of the development agenda with full respect for the principle of equity.

Mr HOR (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN and on behalf of the People's Health Movement, said that the post-2015 development agenda should avoid repeating the mistakes of the Millennium Development Goals, namely focusing on the ends at the expense of the means by which to achieve them. Nor should the agenda repeat the top-down approach used in conceiving, defining and implementing the Goals; it should instead work towards new approaches to national and global decision-making on the basis of such principles as popular participation, direct democracy and equity. The focus on communicable diseases must not be lost in the drive to prioritize noncommunicable diseases; the post-2015 health development framework must focus on the double burden of disease, especially in developing and least developed countries.

Mr WRIGHT (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, said that setting the post-2015 development agenda presented an opportunity to improve global health and reassert the centrality of health as a driver of sustainable development. Building on the Millennium Development Goals, the agenda should be more ambitious, more integrated and more comprehensive. It should seek to ensure an integrated health goal by ending preventable maternal and child deaths and making equitable progress towards universal health coverage by strengthening health systems and expanding financial risk protection. It should also drive reductions in inequalities by tracking progress with respect to equity; establish a multistakeholder, transparent and country-led process for translating

global goals into appropriate country targets and indicators; promote principles of aid effectiveness and acknowledge the globally shared responsibility by increasing domestic and donor resource allocations to health; and build the capacity of civil society to engage meaningfully in accountability processes. He recommended a Health Assembly resolution providing coherent guidance for the high-level meeting to be held during the sixty-eighth session of the General Assembly of the United Nations, in September 2013, to conduct a final review of the Goals.

Dr BOERMA (Health Statistics and Information Systems) said that he was encouraged by the convergence in speakers' detailed comments, including those concerning the Millennium Development Goals for which the progress achieved was either little or relatively recent and those concerning the rapidly growing burden of noncommunicable diseases, the risk factors for those diseases, universal health coverage, equity issues and links with social determinants of health and sustainable development goals. Equally encouraging was the fact that many comments broadly coincided with the indications emerging from the health thematic consultation currently taking place with Member States, civil society, academics and the private sector. The challenge lay in the details, including the definition of universal health coverage, indicators and the measurement of goals in a manner that would be meaningful to policy-makers and allow for regular monitoring, and the rightful place of health in the full development agenda. The Secretariat was working closely through its country offices to engage health ministers and the health sector in the regional discussions taking place on a complex agenda, and it had also involved UNICEF in the process as part of the efforts to disseminate the message as widely as possible. The final report on the thematic consultation would be posted on the relevant page of the WHO web site and the Secretariat would consider how best to keep Member States updated of progress thereafter. The thematic consultation was merely one milestone in the overall process, however, and he looked forward to continuing work on the post-2015 development agenda over the coming two years.

The DIRECTOR-GENERAL said that efforts to achieve the Millennium Development Goals must be intensified while the focus was retained on ensuring the rightful place for health on the post-2015 development agenda. The multiple channels of consultation were beneficial, but demanding in terms of capacity. She was therefore mobilizing WHO's country representatives to ensure that the consultation in the 100 selected countries was supported by UNDP and that health ministers were fully engaged in the process. Noting the concerns expressed in that connection, she said that the place of health in the post-2015 development agenda would be an appropriate theme to be taken up by health ministers at the forthcoming Health Assembly, thereby strengthening WHO's mandate to champion the cause of health and advocate on behalf of its Member States.

The Board noted the report.

Social determinants of health: Item 7.3 of the Agenda (Document EB132/14)

Dr VALENTIN (Seychelles), speaking on behalf of the Member States of the African Region, praised the Organization's role in bringing together governments, ministers and other representatives for the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, 19–21 October 2011) which had led to the Rio Political Declaration on Social Determinants of Health. It was encouraging that the Secretariat had drawn up a plan to implement the recommendations of the Conference. The Region's Member States were currently working on a similar document and were strongly committed to addressing social determinants of health, which was the only way for Africa to achieve the Millennium Development Goals. A few weeks before, the Chairperson of the African Union Commission had spoken of the Union's determination to work with Member States, WHO and other partners, including those in other sectors than health, to meet the region's health challenges. Universal health coverage and efforts to address the social determinants of health should underpin efforts to improve health in Africa. To that end, governments and international agencies needed to use more innovative approaches to secure adequate resources for both the health sector and beyond.

He commended the Secretariat's efforts to prioritize social determinants of health in the draft twelfth general programme of work, and looked forward to receiving tools and guidelines for implementing health-in-all policies. Across the world, a better understanding of the need for solutions to social determinants of health had contributed to an upsurge of activity. He called on the Secretariat to work with Member States to ensure that the theme remained high on the political agenda.

Dr EL MENZHI (Morocco) said that social determinants of health were variables that directly affected health indicators and were difficult for health professionals alone to control. Government and civil society were equally responsible for addressing health problems, including the social determinants of health, which were at the root of health inequities. WHO's Commission on Social Determinants of Health had been primarily tasked with finding ways for governments, international organizations, civil society and donor bodies to improve social conditions in order to promote health. The Regional Office for the Eastern Mediterranean had also selected four model sites, including Morocco, for the creation of national commissions on social determinants of health.

Socioanthropological studies had found that poverty, economic marginalization and illiteracy were among the main health-related determinants and that such integrated projects as the WHO European Healthy Cities Network and Morocco's National Human Development Initiative strengthened intersectoral coordination for improved health when shaping public policies and implementing the Rio Political Declaration on Social Determinants of Health in order to orient the health sector further towards reducing health inequities. He called on WHO to support such initiatives as part of the twelfth general programme of work and to prepare for the benefit of the Board, the Health Assembly and the regional offices a paper on how to redress health inequities by tackling the social determinants of health.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that placing health at the heart of all policies ensured that leaders and decision-makers continued to be involved in improving health equity. For Cuba, health was a priority social action. The Government's accessible and regionalized health system, based on primary health care, guaranteed universal health coverage and prevented undesirable and unacceptable health inequalities. The four pillars of the health policy were: investment in development and social welfare; constant improvement of the health system and health services; qualitative and quantitative improvements in human and social resources; and the expansion of networks for social participation.

He emphasized the need to combat health inequities, including those resulting from poor living conditions, inadequate access to health care and the structure of society. Focusing on the social determinants of health would contribute to sustainable development and the achievement of the Millennium Development Goals.

Mr LINDGREN (Norway), speaking on behalf of the Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, welcomed the report, which highlighted actions at national, regional and global levels among an emerging cluster of organizations. Social determinants of health should be addressed through various policies and initiatives, not least the post-2015 development agenda. WHO's workplan on social determinants of health in collaboration with United Nations partners was a step in the right direction, as was the focus on social, economic and environmental determinants of health in the draft twelfth general programme of work. All areas of WHO's work should have such a focus, with the necessary capacities and human resources provided. However, attention should be paid not only to health systems and disease prevention, but also to policies in other areas. Indeed, it was even more crucial to remain focused on equality and equity in health-care access at times of austerity so as to limit the adverse effects of the economic crisis.

The title of the Eighth Global Conference on Health Promotion, scheduled to be held in Helsinki in June 2013, was health in all policies, which was an essential aspect of social determinants of health. The conference would be a forum for follow-up and assessment of action on social determinants of health and should provide a platform for dialogue on ways to advance and strengthen work on the social determinants of health in the context of health-in-all policies.

Ms ALI (Maldives) endorsed the Secretariat's capacity-building initiatives for implementing health-in-all policies. Stakeholders at various levels, including local authorities, schools and civil-society organizations, should create better partnerships with the health sector in order to redress structural and systematic inequalities and health inequities. Her country followed a whole-of-government approach in tackling determinants outside the health sector which nevertheless influenced health. The private sector should also be included. Income and health were directly related, and universal health coverage would be essential for reducing inequity. The results-oriented two-year workplan currently being drafted in partnership with ILO and other bodies in the United Nations system would ensure a better allocation of support for advocacy, research, capacity building and technical assistance.

Dr de Assunção Saide took the Chair.

Dr SHI Guang (China) endorsed the report and applauded WHO's provision of technical support to Member States and its efforts to strengthen cooperation with other United Nations agencies. China had always actively championed and participated in the debate on social determinants of health and had also rolled out a national action plan for health reform in 2009 in implementation of the Rio Political Declaration on Social Determinants of Health. WHO should further review country practice and facilitate experience-sharing among Member States, as well as technical training, in the context of addressing the social determinants of health with a view to narrowing health inequities substantially and promoting global sustainable development. Concerning the post-2015 development agenda, the Secretariat should provide support to Member States in conducting research on the relevant health targets and incorporate the findings into that agenda.

Dr REYNDERS (Belgium) expressed strong appreciation for the Secretariat's initiatives to advance progress on social determinants of health, including the organization of sectoral briefings and the creation of the Action:SDH web platform. Social determinants of health were a clear priority for Belgium and they were an essential element of the multisectoral approach required to prevent noncommunicable diseases and improve life expectancy. In addition, they were an essential factor in the pursuit of universal health coverage. Access to health care was directly linked to social determinants such as education, labour, living conditions and income.

Consideration of the social determinants of health necessarily involved a multisectoral, health-in-all policies approach, including close collaboration with local communities. Belgium would continue to support WHO's work on social determinants of health, particularly the integration of social determinants into the relevant sectors.

Professor NICKNAM (Islamic Republic of Iran) favoured local health observatories as a tool to monitor environmental, economic and social risk factors. The Secretariat should share the experience of the WHO Centre for Health Development in Kobe, Japan, in establishing urban health observatories. It should collaborate with Member States in integrating them into public health programmes, such as syndromic surveillance systems which could provide non-clinical data to supplement conventional disease-based surveillance and give early warning of outbreaks of epidemic-prone diseases after various environmental or social events. His country was already identifying key non-clinical data sources for epidemic-prone diseases subject to the International Health Regulations (2005) and would share the findings with WHO upon completion.

He recommended using a uniform framework for evaluating Member States, such as the WHO Urban Health Equity Assessment and Response Tool. After pilot-testing in at least one city of every Member State in good time before the launch of the sustainable development goals in 2015, the tool could be tailored to the different contexts of Member States and serve to galvanize and engage various sectors of society to reduce urban health inequities. The modified framework could then become a monitoring tool to measure a country's progress once the post-2015 development goals had been finalized.

Dr VALLEJO (Ecuador) said that his Government's political and social position was fully consistent with the concept of social determinants of health, as it aimed to combat inequity and employed a broad concept of well-being with a strong emphasis on health.

The report showed the differences in achievement between different regions of the world, but it lacked further explanations of the factors impeding the application of a social determinants approach in certain regions. It was essential that the specific context of the health problems experienced by countries be taken into account in setting the post-2015 development goals. The current consultations should seek to harmonize the needs of States and regions and acknowledge the need for concerted action. Social determinants of health were priorities that should be reflected in the Organization's budget and used not only in indicators but also in practice. He highlighted the adoption of the Minamata Convention on Mercury (on 19 January 2013), the first instrument on the environment to contain an article specifically on health, as a good example to be followed in other development initiatives.

Dr ÁLVAREZ LUCAS (Mexico) welcomed the initiative relating to social determinants of health. It should include the creation of integrated State-public information networks containing data for measuring the magnitude and distribution of social determinants of health. As there were so many determinants, WHO should contribute to the enormous task of data collection faced by national health systems.

Dr VALVERDE (Panama) said that social determinants of health were a technical issue of great importance. Appropriate activities benefited the health of the entire population and should be centred on health promotion and disease prevention campaigns for vulnerable groups such as families, people in extreme poverty, the elderly and the very young. Those activities would require a mechanism for intersectoral coordination. She expressed her appreciation for WHO's contributions to training-the-trainers activities. It was vital to work with the entire United Nations system for promotion, research, capacity building and direct technical support, and plans of work should take into account and complement United Nations initiatives.

Ms BERMUDEZ ARCINIEGAS (Colombia),¹ while endorsing the report, regretted that it did not adequately reflect the progress made in the area of social determinants of health in the Americas, particularly at the country level. Colombia had prioritized social determinants in its individual and community health policies and aimed to establish a sounder evidence base for the cost-effectiveness of its actions derived from pilot projects of various models of primary health care in the country.

Colombia had hosted Latin American regional meetings on policy-making and the development of regional follow-up indicators for the social determinants of health. The meetings had highlighted that common denominators existed between countries, such as early-years provision and conditional cash-transfer programmes. She reiterated her country's request for social determinants of health to be granted a central role in the twelfth general programme of work, as they deserved to constitute a category in their own right as well as being considered a cross-cutting issue.

Ms POLACH (Argentina)¹ said that her country had set social determinants of health as a priority and established an office specializing in social determinants, the reduction of inequities and the implementation of health-in-all policies. The Health Agenda for the Americas 2008–2017 had centred on social determinants of health and reduction of inequalities between and within countries – a pattern repeated in recent high-level summits, such as those of the Union of South American Nations, and at the World Conference on Social Determinants of Health and the United Nations Conference on Sustainable Development (Rio de Janeiro, Brazil, 20–22 June 2012). The draft twelfth general programme of work and the proposed programme budget 2014–2015 did not accord social

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

determinants of health the central role or the budget allocations they deserved, and the subject's cross-cutting nature demanded that it be considered separately, in particular in the consultations on the post-2015 development goals. If WHO wished to ensure that health was a significant aspect of development, it would first have to make sure social determinants were paramount in the Organization. It was essential that the living and working conditions of the population were improved by implementing health-in-all policies, and that WHO should take centre stage as the main motivating force of all key players, governments and international and civil-society organizations.

Ms DHATT (International Federation of Medical Students Associations), speaking at the invitation of the CHAIRMAN, acknowledged the support provided by WHO headquarters and regional offices for the implementation of the Rio Political Declaration as well as the joint work with other United Nations bodies to bring attention to the health-in-all policies approach. However, although the report recognized health inequities as one of the three overarching recommendations of the Commission on Social Determinants of Health, it failed to identify the root causes of those inequities or propose specific action to address them. Overcoming inequalities worldwide would be a challenging task: action on social determinants of health that would help to reduce the inequality gap would only be possible with the help of innovative funding schemes devised by Member States and the Secretariat. Young people should be educated in the principles of equity and social determinants, which would provide an avenue for the smooth transfer of knowledge, ensure the movement's sustainability and foster innovation. Their innate energy, vision and grasp of technology would help to advance the cause of health and equity for all.

Dr KIENY (Assistant Director-General) noted that Member States had emphasized that the Secretariat's actions must be undertaken in a more clear and specific way. She appreciated the observation by the member for Norway about the collaboration of a cluster of agencies across the United Nations in the area of social determinants of health, which was precisely what WHO was aiming to achieve through the establishment of the United Nations platform on the social determinants of health. The results of the platform's work would be shared with Member States at a future governing body meeting. Member States had also asked for further support in the implementation of health-in-all policies. With the generous assistance of the Government of Australia, training tools were currently being developed which would be made available to Member States.

In reply to the member for Iran about observatories and the Urban Health Equity Assessment and Response Tool, namely the use of principles for measuring social determinants of health at the local and municipal levels, she said that one section of the WHO Global Health Observatory data repository was devoted to health equity and social determinants of health. It provided Member States with statistics on equity in different sectors of the population as well as creating indicators for measuring and evaluating the progress and impact of models that used social determinants of health. The Urban Health Equity Assessment and Response Tool had the same functions but was tailored for use by governments at the local level.

WHO took a cross-cutting approach to social determinants of health across the entire Secretariat. The relevant activities were described under category 3, Promoting health throughout the life course, in the proposed programme budget, but there was close collaboration with all other programmes including, for example, those dealing with infant health and malaria that had taken social determinants of health into account. She was confident that in the future, every WHO activity would involve an approach to social determinants of health.

Dr KRECH (Ethics and Social Determinants of Health), replying to the question raised by the member for Ecuador about the reasons for the slow improvement of the social determinants of health in certain regions, explained that the report had entailed an analysis of the different rates of advancement in the various regional offices. At the Regional Office for Europe, the long-term health policy had been oriented to social determinants of health. The quinquennial report of PAHO's Director on progress in health in 2008–2012 in the Region of the Americas had focused on social determinants of health, and particularly on equity measures. In the African Region, specific actions had been

undertaken, although in some countries further discussion was required to determine how to apply the social determinants approach in practice. In the South-East Asia Region, considerable efforts had been made primarily in large countries such as India, and to a lesser extent in smaller countries. In the future, it would be useful to analyse the reasons for the uneven rates of advancement.

Dr de BERNIS (United Nations Population Fund) outlined his agency's work on the promotion of health through the life course. UNFPA worked closely with WHO, UNICEF, the World Bank, UNAIDS, the United Nations Entity for Gender Equality and the Empowerment of Women (UN-WOMEN) and H4+ in supporting the United Nations Secretary-General's Every Woman, Every Child strategy, working towards Millennium Development Goals 4 (Reduce child mortality) and 5 (Improve maternal health) and partly towards Goals 6 (Combat HIV/AIDS, malaria and other diseases) and 3 (Promote gender equality and the empowerment of women). Two commissions had been established under the strategy, including the Commission on Life-Saving Commodities for Women and Children, headed by UNFPA, which took into account an analysis of social determinants for health whenever feasible.

The London Summit on Family Planning (London, 11 July 2012) had raised the hope that family planning would be included as a central component of sexual and reproductive health services, including women's right to decide how many children to have and when; means of avoiding unintended pregnancies; and prevention of unsafe abortion. UNFPA was committed to working with governments to prevent the early marriage of adolescent girls, to ensure that they stayed in school and to prevent early pregnancies. The Executive Director had launched the International Day of the Girl Child and UNFPA planned to working closely with governments on the issue.

For the post-2015 development agenda to succeed, it would have to give prominence to: empowering women, adolescents and youth to exercise their reproductive rights; universal access to sexual and reproductive health services within a framework of human rights and gender equality; and the understanding of the implications of population dynamics. Women and adolescents, in particular, faced significant but preventable health risks, therefore providing for their health and well-being would significantly reduce health inequities, prevent catastrophic health costs for individuals, families and countries, and benefit overall socioeconomic development. He endorsed earlier statements that placed sexual and reproductive health and rights at the centre of the Organization's plan of work. UNFPA was collaborating with WHO and other agencies on maternal and newborn health, family planning and health system strengthening, particularly human resources for health and midwifery.

The Board noted the report.

2. NONCOMMUNICABLE DISEASES: Item 6 of the Agenda (continued)

Disability: Item 6.5 of the Agenda (Documents EB132/10 and EB132/10 Add.1) (continued from the third meeting)

The CHAIRMAN invited the Board to consider a revised version of the draft resolution on disability, with amendments proposed by Member States.

“The Executive Board,
Having considered the report on disability,¹

¹ Document EB132/10.

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

The Sixty-sixth World Health Assembly,

PP1 Having considered the report on disability;

PP2 Recalling resolution WHA58.23 on disability, including prevention, management and rehabilitation;

PP3 Recalling the Convention on the Rights of Persons with Disabilities, signed by 154 countries and regional integration organizations and now ratified by 126, which highlights that disability is both a human rights issue and a development issue and requires that **national policies and [EU] international development programmes** are inclusive of and accessible to persons with disabilities;

PP4 Recalling United Nations General Assembly resolutions calling for the mainstreaming of disability in the development agenda (64/131 on realizing the Millennium Development Goals for persons with disabilities, 65/186 on realizing the Millennium Development Goals for persons with disabilities towards 2015 and beyond, and 66/229 on Convention on the Rights of Persons with Disabilities and the Optional Protocol thereto); resolution 66/288 endorsing the outcome document of the United Nations Conference on Sustainable Development; and resolution 66/124 deciding to convene a High-level Meeting of the General Assembly on the realization of the Millennium Development Goals and other internationally agreed development goals for persons with disabilities;

PP4bis Recognizing existing national and regional efforts to facilitate the enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity; [Ecuador]

PP5 Welcoming the first World report on disability,¹ which is based on the best available scientific evidence and which shows that many of the barriers people with disabilities face are avoidable and that the disadvantage associated with disability can be overcome;

PP6 Noting that an estimated 1000 million people live with disabilities and that this number is set to increase as populations age, the prevalence of chronic health conditions rises and in response to trends in environmental and other factors; that disability disproportionately affects vulnerable populations, notably women, older people and poor people, and that low-income countries have a higher prevalence of disability than high-income countries; and that people with disabilities, particularly those in developing countries, experience poorer health than people without disabilities, higher rates of poverty, lower rates of educational participation and employment, increased dependency and restricted participation and higher rates of violence and abuse than non-disabled people;

PP6bis Recognizing the responsibility of Member States to ensure, within existing resources, equal access to health services and care for people with disabilities; [EU]

PP7 Recognizing that people with disabilities have the same need for general health care as non-disabled people, yet have been shown to receive poorer treatment from health care systems than non-disabled people;

PP7bis Recognizing the important role that formal and informal carers play in supporting people with disabilities and that whilst informal carers cannot substitute the role of the national and local authorities, they do need particular attention from the authorities to help them with their tasks. Noting that their role is increasing in the

¹ World Health Organization and World Bank. *World report on disability*. Geneva, World Health Organization, 2011.

context of the sustainability of the health systems and in the context of ageing of the population; [EU]

PP8 Also recognizing the extensive unmet needs **for habilitation and [USA]** rehabilitation services, which are vital to enable many people with a broad range of disabilities to participate in education, the labour market, and civic life, and further that measures to promote the health of people with disabilities and their inclusion in society through general and specialised health ~~services~~ **are [EU]** are as important as measures to prevent people developing health conditions associated with disability;

PP9 Acknowledging that **a comprehensive multisectoral approach is required to meet the multiple barriers faced by persons with disabilities and that [Ecuador]** mainstreaming disability in development is the most efficient and cost-effective way of meeting the needs of people with disabilities;

PP10 Welcoming the work of WHO's Task Force on Disability to raise awareness of disability as a cross-cutting issue in WHO's technical work, and in removing physical, information and policy barriers to the participation of people with disabilities in WHO's work,

1. ENDORSES the recommendations of the World report on disability, which offer strategies for the implementation of the Convention on the Rights of Persons with Disabilities;
2. URGES Member States:¹
 - (1) to implement the Convention on the Rights of Persons with Disabilities;
 - (2) to develop plans of action, **in close consultation with and active involvement of persons with disabilities, including children with disabilities, through ~~with full participation of people with disabilities and [EU]~~ their representative organizations, as appropriate, [Norway]** so that different sectors and different actors can coordinate effectively to remove barriers and enable people with disabilities to enjoy their human rights;
 - (3) to gather appropriate **sex and age-disaggregated [Canada]** data on disability, including prevalence, needs and unmet needs, direct and indirect costs, barriers and quality of life, using the International Classification of Functioning, Disability and Health to ensure that data are nationally relevant and internationally comparable **and that successful programmes and good practices are developed in different regions; [Ecuador]**
 - (4) to **work to [USA]** ensure that all mainstream health services are inclusive of ~~people~~ **persons [USA]** with disabilities, an action that will necessitate, inter alia, adequate financing, comprehensive insurance coverage, accessible health-care facilities, services and information, and training of health-care professionals to respect the human rights of ~~people~~ **persons [USA]** with disabilities and to communicate with them effectively;
 - 4bis to ensure that informal carers, in supplementing the services provided by health authorities, receive adequate training and support; [EU]**
 - (5) to promote **habilitation and [USA]** rehabilitation across the life-course and for a wide range of health conditions through: early intervention; integrated and decentralized rehabilitation services, **including mental health services [USA]**; improved provision of wheelchairs, hearing aids, low vision devices and other assistive technologies; and training to ensure a sufficient supply of rehabilitation professionals to enable people with disabilities to achieve their potential and have the same opportunities to participate fully in society;

¹ And, where applicable, regional economic integration organizations.

(6) to promote and strengthen community-based rehabilitation programmes as a multisectoral strategy that empowers all persons with disabilities to access, ~~and~~ [USA] benefit from, **and participate fully in** [USA] education, employment, health and social services;

6bis to prohibit and prevent discrimination against persons with disabilities in the provision of health services in order to promote equality; [EU]

3. REQUESTS the Director-General:

(1) to provide support to Member States in implementing the recommendations of the World report on disability;

(2) to provide support to Member States, **and intensify collaboration with a broad range of stakeholders including organizations of the United Nations, academia, the private sector and organizations of persons with disabilities, [Ecuador]** in the implementation of the Convention on the Rights of Persons with Disabilities, in particular Articles 19 (Living independently and be included in the community), 20 (Personal mobility), 25 (Health), 26 (Habilitation and rehabilitation) and 31 (Statistics and data collection) across the global health agenda;

(3) to ensure that the health needs of children and adults with disabilities are included in WHO's technical work on, inter alia, child and adolescent health, **sexual, [EU]** reproductive and maternal health, long-term care for older people, care and treatment of noncommunicable conditions, work on HIV/AIDS and other communicable diseases, emergency risk management, and health systems strengthening;

(4) to ensure that WHO itself is inclusive of people with disabilities, whether they be visitors, collaborators or employees, by continuing to create accessible premises and information, providing reasonable accommodation, and by ensuring that people with disabilities **are consulted closely and involved actively through** ~~and~~ [EU] their representative organizations are consulted wherever necessary and appropriate;

(5) to support and participate in the High-level Meeting of the United Nations General Assembly on the realization of the Millennium Development Goals and other internationally agreed development goals for persons with disabilities, and efforts to include disability in the post 2015 development agenda by drawing attention to disability data, and health and rehabilitation needs and related responses;

(6) to prepare, in consultation with other United Nations organizations, a comprehensive cross-organizational disability WHO action plan with measurable outcomes, based on the evidence in the World report on disability, in line with the Convention on the Rights of Persons with Disabilities and the outcomes report of the High level Meeting on Disability "The way forward: a disability-inclusive development agenda towards 2015 and beyond" for consideration by Member States by the Sixty-seventh World Health Assembly through the Executive Board; [Ecuador]

~~(6)~~(7) to report on progress in implementing this resolution through the Executive Board to the Sixty-eighth World Health Assembly."

Dr VALLEJO (Ecuador) proposed the following amendments, which had been agreed with Australia, the European Union and its Member States, Norway, the United States of America and his delegation on behalf of the Union of South American Nations.

In the third preambular paragraph, the number 154 should be changed to 155; the figure 126 should be replaced by "127 countries"; and the phrase "and requires" should be replaced by "and, for States Parties, recommends". In preambular paragraphs 6bis and 7bis and operative subparagraph 2(5) "people with disabilities" should be amended to read "persons with disabilities". In preambular paragraph 6bis, the phrase "to take appropriate measures" should be inserted before "to ensure". In preambular paragraph 7bis, "carers" should be replaced by "caregivers" in both the instances in which it occurred, and "the" should be deleted before the words "health systems".

In the operative section, subparagraph 2(1), the wording “as States Parties” should be inserted after “to implement”; in subparagraph 2(2), the words “as appropriate” should be deleted from after “representative organizations” and inserted after “to develop”. In subparagraph 2(3), the end of the phrase should be amended from “using the International Classification of Functioning, Disability and Health to ensure that data are nationally relevant and internationally comparable and that successful programmes and good practices are developed in different regions” to read “using the International Classification of Functioning, Disability and Health, and effective programmes and good practices developed in different regions in order to ensure that data are nationally relevant and internationally comparable.” The phrase in subparagraph 2(4)*bis* should be amended to read “to promote that informal caregivers, in supplementing the services provided by health authorities, receive appropriate support”. Subparagraph 2(6)*bis* should be amended to read “to prevent discriminatory denial of health care or health services on the basis of disability in order to promote equality”.

In subparagraph 3(2), the wording “16 (Freedom from exploitation, violence and abuse),” should be inserted before “19 Living independently and be included in the community”; in subparagraph 3(6), “and within existing resources” should be inserted after “other United Nations organizations”. Subparagraph 3(7) should be deleted.

He also requested the Secretariat to circulate a first draft of the plan of action among the regional offices.

Dr GRABAUSKAS (Lithuania), speaking on behalf of the European Union and its Member States, expressed appreciation for the efforts by the delegations of Ecuador and other countries in negotiating the amendments.

Dr DAULAIRE (United States of America) added his appreciation. The amended text was entirely consistent with the Americans with Disabilities Act of 1990. The draft resolution was important for WHO to fulfil its essential role of ensuring that no person was denied access to health services.

Professor HALTON (Australia) affirmed that the revised draft resolved her country’s concerns about WHO’s mandate. The International Year of Disabled Persons in 1981 had marked the start of a long process of recognizing the challenges faced by people with disabilities across society, and especially in health systems. The draft resolution was part of that process and WHO was playing a crucial role in the build-up to the United Nations General Assembly High-Level Meeting on Disability and Development (New York, 23 September 2013) by ensuring that the rights of people with disabilities were not only protected at the national level, but also at the international level.

The draft resolution, as amended, was adopted.¹

3. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 8 of the Agenda

Implementation of the International Health Regulations (2005): Item 8.1 of the Agenda (Documents EB132/15 and EB132/15 Add.1)

Mr HAZIM (Morocco) supported the recommendations made by the Review Committee on the Functioning of the International Health Regulations (2005) (document EB132/15), and put forward additional proposals, namely to strengthen the role of National IHR Focal Points; introduce priority measures for implementation of the action plans to strengthen core capacities during the period 2012–2014; provide technical and logistical support to facilitate resource mobilization for States Parties not in a

¹ Resolution EB132.R5.

position to develop the core capacities within the set time-limit; and promote partnerships with international organizations, other institutions and donors for supporting implementation of the Regulations. Those proposals were consistent with the Review Committee's recommendations and were designed to promote the development of national core capacities, where required. Action must be stepped up, however, in view of the limited time available, in accordance with Recommendation 1. With respect to the criteria for extensions after 2014, regional intercountry meetings should be organized for the purpose of developing and reviewing those criteria before they were published. Concerning Recommendation 13 on creating a contingency fund for public-health emergencies, it would perhaps be prudent to create a fund to help countries to strengthen their national core capacities, so as to guarantee the improvement and maintenance of global health security.

As to the first criterion for extensions in 2014 (document EB132/15 Add.1), it would be preferable to formulate more objective criteria, with verifiable results, to confirm whether a State Party had the minimum capacities required by the end of 2014. The response to such criteria should be subjected to expert scrutiny during external missions to the countries concerned.

Dr ÁLVAREZ LUCAS (Mexico) acknowledged the Secretariat's technical support, in particular for training in biosafety, biosecurity, emergency management and the communication of risks. In risk and emergency management, workshops, table top exercises and local drills were effective tools for refining the application of the Regulations, and especially for improving response capacities. With regard to the report's recommendations, his Government would willingly provide feedback on the WHO Event Information Site (Recommendation 2). The explanatory video on the function of National IHR Focal Points (under Recommendation 4) was keenly awaited, and he appreciated the clarifications of the Secretariat's functions and responsibilities in emergency responses (Recommendation 5).

Mr LI Quanle (China) expressed his appreciation of the recommendations and the listing of capacity scores for States Parties (document EB132/15, Annex), which would allow States Parties to learn from one another's experience. Although the Secretariat had proposed criteria for the extension of States Parties' deadlines for capacity building beyond 2014, the provision of practical support would be more important. China was strengthening its core capacity-building capability in order to reach the required level by 2014.

Dr BAYE LUKONG (Cameroon), speaking on behalf of the 46 Member States of the African Region, said that the implementation of national core capacities continued to present technical challenges in the Region. To date, 44 had assessed their capacities and developed plans of action; of those, 30 had requested a two-year extension of the deadline for establishing those capacities to 15 June 2014. On the positive side, 14 had adopted the new Technical Guidelines for Integrated Disease Surveillance and Response in the African Region; 21 ship inspectors from eight countries had been trained in ship sanitation inspection and control certificate issuance; some countries had developed national preparedness and response plans for common epidemic-prone diseases; and the African Public Health Emergency Fund had gone into operation in order to supplement emergency response resources. Greater use of the Regional Rapid Response Team had enhanced national and regional capacities for the timely detection of outbreaks and the response to acute public health emergencies. Two regional meetings of stakeholders had been organized, at which unmet needs had been mapped and the process of identifying support and resources to fill gaps had been initiated. The Regional Committee for Africa at the sixty-second session had adopted resolution AFR/RC62/R8 on implementation of the International Health Regulations (2005).

Challenges included the unpredictability of funding for national action plans; inadequacy of human and financial resources, loss of highly skilled health personnel and high staff turnover among the National IHR Focal Points; insufficient training of personnel at points of entry and lack of essential equipment and infrastructure; poor laboratory capacity at subnational and district levels; failure to implement the guidelines on surveillance and response, leading to delays in detection and notification; failure to incorporate the Regulations' provisions into legal frameworks and varying interpretation of

the requirements; and a fragmented approach to implementation of the Regulations as a result of poor coordination and collaboration. Full empowerment of the National IHR Focal Points was therefore a priority.

Resolution AFR/RC62/R8 urged Member States to take steps to accelerate implementation of the Regulations through, *inter alia*: regular mapping, assessment and monitoring activities; sharing best practices and working with partners and donors to support and strengthen core capacity building; and ensuring that the proposed criteria for extension placed no obstacles in the way of implementation.

She expressed satisfaction with the proposed criteria for extension of the target date (document EB132/15 Add.1). Member States in the Region were aware of the need to maintain momentum in order to accelerate implementation of the Regulations by the 2014 deadline.

Dr GRABAUSKAS (Lithuania), speaking on behalf of the European Union and its Member States, said that Croatia, the former Yugoslav Republic of Macedonia, Montenegro, Iceland, Serbia, Albania, Bosnia and Herzegovina, Ukraine, the Republic of Moldova, Armenia and Georgia aligned themselves with his statement. He welcomed the Secretariat's support for Member States' initiatives to implement the Regulations at the national level, as called for in resolution WHA65.23. The European Union and its Member States remained highly committed to implementing the Regulations in a coordinated and coherent manner, demonstrating the importance they attached to controlling the international spread of communicable diseases and other health threats and to maintaining and strengthening global health security.

Efforts to implement resolution WHA65.23 must be intensified, however, in particular by strengthening the Secretariat's mandate so that it could fulfil its mission, assisting States Parties in the most urgent areas of implementation and assessing the effective functioning of any core capacities already established. Further work should be done on the criteria for extension of the deadline for establishing those capacities, which should be granted only in exceptional circumstances. With respect to Recommendation 13, it would be politic to issue a report explaining the functioning, purpose and origin of the contingency fund for public-health emergencies and the destination of the funding.

Ms ALI (Maldives) expressed appreciation for WHO's support in building her country's core capacities. Maldives had been granted a two-year extension for compliance with the core capacity requirements because its implementation of those capacities, while progressing, continued to be uneven. The major challenges lay in developing a legal framework, building human capacities, formulating preparedness plans for the management of chemical and radiological hazards, and improving the surveillance and management of zoonoses and environmental health. Furthermore, under the proposed programme budget 2014–2015, the preparedness, surveillance and response category into which the Regulations fell (category 5) would receive the lowest allocation of all categories, indicating that it was liable to be under-resourced, taking into account the overall resource allocation for the South-East Asia Region. It was therefore a matter of grave concern for her country, among others, that such a reduction would create significant challenges for the establishment of core capacities within the agreed deadline.

Mr LINDGREN (Norway) said that members' comments substantiated the evidence contained in the report (document EB132/15) that WHO was making clear progress in terms of its ability to respond to and manage crisis situations and promote the improvement of national core capacities. Nonetheless, the outstanding need for implementation assistance appeared to be extensive, and the number of Member States seeking or receiving extensions of the implementation deadline was disconcerting, signalling that their current capacity for response in the event of a crisis situation was limited. He commended the Secretariat's increased provision of support to Member States and the proposed criteria for any necessary extensions in 2014, but stressed that States Parties must step up their own efforts to fulfil the core capacity requirements by June 2014.

Professor NICKNAM (Islamic Republic of Iran) appreciated WHO's efforts to attract funding for the implementation of the Regulations. Donor funds should be directed towards States Parties facing the greatest obstacles in public health surveillance and response. The WHO monitoring checklist and the country review missions conducted in the regions showed that some countries, including his own, had effectively achieved the core capacity requirements and could serve as good models for their respective regions. His country had also developed a fully electronic influenza surveillance system. With respect to Recommendation 15 concerning influenza research and evaluation, he confirmed that his country was ready to share its modern influenza surveillance model with the Secretariat and interested Member States. Important areas of technology transfer meriting WHO's support included surveillance and the production of vaccines and antiviral agents, high-technology laboratory equipment and personal protective equipment. Insufficient attention and support had been devoted to strengthening laboratory capacities through technology transfer. Information on advance agreements for vaccine distribution and delivery (Recommendation 11) was included in the Pandemic Influenza Preparedness Framework and he suggested that WHO conduct regional workshops for further discussion of those agreements and related mechanisms.

Dr DAULAIRE (United States of America) observed that global health security was the sum of common actions taken to protect the world's people from potentially catastrophic health threats, which were numerous and continued to emerge and evolve. It was imperative to build further on the commendable progress already made towards global implementation of the Regulations, which was the cornerstone for detecting and responding to public health emergencies of international concern and a vital mission in WHO's mandate. His country continued to collaborate actively with the Secretariat and States Parties in that regard. He welcomed the participation of potential partners and donors in the recent meetings organized for regional stakeholders; the opportunity to engage directly in a robust discussion of needs and gaps had been extremely helpful for better identifying and planning for additional areas of assistance and technical cooperation.

He also strongly supported WHO's central role in situational awareness and coordinating the evaluation and assessment of public health capacities, in providing and facilitating technical cooperation, and in mobilizing financial resources in support of developing countries. Indeed, WHO's active oversight was essential for choreographing an effective overall approach to meeting needs in an efficient and timely manner. The United States had furthermore engaged in multilateral and multisectoral forums, as well as bilaterally, to promote the development of new partnerships and the mobilization of additional assistance for WHO and its regional offices. It looked forward to further collaboration aimed at addressing the challenges of prioritizing and phasing activities for the implementation of the Regulations and monitoring the progress and milestones achieved.

Dr St. John resumed the Chair.

Professor HALTON (Australia) acknowledged the significant work thus far completed towards full implementation of the Regulations, but called for a redoubling of efforts to support those countries for which implementation remained a challenge. In that regard, the support provided by the regional offices should be prioritized. The implementation timetable had always been ambitious, but preparedness in the face of unpredictable threats to global health was a crucial issue. She supported the recommendations of the Review Committee, notably Recommendation 8 concerning the development and application of measures to assess severity, as it demonstrated the capacity for an evolving approach. She also echoed the emphasis on work with partners, including, among others, vaccine manufacturers.

The CHAIRMAN, speaking in her capacity as the member for Barbados, commented that, in the Caribbean subregion of PAHO, the member countries of the Caribbean Community and Common Market were working collectively to improve efficiency. Barbados had seconded two officers to PAHO for that purpose.

Dr SOE LWIN NYEIN (Myanmar) said that, thanks to WHO's valuable support, the solidarity of Member States and the adoption of the whole-of-society approach, Myanmar had achieved multiple successes during its five years of implementation of the Regulations, particularly with respect to management of the H1N1 influenza pandemic in 2009. Nonetheless, the lessons learnt and the assessment of national core capacities demonstrated that there remained much room for improvement. In that regard, the recommendations of the Review Committee were highly relevant, especially Recommendation 1 (Accelerate implementation of core capacities required by the IHR) and Recommendation 4 (Ensure necessary authority and resources for all National IHR Focal Points).

Progress was uneven in establishing national core capacities in the South-East Asia Region, which also continued to show the lowest implementation rate of core capacities for the management of chemical and radiological hazards. It was therefore imperative to strive for implementation of the Regulations and achievement of the core capacity requirements at all levels, inter alia, through plans based on identified gaps and priorities, as well as through existing strategic frameworks. To that end, regular testing and systematic evaluation should be carried out with a view to updating plans accordingly. Priority areas for strengthening core capacity implementation included public health legislation, points of entry, and chemical and radiological safety.

Ms KRISNA NUR ADRIANA PANGESTI (Indonesia),¹ welcoming the recommendations of the Review Committee, confirmed her country's full commitment to implementation of the Regulations. It had nonetheless encountered several challenges in establishing its core capacities in particular. It had therefore obtained an extension until 2014 and was implementing a detailed workplan for meeting the requirements of the Regulations. A ministerial committee had been established to perform functions that included policy development, intersectoral coordination, advocacy, the formation of task forces and resource mobilization at the national, provincial and district levels. Technical implementation guidelines at all levels had likewise been developed with the aim of meeting the new deadline in 2014. Indonesia looked forward to receiving the Secretariat's continued technical support to that end.

Mr TOBAR (Argentina)¹ acknowledged the importance of the training activities regarding points of entry (document EB132/15, paragraph 3), but admitted that so far they had been limited only to inspection of ships. Training should also be supplied in other areas, as human resources in general had obtained a low score in the comparison of capacity monitoring data. MERCOSUR countries did not require the missions to assess country capacity (as mentioned in paragraph 4) because, with the support of PAHO, they had already developed instruments and performed assessments before the period considered in the report.

Turning to recommendation 3 on evidence-based decisions on international travel and trade, he noted that, in the 2012 edition of the WHO publication *International travel and health*, the term "country" was used in Annex 1, which listed areas at risk of yellow fever, in a way that was not consistent with the Regulations, namely as an umbrella term for countries, territories or areas. That might mean, for example, that another country might require all Argentinian workers to be vaccinated when it was not necessary. He therefore proposed that the term should be modified and, as had been done in the case of Trinidad and Tobago, the area of the country affected should be specified.

Argentina was particularly interested in the activities to strengthen National IHR Focal Points referred to in paragraph 16 and the activities described in paragraph 18. States Parties should contribute to the development of guidance documents (Recommendation 9), which should also be made available in Spanish. The Pandemic Influenza Preparedness Framework, referred to in paragraphs 25 and 28, would help to guarantee equity in access to vaccines for all countries at accessible prices.

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

The CHAIRMAN, speaking in her capacity as the member for Barbados, agreed that yellow fever was a critical issue, particularly concerning entry of carriers into a country. Barbados had experienced that problem and was working to develop a protocol for dealing with it.

Dr DARIN AREECHOKCHAI (Thailand)¹ said that, before granting any exceptional extensions beyond 15 June 2014, the Secretariat must ensure that countries that had obtained an extension in 2012 were in a position to improve their core capacities in accordance with their respective implementation plans. It must also follow up on any country that had requested an extension in 2012 but failed to submit an implementation plan. Each Member State that had been granted an extension should also be requested to submit a report by June 2013 on the progress made in fulfilling the requirements under its implementation plan. That would enable the Secretariat and Member States themselves to be aware of improvements in core capacities having been made in accordance with the implementation plans. If there had been no improvement, there was a year's grace to step up the pace of implementation before the 2014 deadline.

Ms MEL'NIKOVA (Russian Federation)¹ said that implementation of the Regulations was fundamental to international obligations in the maintenance of public health, in which monitoring of trends in national capacities and the progress achieved were extremely significant. Much work, based on the recommendations of the Review Committee, had been done to strengthen WHO's technical and financial support for countries with limited capacity, including strengthening their laboratory services and organizing training for their human resources. Global partnerships for the implementation of the Regulations had been strengthened and communications improved, and new guidance tools were being developed. Her Government had prepared several decisions relating to the financing of its share of international programmes to combat communicable diseases, including equipment, organizational and methodological support and training for health workers in developing countries. It was currently planning a joint project with the Secretariat on implementing the Regulations and increasing laboratory capacity in countries in Africa, Central Asia and the eastern Mediterranean. Russian experts and institutions should be more closely involved in epidemic response in future.

The Organization should establish a clear time frame for the submission of information by States Parties on their implementation of the Regulations and send out the questionnaire in good time in all official languages. Only 51% of States Parties, not including her own country, had reported on their national capacity so far. The possibility of entrusting the task to the regional offices should be investigated.

Mr KLEIMAN (Brazil)¹ said that his Government was committed to establishing and assessing its core capacities with respect to monitoring and responding to public health emergencies. All countries must show that commitment and the Organization should provide the necessary support. His Government was ready to support countries in the implementation of the Regulations in the context of South-South cooperation. With regard to paragraph 14 of document EB132/15 on areas at risk of yellow fever transmission, he agreed with the views expressed by the member for Argentina. WHO should continue its efforts to identify high-risk areas and to strengthen the concept as used in the Regulations.

Dr FUKUDA (Assistant Director-General), thanking speakers for the continued support for implementing the Regulations, which remained central to responding to a number of global public health emergencies, acknowledged that both the Secretariat and States Parties should keep up their efforts. He invited Member States to submit specific suggestions for ways to improve the criteria for extensions in 2014. The current draft criteria reflected the basic purpose of the Regulations and were

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

intended to help countries to identify their weaknesses, not to penalize them, and to enable the Secretariat to help them more effectively.

The Secretariat had organized several regional meetings in 2012, bringing together States Parties, potential technical partners and donors (and another was planned for the following month). Rather than conduct a general assessment of the existing gaps in core requirements, the purpose of the meetings had been to focus on the critical shortcomings and set priorities for each region. Based on those findings, the Secretariat knew where to focus its capacity-building efforts and the attention of the donors. Responding to the question from the member for Mexico, he said that the video on National IHR Focal Points should become available in February 2013.

Member States had understandable concerns about the heavy burden placed on an entire country when it was identified as being at risk for yellow fever even though only parts of it were affected. The risks associated with the disease persisted for a long time, which complicated the identification of specific areas. The Secretariat had held consultations with scientists in an effort to map out the areas at risk.

The Secretariat appreciated the offers of support, including provision of country-to-country assistance, that had been made by the member for Iran and the representatives of Brazil and the Russian Federation and welcomed all such capacity-building efforts.

The DIRECTOR-GENERAL commented that the original International Health Regulations had been among the earliest instruments designed to protect people from the cross-border movement of diseases while minimizing disruption of traffic and trade. The outbreak of severe acute respiratory syndrome in 2003 had galvanized Member States into revising the Regulations.

Speakers' comments had highlighted difficult issues such as points of entry or radiological and chemical hazards. Nevertheless, the weakest links were the places that lacked core capacities, which meant that outbreaks could go undetected and the problem was exacerbated by the fact that more than 60% of new diseases could cross the animal-human boundary. She encouraged countries to continue implementing the core capacities and assured them of the Secretariat's support, and she thanked those Member States that had generously offered bilateral assistance. Available funding was tightly tied to other programmes and she was limited in her ability to transfer funds.

Replying to the point raised by the member for Lithuania about the need for the proposed contingency fund for public health emergencies, she welcomed the fact that the European Union appeared to have softened its previous position regarding that recommendation. Such a fund was needed at the regional and global levels, as had become evident when the Organization faced the H1N1 influenza pandemic in 2009 but had no funds to face that emergency. Funds had then started to come in and she had been able to arrange temporary internal loans and transfers.

Responding to the suggestion from the member for Morocco that national core capacities should be externally evaluated, she reminded States Parties that a self-reporting questionnaire was being used out of respect for their sovereign rights. Although self-reporting had its limitations, she did not want to police the States Parties. Was the member suggesting that the Secretariat needed to consider introducing an element of validation?

She recalled that in document EB132/15 Add.1 the Secretariat had proposed criteria that she would use when considering a second extension if States Parties failed to meet the core capacity requirement by 2014. There was, indeed, just enough time for Member States to discuss the criteria in the regional committees, which would be implemented from 15 June 2014.

The CHAIRMAN took it that the Board wished to take note of the reports, on the understanding that the Secretariat would reflect the comments made by Member States in finalizing the criteria proposed in paragraphs 4 and 5 of document EB132/15 Add.1.

The Board noted the reports.

Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits: Item 8.2 of the Agenda (Document EB132/16)

The CHAIRMAN invited the Board to consider document EB132/16, which contained the first biennial report from the Director-General to the World Health Assembly as required under the Pandemic Influenza Preparedness (PIP) Framework, and drew attention to the annexes to the report.

Professor HALTON (Australia) acknowledged the significance of the recent signing of the first Standard Material Transfer Agreement 2 (STMA 2) and the receipt of the first Partnership Contribution. The PIP Framework was a fundamental element of global health security. Picking up the Director-General's comment in the previous discussion, she said that her delegation had already discussed issues of resource mobilization with the Secretariat; losing capability was a bad way of managing. It was also important to know exactly what resources were required to fund the PIP Framework adequately. Funding was vital for ensuring preparedness and should not be provided only in times of crisis. It was important to continue working with the private sector, with a special focus on building vaccine-manufacturing capacity on a global scale.

Dr DAULAIRE (United States of America) said that his Government was committed to the implementation of the PIP Framework and its aim of ensuring the rapid sharing of viruses and accrual of benefits that did not unduly hinder or deter the use of Global Influenza Surveillance and Response System materials. He encouraged the Secretariat to accelerate the conclusion of additional STMA 2s on mutually agreed terms and asked other Member States to provide the necessary human and financial resources for the implementation of the Framework. His Government supported the Organization's efforts to expand vaccine-manufacturing capacity in developing countries. He called on Member States not to ignore the enormous budgetary challenge facing the Organization and their joint responsibility to ensure that it could meet its essential responsibilities with respect to the Framework.

Ms PENEVEYRE (Switzerland) said that her Government was fully committed to the negotiation of the Framework and fully supported its application and that of its annexes. The Framework helped strengthen global health security and international solidarity during pandemics and enabled more equitable access to vaccines. It also showed the growing role of public-private partnerships in finding solutions to problems in the public health sector.

Mr LINDGREN (Norway) expressed the hope that the conclusion of the first STMA 2 and the receipt of the first Partnership Contribution funds would speed up the negotiation of other agreements. He noted that progress had been made with respect to influenza pandemic preparedness, with a substantial increase in the manufacturing capacity of the seasonal influenza vaccine. The full implementation of the Framework faced substantial challenges in the establishment of laboratory and surveillance capacities. He appreciated the intention of the Pandemic Influenza Preparedness Framework Advisory Group to hold regular briefing sessions in Geneva following its meetings so as to allow Member States to follow the implementation process.

Mr LI Quanle (China) said that his Government had organized talks between Chinese vaccine manufacturers and the Secretariat to discuss the implementation of an STMA 2 and to promote the implementation of the PIP Framework. China's National Influenza Centre was a member of the Global Influenza Surveillance and Response System and was a WHO Collaborating Centre for Reference and Research on Influenza. The Centre undertook surveillance of influenza and had fulfilled related obligations. In the future, China would continue to support and participate in global influenza surveillance activities and share influenza viruses promptly. China wished to donate vaccine stocks to all countries while ensuring control over outbreaks at home in order to make new contributions to an effective response to influenza pandemics. The Organization should collect information on vaccine-manufacturing enterprises worldwide and establish more detailed and operable implementation rules to boost the implementation of the Framework.

Ms REITENBACH (Germany)¹ expressed satisfaction at the signing of the first STMA 2, and noted with appreciation the increase in the global manufacturing capacity of the seasonal influenza vaccine. She asked for more information about capacity-building in the different regions with regard to regional production and vaccination to be included in the report to the Health Assembly.

Dr ATTAYA LIMWATTANAYINGYONG (Thailand)¹ said that the implementation of the STMA 2s should be accelerated, as they were an essential step in the implementation of the PIP Framework. She agreed that entities receiving PIP biological materials that were outside the Global Influenza Surveillance and Response System needed to assess what benefits they could contribute based on the benefit they derived from the materials. Partnership Contribution funds provided sustainable and predictable resources to strengthen country surveillance, preparedness and response capacities. WHO should keep track of the institutions that benefited from the Partnership Contribution funds and whether they were used in accordance with the Framework's principles. WHO's Global Action Plan for Influenza Vaccines had contributed to the fourfold increase in influenza vaccine manufacturing capacity worldwide, proving that it was possible to build such capacity in developing countries. The Secretariat should continue its efforts to increase the influenza vaccine supply in the interests of global health security. Legal complexities should not be allowed to block the global health security movement. The Framework provided a solid platform for expansion to other types of fair benefit-sharing.

Ms MEL'NIKOVA (Russian Federation)¹ supported the Organization's efforts to strengthen regulatory capacity, expand vaccine use, increase the H5N1 vaccine stockpile, and strengthen laboratory and disease surveillance capacity for detection and risk assessment of influenza viruses with human pandemic potential. She welcomed the Organization's initiative to develop practical guidance for National Influenza Centres in setting up surveillance of antiviral susceptibility, recommendations on an appropriate antiviral surveillance strategy and guidance on interpretation of laboratory antiviral susceptibility surveillance data. She also welcomed the revision of the pandemic preparedness and response guidelines, using a multisectoral approach to preparedness and drawing on the lessons learnt from the last pandemic.

The Russian Federation was making its contribution to the implementation of the PIP Framework by hosting the WHO H5 Reference Laboratory at the VECTOR State Research Centre for Virology and Biotechnology, Kol'tsovo, and by participating in the WHO External Quality Assessment Project to monitor the quality of diagnostics for both seasonal and avian influenza. The Centre also provided specialized training for health professionals in the Russian Federation and the Commonwealth of Independent States and within the Global Influenza Surveillance and Response System. The first stage of the establishment of a WHO Collaborating Centre for Reference and Research on Influenza at VECTOR had been completed. Her Government hoped for the speedy approval by the Organization of the workplan for the second year.

Mrs CHEDEVILLE-MURRAY (France)¹ welcomed in particular the cross-cutting approach adopted by the Advisory Group with regard to pandemic preparedness and response, which tied in with related ongoing WHO projects. She wished to know more about the disbursement of the Partnership Contribution funds based on the needs identified for each category and about any difficulties encountered by the Secretariat in collecting the funds. She congratulated the Secretariat on the signing of the first STMA 2 and encouraged it to continue negotiations to conclude other agreements for the transfer of materials.

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

Ms KRISNA NUR ADRIANA PANGESTI (Indonesia)¹ said that her Government was among the strongest supporters of the PIP Framework and had recently sent six influenza virus H5N1 isolates to the WHO Collaborating Centre in Japan under an STMA 1 agreement. Information on those isolates and the related candidate H5N1 vaccine virus had been published on the Organization's web site, and Member States were encouraged to make use of it under the Framework. Her Government welcomed the signing of the first STMA 2 with one of the three largest manufacturers of influenza vaccines; it was to be hoped that other such agreements would follow in the near future.

Mr KLEIMAN (Brazil)¹ said that the approach of the Advisory Group to pandemic influenza preparedness could serve as an example for other initiatives, including the reform negotiation process. It was important to support the new mechanism by expanding ties with the private and other sectors in a transparent manner. His Government was ready to provide legal support for the Organization in the STMA 2 consultation process. He congratulated the Organization on having secured 10 million courses of antiviral treatment.

Ms ONODA (Japan)¹ said that the international community must share PIP biological materials in order to enable a rapid response to an influenza pandemic. She noted that the Organization had decided to postpone the collection of Partnership Contribution funds until later in 2013 in view of the complexity of finalizing the formula for calculating the contribution expected from each company. Under the PIP Framework, total annual contributions should be equivalent to 50% of the operating costs of the Global Influenza Surveillance and Response System. The level of the 2013 contributions should be determined in a transparent manner. She asked for the time schedule of work related to the Partnership Contribution, and for details of the programme of work of the PIP Framework Advisory Group for 2013. In order to ensure transparency, the opinions of the various stakeholders involved needed to be considered.

Ms BERNAT (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that, although key elements of the PIP Framework had not been finalized by the end of 2012, including the method for calculating individual company's contributions, several manufacturers of influenza vaccine and antiviral agents, all members of her organization, had taken the initiative to make a collective contribution of US\$ 18 million to the Partnership Contribution fund in order to enable the sustainable implementation of the Framework. Those contributions should enable the Secretariat and the PIP Advisory Group to finalize the methodology, identify contributors, collect contributions and determine how to best use the funds to improve pandemic preparedness, strengthen confidence in immunization, and increase immunization rates. She urged the Secretariat to conduct broad consultation with all stakeholders throughout the process in order to ensure the best possible impact of the Partnership Contribution funds and the sustainability of the Framework.

Mrs TOWNSEND (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN and on behalf of the People's Health Movement and the Third World Network, said that transparency with regard to the implementation of the PIP Framework could be improved. All STMA 2s signed with entities outside the Global Influenza Surveillance and Response System and the identity of entities that had been sent a "Notice of Commencement of SMTA 2 Negotiations" must be made public. Information should be made available on the companies that had made contributions, the contribution levels and the method used to calculate the contributions. Companies, universities and other nonproducing entities that acquired intellectual property on the basis of research that used materials obtained through the Global Influenza Surveillance and Response System must be required to make partnership contributions to reflect the

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

benefits they derived from the System. The Framework had been developed to address the inequities of the previous Global Influenza Surveillance Network, where entities had gained access to and profited from Network materials without committing to benefit-sharing. In order to ensure that such inequity did not re-emerge under the Framework, it was essential to define appropriate mechanisms to ensure that any entity that used the System and benefited from such use made a partnership contribution.

Dr FUKUDA (Assistant Director-General), replying to the points raised, said that STMA 2 negotiations involved discussions directly between the Organization and commercial entities. Under the agreement that had recently been signed with one large vaccine manufacturer, the Organization had secured a predictable source of vaccine in the event of a pandemic for the first time. High-level negotiations were under way on other such agreements, which were critical to ensuring the desired benefits from the PIP Framework, and were being followed up expeditely.

Partnership Contribution funds were separate from the SMTA 2 and were provided by any commercial entity using the Global Influenza Surveillance and Response System. The extensive consultations and discussions with a large number of stakeholders, including vaccine and antiviral manufacturers, to determine the contribution amounts had not been concluded by the end of 2012. Although discussions were continuing on the formula for calculating the distribution of the Partnership Contribution, several companies had made voluntary contributions in 2012 based on their estimated market share to facilitate implementation of the PIP Framework.

The DIRECTOR-GENERAL, responding to comments made about the transparency and speed of implementation of the PIP Framework, said that the Advisory Group comprised members from all six WHO regions and oversaw the Framework's implementation. It was not easy to develop a formula for calculating Partnership Contributions that took into account the diversity of industry stakeholders. The Secretariat had the approval of the Advisory Group to accept contributions from certain companies that wanted to indicate their commitment even though the formula had not yet been finalized. Once the formula was determined, the difference between the contribution that had already been made and the calculated contribution would be factored into the contribution requested for the following year.

STMA 2 negotiations could not have proceeded any faster because expert legal advice was essential in order to arrive at mutually agreed and legally appropriate agreements. Although a few Member States had offered to provide legal support, it had not ultimately proved possible to take advantage of those offers, and Secretariat staff had assumed that role in addition to their regular duties. The Advisory Group had consulted industry representatives and organizations representing civil society before making its decisions behind closed doors.

The Board noted the report.

The meeting rose at 21:40.

TENTH MEETING

Friday, 25 January 2013, at 09:45

Chairman: Dr J. ST. JOHN (Barbados)

1. WHO REFORM: Item 5 of the Agenda (continued from the sixth meeting, section 1)

The CHAIRMAN announced that a non-paper setting out various proposals and issues pertaining to WHO reform had been prepared by the Secretariat, with assistance from Professor Halton, the member for Australia, so as to facilitate the Board's discussions at its informal meeting to be held in the afternoon of Saturday, 26 January. The document was available in all official languages; it would be posted on the Secretariat's SharePoint web platform and e-mailed to focal points.

Professor HALTON (Australia) said that the document was presented in tabular format and provided information on the degree of consensus reached and proposed decision points. Pursuant to a request made by the member for Lithuania on behalf of the European Union, rules of procedure issues had been covered towards the end of the document. She was willing to provide any clarification necessary.

The DIRECTOR-GENERAL, responding to a question from Mr AGHAZADEH KHOEI (Islamic Republic of Iran), said that, although some members had expressed reservations regarding consideration of rules of procedure issues, their inclusion in the non-paper, following the request by the member for Lithuania, would provide additional clarity. There was no consensus on those issues, but members might wish to give their opinions with a view to ascertaining whether agreement was possible.

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

2. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 8 of the Agenda (continued)

Poliomyelitis: intensification of the global eradication initiative: Item 8.3 of the Agenda (Document EB132/17)

Dr DAULAIRE (United States of America) expressed his sympathy to the families of the health workers killed in Pakistan and recognized the renewed statement of support for poliomyelitis eradication by the Government of Pakistan and the concrete measures it was taking to protect health workers.

He welcomed the development of the polio eradication and endgame strategic plan 2013–2018. The Independent Monitoring Board of the Global Polio Eradication Initiative had provided a valuable assessment of the polio eradication plan and made several recommendations, including the strengthening of routine vaccination programmes as an integral element of the plan. The Monitoring Board's mandate should be renewed to allow for monitoring and broad oversight of implementation.

Cross-border transmission remained a threat. He applauded the robust initiatives taken by the Governments of Egypt and Pakistan following the two recent discoveries in Egypt of poliovirus shown to have originated in Pakistan, including the establishment of vaccination counters in international

departure lounges in airports in Pakistan. He recognized the efforts of Nigeria in setting up vaccination posts along its land borders and strengthening cross-border arrangements with neighbouring countries. Other countries with wild poliovirus transmission should take similar steps, and he called upon the Secretariat to provide support to countries in intensifying their efforts to prevent cross-border transmission. Member States should implement fully and with immediate effect WHO's existing recommendations for vaccination of travellers against poliomyelitis¹ and agree with neighbouring countries to refuse transit to travellers who were unable to provide proof of vaccination and unwilling to be vaccinated on the spot.

The polio eradication and endgame strategic plan should include a contingency for the target date not being met. The Review Committee on the Functioning of the International Health Regulations (2005) should consider issuing a recommendation for the vaccination of travellers should transmission not have been interrupted by the end of 2014.

Dr AL-MARRI (Qatar), speaking on behalf of the Member States of the Eastern Mediterranean Region, commended the work being undertaken by the Governments of Afghanistan and Pakistan in collaboration with WHO and other partners in implementing national emergency action plans, and welcomed the substantial decrease in the number of cases reported in both countries in 2012 as compared to 2011. However, major challenges remained, as the recent attacks on polio vaccination workers had shown. Member States of the Region were providing support to Afghanistan and Pakistan through the Regional Office for the Eastern Mediterranean, and he called on the international community to continue its efforts in support of poliomyelitis eradication.

Dr VALVERDE (Panama), recalling that the Health Assembly had declared completion of poliovirus eradication a programmatic emergency for global public health,² supported all efforts to implement the polio eradication and endgame strategic plan 2013–2018. She welcomed the new performance monitoring systems and the progress made in the three countries where the disease remained endemic. She asked if any progress had been made in making good the funding shortfall for eradication activities, and appealed to donors to pool their efforts to that end.

Dr MENZHI (Morocco) said that the international community had made much progress in recent years in combating poliomyelitis through the Global Polio Eradication Initiative, with eradication becoming a real possibility. However, some countries were still experiencing difficulties, and it was important to step up efforts to reduce the risk of poliovirus transmission by: addressing political, social and cultural obstacles that were hampering vaccination efforts; ensuring political commitment at the highest level in countries where transmission had not been interrupted; providing financial support to States for activities under the polio eradication and endgame strategic plan; ensuring continued technical support from WHO; and implementing measures under the International Health Regulations (2005).

Dr DE ASSUNÇÃO SAÍDE (Mozambique), speaking on behalf of the Member States of the African Region, thanked WHO and its partner agencies for their efforts to curb the spread of wild poliovirus in the African Region in particular. The establishment of the Global Polio Emergency Action Plan 2012–2013 and of the Polio Emergency Steering Committee had significantly contributed to ongoing eradication activities. He acknowledged the efforts and additional measures taken by States where the poliovirus remained endemic, including securing the highest political commitment and the provision of additional funding and resources. He also noted the increased collaboration between countries and sectors of government to support the implementation of national emergency plans.

¹ *International travel and health*. Geneva, World Health Organization, 2012.

² Resolution WHA65.5.

Mindful of the risk of wild poliovirus transmission, the Member States in the Region had taken steps to increase the quantity and quality of Immunization Plus Days, develop innovative responses in security-challenged locations, intensify communication and advocacy, and enhance surveillance. A polio emergency operations centre had been established in Nigeria and was expected to ensure that targets were met. Joint operations between neighbouring countries were an additional tool to stop the circulation of poliovirus in the Region.

Commending the development of the polio eradication and endgame strategic plan 2013–2018, he called for additional measures to promote the transfer to developing countries of new production technology for inactivated poliovirus vaccine using Sabin-strain viruses during the period of the strategic plan. He would welcome regular consultation with stakeholders, in particular end-users of the new vaccines, in order to raise awareness, trust and confidence. WHO should provide technical leadership; input from other groups, such as the Strategic Advisory Group of Experts on immunization, would be welcome.

He welcomed measures taken to ensure a long-term interruption of poliovirus transmission and the plan to capitalize on current infrastructure and achievements for routine immunization programmes. Action to integrate knowledge, capacities, processes, disease surveillance and response, and stockpiling and containment measures, would benefit public health programmes greatly. He encouraged continued consultation with stakeholders and sustained resource allocation to ensure that the desired objectives were achieved. He thanked the international community for its solidarity in the eradication efforts, and expressed his sympathy to the families of the health workers killed in Pakistan.

Dr AZODOH (Nigeria) thanked WHO and other agencies for their unprecedented goodwill and support to Nigeria and other Member States that were still grappling with the spread of wild poliovirus. Although Nigeria was the only country in Africa that had not yet fully interrupted the indigenous transmission of wild poliovirus, it had made tremendous progress. Political support at the highest level had been secured and a presidential task force routinely reported to the President and state governors on implementation of the national plan. The recurrent cycle of large-scale national outbreaks had been circumscribed into well-defined pockets in a few northern states with more concentrated transmission. Nigeria had undertaken to interrupt poliovirus transmission by December 2013 and to have no case of poliomyelitis after June 2013. Much of the progress already made had been due to an increase in the number and quality of Immunization Plus Days; seven rounds of such days had been conducted in 2012 and the number of areas achieving 80% coverage had doubled. A special immunization day had already been held in 2013 in the three states where 63% of the 119 cases of poliomyelitis recorded in 2012 had occurred. Efforts had been increased to reach those children who lived in hard-to-reach settlements in border areas and children of nomadic herdsmen who were often missed by vaccination teams. Work with community and religious leaders had also been intensified to ensure that perceptions leading to refusal to be vaccinated were overcome. Vaccination activities at land borders had also been stepped up and would be expanded further to cover all movements into and out of Nigeria, so that no child who was not fully vaccinated could enter or leave the country.

A polio emergency operations centre had been established and was fully functioning to ensure implementation of the strategic priorities set for 2013, which included enhancing the quality of supplementary immunization activities, developing the 2013 polio emergency plan, implementing an accountability framework, deploying personnel to areas of need, and mobilizing volunteers. Similar centres were being set up in high-risk states. In order to prevent cross-border transmission, different sectors of government, including immigration and port health services, were supporting the implementation of national emergency plans, and Nigeria had intensified its collaboration with neighbouring countries.

She welcomed the polio eradication and endgame strategic plan 2013–2018, and appreciated WHO's decision to recruit additional workers to support the efforts against poliomyelitis. WHO was to be commended for its interaction with other partners, including vaccine manufacturers and regulatory agencies, in order to enhance affordability and access to vaccines globally. She called for additional measures to promote technology transfer and to ensure sustainability of public health

actions. She supported the goals of legacy planning for the broader benefit of other public health programmes.

Extending condolences to the families of the polio vaccination workers killed in Pakistan, she reaffirmed Nigeria's steadfast commitment to eradicating poliomyelitis and thanked the international community for its support.

Dr SOE LWIN NYEIN (Myanmar) said that Myanmar had remained poliomyelitis-free for more than five years. India's laudable achievement in remaining free of poliomyelitis for more than two years was highly positive for the South-East Asia Region and the global eradication efforts. As a result of WHO's technical support and the solidarity of Member States, the Region was on track for certification as poliomyelitis-free in February 2014, three years after its last reported case due to wild poliovirus. However, many challenges to polio eradication in the Region remained, including vaccine-derived polioviruses, importation of globally circulating wild poliovirus, gaps in the surveillance of acute flaccid paralysis, delays in detection of wild poliovirus and inadequate funding. Steps were being taken to ensure high-quality surveillance, improve and maintain population immunity through routine vaccination and supplementary immunization activities, and to strengthen cross-border activities by enhancing the core capacities required by the International Health Regulations (2005). The Secretariat should provide additional technical and funding support to enable the Region to achieve its goals and provide for the implementation of an emergency action plan.

Dr CESARIK (Croatia), speaking on behalf of the Member States of the European Region, welcomed the development of the ambitious polio eradication and endgame strategic plan 2013–2018 with its four major objectives. He commended the strong commitment of the affected countries and welcomed the development of national emergency action plans. Strongly condemning the violence faced by some health workers and deploring the recent killings in Pakistan, he asked what strategies were being put in place to reduce risks and ensure the security of health workers.

WHO should continue its discussions with vaccine manufacturers and regulatory agencies in order to enhance the availability and affordability of inactivated poliovirus vaccine. He supported the two main goals of legacy planning for the Global Polio Eradication Initiative, particularly that of mainstreaming all poliomyelitis-related work into existing public health programmes, and welcomed the consultative process that was to take place in the coming months. Funding for the programme remained a concern, but previous achievements could be lost if the necessary funds and human resources were not made available. The recent outbreak in Niger, a State that had not experienced a case of poliomyelitis for almost one year, served as a timely reminder of the fragility of the current situation.

Professor NICKNAM (Islamic Republic of Iran) welcomed the progress made in implementing the Global Polio Emergency Action Plan 2012–2013, and thanked WHO and UNICEF in particular for recruiting almost 5000 additional workers to support government efforts against poliomyelitis in Afghanistan, Nigeria and Pakistan. He regretted the targeted attacks against health workers in Pakistan and commended the determination of the Government of Pakistan to continue striving to turn the dream of poliomyelitis eradication into a reality by 2018, despite the difficult situation on the ground.

His country shared borders with two of the three countries where poliomyelitis remained endemic and the Government provided complementary vaccination for more than one million people from those countries each year. It was willing to provide further technical assistance to its neighbours with regard to routine and complementary vaccination, and monitoring and evaluation of activities. Collaboration could also take place within the existing health forum set up between Afghanistan, the Islamic Republic of Iran, Iraq, Pakistan and WHO.

With regard to the objectives of the polio eradication and endgame strategic plan 2013–2018, he said that, if transmission of residual wild poliovirus were to be interrupted by the end of 2014, elements of the global and national emergency action plans should be revised, such as oversight, monitoring and accountability, surveillance, and planning and assessment of supplementary immunization activities and routine immunization, in particular in countries at highest risk of

poliovirus importation. He called upon WHO and developed countries in a position to do so to take concrete steps to transfer new production technology for inactivated poliovirus vaccine to developing countries. Such action would help to achieve the second objective of the strategic plan (document EB132/17, paragraph 6), namely withdrawal of the type 2 component of the trivalent oral poliovirus vaccine from routine immunization programmes globally. The introduction of the existing, expensive full-dose inactivated poliovirus vaccine would not resolve the issue of providing a long-term affordable vaccine for all countries.

Mr LI Quanle (China) expressed appreciation of WHO's efforts in the area of poliomyelitis eradication. In order to attain the objectives of the endgame strategic plan, WHO should offer technical and financial support to the countries where the disease was endemic. Funding support should be given to the neighbours of countries in which the disease was endemic for strengthened surveillance in border areas and regular risk evaluation, and to ensure that no area was missed in vaccination campaigns.

WHO should develop an information and data sharing system, and national and regional cooperation should be strengthened in the area of data analysis and outbreak surveillance. Strategies for cross-border and cross-regional cooperation should also be adopted by countries experiencing outbreaks and by their neighbours. A period of transition should be established for the introduction of inactivated poliovirus vaccines, in particular for developing countries. Efforts should be made to promote research and development and the production of inactivated poliovirus vaccine using Sabin-strain viruses, and to encourage countries to establish a timeline for the transition from oral poliovirus vaccine to inactivated poliovirus vaccine. Funding should be provided for the policy update on routine immunization, and technical and financial support should be made available for the withdrawal of the type 2 component of the oral poliovirus vaccine.

He commended the remarkable progress made by Pakistan over the preceding year, and called upon the international community to continue to support Afghanistan, Nigeria and Pakistan in their fight against poliomyelitis.

Professor HALTON (Australia), recalling the successful elimination of smallpox, said that poliomyelitis eradication was a much harder task, although India was to be congratulated on its remarkable achievement of remaining poliomyelitis-free for two years.

She strongly condemned the recent tragedy in Pakistan and praised the dedication and continued commitment of health workers there. She applauded the efforts of the countries where wild poliovirus was still present. A combined emphasis on strengthening routine immunization and other measures, such as the establishment of partnerships, was essential to achieving the objectives of the endgame strategic plan, which Australia strongly supported. In the absence of shared goals and political commitment, it was not enough for the international community to mobilize financial and human resources. However, she was heartened by the support expressed for the strategic plan and believed that its objectives were achievable.

Dr SARMENTO P. DA COSTA (Timor-Leste), welcoming the report, said that her country had set up a poliomyelitis-free certification committee in close collaboration with organizations including WHO and UNICEF. Political commitment had been secured at the highest level, providing for the allocation of human and financial resources, better-quality supplementary immunization activities and vaccination campaigns implemented through integrated community health and home visiting services. In accordance with the International Health Regulations (2005), steps were being taken to strengthen inspection activities at border crossings, ports and airports in order to facilitate the rapid detection of imported cases. She drew attention to other health-related issues to be taken into account in the eradication efforts, such as poverty, migration and the availability of potable water, and expressed appreciation of the technical support provided by WHO, which she hoped would continue until eradication had been achieved.

She expressed her sympathy to the families of the volunteer workers killed in Pakistan.

Mr ALI KHAN (Pakistan),¹ welcoming the report, said that much work had been done since the Sixty-fifth World Health Assembly had declared the completion of poliovirus eradication a programmatic emergency for global public health. Despite the challenges Pakistan faced, such as national disasters and serious security issues, the number of poliomyelitis cases had fallen by 65% in 2012 as compared to 2011. There was unwavering political commitment at the highest level. A reliable and credible monitoring system had been established and transit vaccination points had been set up at major transportation hubs. Strict accountability standards were followed.

To build upon the success of the preceding year, the Government had developed a national emergency action plan for poliomyelitis eradication in 2013, following a thorough consultative process involving a wide range of participants. The plan had been reviewed by a technical expert group together with the provincial health departments before its endorsement by a national task force. It focused on greater ownership, oversight and accountability at the federal, provincial and district levels. Strategies had been devised to ensure access to security-compromised areas and to counter negative propaganda against polio eradication campaigns.

Pakistan's efforts at the national level had received strong support from international partners, and he looked forward to the continuation of the work of WHO and other partners in Pakistan. He assured the international community that the deaths of the nine health workers would not be in vain, and noted that suspects had been apprehended and were currently being investigated by the authorities. National and international outrage had been expressed at the tragic events and he thanked the international community for its condolences and continued support for Pakistan's eradication programme. The Government had started to conduct campaigns in a more secure environment and had devised a new security and operations strategy with the involvement of the law enforcement agencies where required. It was seeking to build broader and stronger support for the programme among the most affected communities and was encouraging religious leaders to become involved in those efforts. In order to prevent the exportation of the poliovirus, permanent vaccination counters were being set up inside international departure lounges at all airports in the country to ensure that all children under five years of age leaving the country were vaccinated against the disease.

More needed to be done to achieve global poliomyelitis eradication. The momentum achieved should not be lost, and the international community should demonstrate global solidarity, commitment and a shared sense of responsibility. Pakistan was fully committed to continued and concerted action to eradicate poliomyelitis from its territory.

Ms GOLBERG (Canada)¹ commended the efforts of all who had contributed to the important progress made in eradicating poliomyelitis since the declaration of a global emergency in May 2012. Eradication could be achieved through collective action, given that the prerequisites for success were in place, including a global mandate to eradicate the disease; leadership and coordination globally through the Global Polio Eradication Initiative; effective vaccines; and political will.

Failure to eradicate poliomyelitis would be unforgivable, but the significant challenges that existed had to be met. Obstacles in relation to security and public opinion had to be overcome, and the support of national and local leaders must be sought, particularly in countries where poliomyelitis was endemic. She commended the courage of vaccinators and the responses of the Governments of Afghanistan, Nigeria and Pakistan and their neighbours that continued to attach high priority to eradication. She agreed that consideration could be given to ways of reinforcing the vaccination of travellers, consistent with the International Health Regulations (2005). Another challenge was the cost of eradicating poliomyelitis and the reluctance to invest large sums in combating the disease. However, if poliomyelitis was not eradicated, the resources required for continued vaccination would quickly exceed the cost of the eradication efforts. The cost to the gross domestic product and health care systems of the societies affected should also be borne in mind.

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

She supported a strong polio eradication and endgame strategic plan and welcomed the contribution of the Global Polio Partners' Group to its development. She was pleased that the new strategic plan acknowledged the need for alignment with the goals of the global vaccine action plan, established linkages with other partners and identified strategies for risk mitigation. The legacy of poliomyelitis eradication must be preserved and provide a solid foundation for current and future immunization activities. Canada would work to ensure that the capacity developed with regard to surveillance, vaccination, expertise and outreach would continue to be of benefit to work on other related maternal and child health challenges.

Mrs ESCOREL DE MORÃES (Brazil)¹ said that urgent global action was required to support the efforts of the Governments of Afghanistan, Nigeria and Pakistan in a final push to eradicate poliomyelitis. The cost of failure would be huge. The latest data for the Global Polio Emergency Action Plan 2012–2013 were positive, but did not allow for complacency, and countries that had already been declared poliomyelitis-free should share their experiences with others. Congratulating India on its laudable achievement in remaining poliomyelitis-free for two years, she said that Brazil had been declared poliomyelitis-free in 1994. Much of its success had been due to social mobilization, the firm commitment of families, communities and local institutions to vaccination campaigns, and a culture of regular routine immunization across the country. Brazil was assisting Haiti in its immunization campaigns and had, together with other partners, collaborated with the Government of Angola on poliomyelitis eradication. It had donated vaccines and assigned health professionals to assist other countries in their immunization programmes.

She congratulated WHO and the partner organizations of the Global Polio Eradication Initiative on their commitment and hard work. The polio eradication and endgame strategic plan for the period 2013–2018 presented an opportunity for renewed commitment and a continued focus on global health priorities.

She too extended her country's sympathy to the families of those who had lost their lives in the course of their work to immunize populations in need.

Dr WARIDA (Egypt)¹ said that his country had experienced no case of poliomyelitis since 2006, but, given the risk of reintroduction of the virus his Government had not been complacent and had conducted regular surveillance. That activity had detected poliovirus in two environmental samples (of sewage) collected in Cairo in December 2012. The viruses were found to be related to viruses from South-east Asia. The health authorities had acted promptly to step up epidemiological surveillance, scrutinize eradication activities and increase environmental sampling. A Cairo-wide campaign to immunize children under five years of age was also due to be implemented imminently. In that connection, WHO played a vital role in helping developing countries to procure sufficient quantities of vaccine, as well as in documenting success stories of eradication.

With reference to the report, he highlighted the importance of WHO's endeavours to strengthen capacity building and ensure the availability of inactivated poliovirus vaccine. Similarly important for developing countries were its continuing efforts to support immunization, enhance the affordability and availability of vaccines, and facilitate the transfer of vaccine-manufacturing technology, which were essential prerequisites for the success of national efforts to combat the disease and eradicate the virus. He thanked the Secretariat, the Regional Office for the Eastern Mediterranean and international partners for supporting the documentation of national success stories. He also welcomed the measures announced by the representative of Pakistan for making the vaccine available to travellers and for preventing the cross-border spread of the virus.

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

Ms MEL'NIKOVA (Russian Federation)¹ said that the implementation of the Global Polio Eradication Emergency Action Plan 2012–2013 in coordination with national emergency plans in polio-endemic countries had demonstrated the effectiveness of such joint measures. Clear goals and monitoring had boosted vaccination coverage rates and had reduced the number of cases caused by wild polioviruses in most of those countries. Weak national immunization programmes and safety concerns were impeding progress, however. In view of the ambitious timeline indicated in the report, all countries needed to demonstrate their resolve to achieve the Plan's goals. Additional resources and guarantees that those resources would be well spent were also needed.

Ms LANTERI (Monaco),¹ reaffirming her country's continued commitment to the Global Polio Eradication Initiative, said that vaccination campaigns and supplementary immunization activities should be strengthened in order to achieve the high coverage rates essential for eradication. The challenges that existed in some countries must be overcome, and she welcomed the recent vaccination activities undertaken by Nigeria and Pakistan at airports and border crossings. Despite the cases of poliomyelitis reported in Niger and the detection of poliovirus in Egypt, she expressed the hope that, with the continued and strengthened efforts of the countries where the disease was endemic, the historic milestone of poliomyelitis eradication would be achieved. She expressed appreciation of the work of the Global Polio Partners' Group, which offered an informal forum for discussion of the progress made in achieving eradication.

Dr DARIN AREECHOKCHAI (Thailand)¹ welcomed the untiring commitment of WHO, its partner agencies and other stakeholders to developing the polio eradication and endgame strategic plan 2013–2018. She was concerned, however, that the withdrawal of the type 2 component of the trivalent oral poliovirus vaccine from routine immunization programmes meant that all countries using the oral poliovirus vaccine would need not only to have a licensed bivalent oral poliovirus vaccine but also to make inactivated poliovirus vaccine available in the event of the reintroduction of the virus. She urged WHO, in collaboration with its development partners, to support the transfer to developing countries of production technology for inactivated poliovirus vaccine in order to ensure a sufficient supply of affordable inactivated poliovirus vaccine that should, in the interests of efficacy, be administered by skilled health personnel.

Reaffirming her country's commitment to poliomyelitis eradication, she expressed her condolences to the families of the health workers who had lost their lives in Pakistan.

Mr PUSP (India)¹ said that the national health plan set out priorities for poliomyelitis eradication efforts in India, such as high-quality surveillance, identification of high-risk populations, high levels of routine immunization coverage, regular vaccination campaigns and the development of emergency preparedness and response plans. India's National Regulatory Authority and its affiliated institutions had recently been assessed by WHO and found to be a functional vaccine regulatory system. He was confident that, with sustained effort and strong political commitment, India would receive certification of its poliomyelitis-free status in February 2014, and thanked the international community for its support.

Dr JANE (United Kingdom of Great Britain and Northern Ireland),¹ commending the report, welcomed the political commitment in Nigeria and Pakistan, and expressed his condolences to the families of the health workers killed in Pakistan. Poliomyelitis eradication, which was within reach, could only be achieved with long-term political and financial commitment. He reaffirmed his Government's wholehearted support for the endgame strategic plan 2013–2018.

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

Ms WIDIYARTI (Indonesia)¹ agreed that a comprehensive endgame strategy and a strong post-eradication strategy were vital for global eradication of poliomyelitis. Indonesia was working to strengthen its health system in collaboration with civil society organizations and partners such as the GAVI Alliance. Financial and technical resources were required to ensure the success of the endgame strategy and she requested technical support on vaccine production capacity from WHO and other agencies.

Mr CHIKH (Organisation of Islamic Cooperation), speaking at the invitation of the CHAIRMAN and noting that all the 233 new cases of poliomyelitis in 2012 had occurred in member countries of his organization, acknowledged the work done by WHO to reduce reinfection risks. Mass immunization campaigns carried out in 27 of his organization's member countries in 2012 had enabled 996 million doses of vaccine to be administered to some 198 million children under the age of five years. Such efforts were crucial, particularly given the security situation and acts of violence perpetrated against health workers in Pakistan, which threatened decades of mobilization, and he expressed condolences to the families of the victims. Increased political will and advocacy vis-à-vis religious and community leaders were important awareness-raising tools, but strong financial commitment was crucial if poliomyelitis was to be eradicated around the world. He welcomed the significant financial contribution made by the Islamic Development Bank over the years. The issue would be high on the agenda of the fourth session of the Islamic Conference of Health Ministers (due to be held in Jakarta, in October 2013) who would be discussing a new health action plan for the Organisation of Islamic Cooperation for the period 2013–2022.

Ms HALL (UNICEF) welcomed the progress made in 2012. She acknowledged the impact of the Global Polio Emergency Action Plan 2012–2013 and support work on the eradication and endgame strategy. Community support for vaccination was the key to eradicating poliomyelitis; UNICEF played a leading role in communications and social mobilization in order to build demand for immunization services and to respond to community concerns about poliomyelitis. By increasing awareness, creating demand and countering refusal of vaccination, the Global Polio Eradication Initiative would be better able to stop transmission and reach children in the most disadvantaged and marginalized communities. Capacity had been significantly enlarged in 2012 and UNICEF was also working with manufacturers and countries to ensure the timely supply of vaccine and to develop plans to manage the withdrawal of the type 2 component of oral polio vaccine and the introduction of inactivated polio vaccine. Global eradication of poliomyelitis was within reach; a final push was needed to reach some of the most vulnerable children in the world. UNICEF strongly supported the strengthening of routine immunization programmes to provide equitable access to essential vaccines for all children and would work with partners to ensure that the poliomyelitis programme was contributing to that goal. She welcomed the support that the programme received from governments, partners and donors and recognized that WHO played an important leadership role on technical aspects. Particular thanks were due to Rotary International, the Bill & Melinda Gates Foundation and the Centers for Disease Control and Prevention of the United States of America for their tireless efforts and support. She expressed her condolences to the families of the health workers who had been killed in Pakistan; they, and others like them, who worked in some of the most dangerous areas of the world, deserved respect and profound gratitude.

Mr STENHAMMAR (Rotary International), speaking at the invitation of the CHAIRMAN, said that the draft polio eradication and endgame strategic plan 2013–2018 provided a blueprint for action, but its success depended on the support and commitment of polio-affected countries, donors and partners. Significant progress had been made in 2012, but that progress had been marred by the attacks on health workers. He called on all relevant parties to condemn such attacks strongly and secure the

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backing of religious leaders in order to ensure access to all children. For the strategic plan to be successful, stronger oversight, accountability and management were required at all levels in the remaining endemic countries and among partners. Increased focus on routine immunization would also strengthen population immunity in high-risk areas. Sustainable, multi-year funding was crucial to the success of the strategic plan and he urged the donor community to provide the necessary support. The success of India in eradicating poliomyelitis had shown that collective action, strong commitment and accountability at all levels could produce the desired results.

Dr ALWAN (Regional Director for the Eastern Mediterranean), acknowledging the importance of the issue to the Eastern Mediterranean Region, said that both Afghanistan and Pakistan had made significant progress in 2012, but challenges remained, particularly in terms of access and security. Both countries were reorganizing and strengthening their action plans to secure optimal benefits during the low transmission period. They had recently updated their emergency action plans and were putting in place a performance monitoring system to track vaccination coverage levels and guide corrective action. However, the challenges in some areas, such as cross-border transmission, strengthened regional collaboration and coordination, and community mobilization and communication, required new approaches. WHO and UNICEF were working closely with governments, key Islamic scholars and institutions across the Region to provide support and address threats to vaccination in isolated areas. The threats and misinformation being spread by some groups had no grounds in religion and contradicted the principles of Islam. He expressed sincere appreciation for the increased engagement of Member States with the two countries concerned and looked forward to further engagement during 2013. Particular thanks were due to the Islamic Development Bank and the Organisation of Islamic Cooperation for their support. Eradication of poliomyelitis was a top regional priority and had been endorsed as such by all 23 Member States of the Region.

Dr AYLWARD (Assistant Director-General) said that, since the report had been prepared in November 2012, there had been continued intense pressure on the poliovirus, resulting in a decline in cases of poliomyelitis during the high season for transmission, for the first time ever, indicating that viral transmission intensity may have been falling globally. Vaccination coverage had increased significantly in the most difficult areas in recent months in the countries endemic for the disease. In Afghanistan, the number of inaccessible children in the south of the country had halved in the past six months; Nigeria had seen a 20% increase in coverage rates in the worst performing areas; and in Pakistan, the Government had implemented measures to ensure the safety of health workers, enabling vaccination campaigns to restart in mid-January 2013. Responding to comments on security and safety, he pointed to WHO's activities in 2012 at both international and national levels, including: establishment of an interagency think tank on security, involving WHO and partners such as UNICEF, the International Committee of the Red Cross, the United Nations Department of Safety and Security and the World Food Programme; the commissioning of a study on best practices and lessons learnt in insecure areas, which were being implemented across the Global Polio Eradication Initiative; and the recruitment of full-time security analysts in some key areas. WHO saw security as a major risk and took it very seriously. He expressed appreciation to the Organisation of Islamic Cooperation for its collaboration on security issues.

He expressed appreciation to India for sharing the lessons learnt from its experience and welcomed the comments made by the members for the Islamic Republic of Iran and Myanmar regarding the importance of global surveillance. He assured the member for China that WHO was carrying out regular risk assessments in poliomyelitis-free areas in order to guide activities in those areas.

The draft polio eradication and endgame strategy 2013–2018 would be the last action plan on poliomyelitis, as it mapped out the road to completion of the Global Polio Eradication Initiative after 25 years of concerted effort. The plan had been updated to address some of the issues raised; it had a clearer results chain and the objectives had been restructured in order to raise the profile of routine immunization work, which must have the same imperative as the eradication work itself. The plan also described the specific work being done in collaboration with the GAVI Alliance in the context of the

global vaccine action plan to effect significant changes in routine service delivery. He expressed appreciation to the United States of America for its support in developing contingency plans; some of the suggested language on how further to reduce international spread of the virus in the context of the plan would be included during its finalization. The Secretariat would take into account the guidance received from the Board and aimed to complete the plan by mid-February 2013. In addition, the Independent Monitoring Board of the Global Polio Eradication Initiative had agreed to extend its mandate to the end of 2015, or beyond, in order to exercise oversight on the work of interrupting transmission.

With regard to inactivated poliovirus vaccine, the Secretariat was working closely with manufacturers and partners on the development of Sabin-strain inactivated poliovirus vaccine, and the results of the first trial of the vaccine had been successful. He thanked the Government of the Netherlands for its work in that regard. Other developments included a reduction of 66% in the price of inactivated poliovirus vaccine owing to the entry of a new manufacturer into the production arena. Within two years, the vaccine might be available for less than US\$ 1 per dose. He acknowledged the importance of planning for the transition to inactivated poliovirus vaccine and bivalent vaccine. Headquarters and regional offices were working with Member States to facilitate such planning, although the transition would not be made until all countries had access to the products that they needed.

At the current time, if all the pledges that had been made were fulfilled, the funding shortfall for eradication activities in 2013 would be less than US\$ 100 million and he expressed appreciation for the generous pledges made by Member States and especially the countries endemic for poliomyelitis, as well as by the Islamic Development Bank, the World Bank, the Bill & Melinda Gates Foundation and Rotary International – the overall contribution by Rotary International amounted to more than US\$ 1000 million. The endgame strategic plan would cost US\$ 4500 million between 2014 and 2018. Legacy planning was seen as vitally important and a consultative process was being initiated with a view to producing a paper on the topic for consideration by the regional committees in the autumn of 2013. He paid tribute to the efforts of Afghanistan, Nigeria and Pakistan, which were taking a “whole-of-government” approach to the task of eradicating poliomyelitis.

The DIRECTOR-GENERAL said that the Health Assembly’s declaration in resolution WHA65.5 that the eradication of poliomyelitis was a programmatic emergency had galvanized support, with significant progress being achieved by Afghanistan, Nigeria and Pakistan. She paid tribute to the leadership of the United Nations Secretary-General, who had brought together world leaders to renew their commitment to the eradication of poliomyelitis, and the governments of the three countries still endemic for the disease. Particular thanks should also be given to Mr Bill Gates, who had travelled around the world to raise funds for polio eradication. She expressed appreciation to Brazil, China, India, the Russian Federation, and South Africa for demonstrating that support did not have to be in the form of funding; technical support was also extremely helpful. Additional thanks were due to numerous other entities and individuals, including the Organisation of Islamic Cooperation, partners such as Rotary International and UNICEF, the Independent Monitoring Board of the Global Polio Eradication Initiative, Member States for their financial support, and the members of her staff. Acknowledging the sympathy that had been expressed with regard to the intimidation and deaths of health workers in Pakistan, she said that their only crime had been to try to save lives and it must be ensured that their lives had not been lost in vain. She committed the Organization anew to eradicating poliomyelitis by the end of her term. Failure to do so would be unforgivable.

The CHAIRMAN agreed that failure was not an option. She took it that the Executive Board wished to take note of the report.

The Board noted the report.

3. COMMUNICABLE DISEASES: Item 9 of the Agenda

Global vaccine action plan: Item 9.1 of the Agenda (Document EB132/18)

Dr DAULAIRE (United States of America), noting the report, agreed with the proposed alignment and incorporation of multi-year costed immunization plans within the broader national health system planning and budgeting process. A high level of continued national commitment to collect data and produce annual reports would be critical to successfully monitoring and evaluating the goals and strategic objectives of the global vaccine action plan. He strongly supported the tracking of national immunization expenditures and encouraged opportunities for leveraging of funds across broader national health system budgets. Turning to the proposed framework for monitoring, evaluation and accountability, he said that some components of the implementation plan and indicators would require further definition and clarification of data sources. For example, it would be important to identify how countries would translate the results into actions and how regional committee recommendations would be implemented. Standardization within and between Member States would be necessary to allow for analyses over time and across different countries. Moreover, for low-income and middle-income countries that were not eligible for funding from the GAVI Alliance, identifying financial resources would be critical to the implementation of the proposed framework. He commended the reinvigorating effect that the Decade of Vaccines had had on the debate on routine immunization and the fact that it included among its goals the eradication of poliomyelitis and accelerated progress towards the elimination of measles, rubella and neonatal tetanus. Active collaboration should be encouraged in that regard.

Dr ÁLVAREZ LUCAS (Mexico) said that, in line with its concern to reduce the under-five mortality rate by two thirds by 2015 in relation to 1990, Mexico had introduced new vaccines into its immunization schedule, such as the vaccines against rotavirus and pneumococcal infections, and had started providing tetanus, diphtheria and acellular pertussis vaccines for pregnant women. He urged the Secretariat to start or continue to encourage Member States to undertake epidemiological surveys in order to assess vaccination coverage and obtain reliable figures on seroprotection rates against vaccine-preventable diseases.

Dr MYINT HTWE (Myanmar), expressing support for the points made by the member for the United States of America, said that, in order to ensure that the objectives of the global vaccine action plan were fulfilled and that the comprehensive multi-year plan was aligned with broader national health sector plans, WHO, UNICEF and other stakeholders needed to work as a close-knit team, with a particular focus on monitoring immunization programmes. He expressed concern that there was sometimes limited follow-up to monitoring and evaluation findings. The Secretariat should consider providing additional support in that area. He supported the four elements of the proposed framework for monitoring, evaluation and accountability, which reflected the guidance of the Strategic Advisory Group of Experts on immunization. It was necessary to monitor the extent to which those elements were implemented at the country level and the experience of implementation should be shared at meetings of both the national programme managers and the WHO regional advisers. In the South-East Asia Region, Member States were satisfactorily carrying out immunization activities, with the support of the Regional Office and headquarters staff. However, there was room for improvement, and ongoing Secretariat support, particularly with regard to the development of the comprehensive multi-year plan, should be framed in line with the guidance of the Strategic Advisory Group of Experts on immunization. The comprehensive multi-year plan needed to be practical and viable, and the Secretariat should update the database of immunization programmes so as to facilitate information sharing and increase the analytical capability of immunization health professionals. Putting the global vaccine action plan into practice should go hand in hand with the development of a strong and dynamic data management system. It would be helpful to review the activities of national immunization technical advisory groups and interagency committees whose membership, in some cases, might not have changed for many years.

Dr DE ASSUNÇÃO SAÍDE (Mozambique), speaking on behalf of the Member States of the African Region, commended the significant progress achieved during the previous year in relation to the global vaccine action plan, including advocacy for the Decade of Vaccines at numerous high-level meetings in the African Region. It was important that the momentum should be maintained. Effective implementation of the plan would help to prevent premature deaths and unnecessary morbidity and disabilities. Universal coverage of health services and adequate human and financial resources were key elements in that regard and alignment was required at the national level to ensure sufficient domestic funding for immunization programmes. The Secretariat should ensure alignment between the programme budget and the plan's requirements, and resources should be made available for WHO's technical support to be provided at country level. The proposed framework for monitoring, evaluation and accountability, although well conceived, needed further elaboration before it could be used operationally.

Dr GONZÁLEZ FERNÁNDEZ (Cuba), recalling the key objectives of the global vaccine action plan, said that vaccination was one of the most cost-effective health actions available and helped to guarantee quality of life. In its role as the global health authority, WHO had provided support to other United Nations organizations with regard to the vaccines that they used, ensuring that such vaccines fulfilled WHO requirements in terms of quality and safety. In 2009, WHO had prequalified 10 single or combined vaccines for 26 manufacturers in Brazil, Bulgaria, Cuba, India, Indonesia, the Russian Federation and Senegal.

Cuba's vaccination programme had been in place since 1962 and had helped to eliminate various preventable diseases, such as poliomyelitis, diphtheria, pertussis, measles, rubella and tuberculous meningitis. Moreover, routine vaccination had reduced the mortality and morbidity rates of other diseases such as hepatitis B, typhoid fever and mumps by more than 98%. About six million doses of vaccine were administered yearly and eight of the 11 vaccines used were produced within Cuba. The Decade of Vaccines should focus on efforts to extend access to health care to all communities, using the different strategies that had already proved to be effective. Health services, the public and private sectors and nongovernmental organizations should be involved in those efforts, which should also seek to achieve high rates of coverage with underused or scarce vaccines such as that against *Haemophilus influenzae* type b infection. Policies, strategies and best practices for immunization should be developed and steps should be taken to guarantee the self-sufficiency of national immunization programmes and achieve sustainable financial support.

Dr UDVAL NATSAG (Mongolia) strongly supported the global vaccine action plan. Its successful implementation would depend on the application of updated WHO/UNICEF guidance for developing multi-year and annual national immunization plans and the specific guidance for Member States to develop national monitoring, evaluation and accountability processes. The first element of the proposed framework for monitoring, evaluation and accountability, namely, monitoring results on the basis of goal-level indicators and targets and strategic objectives, was acceptable and had no implications for the implementation of the global vaccine action plan. The second element, namely documenting and monitoring commitments for immunization, was also acceptable but could be supplemented by a reference to safety and quality of vaccines. With regard to monitoring resources invested in immunization activities, she preferred the second component, namely, improved quality of financial reporting, as it promoted accountability and sustainability for immunization financing. In that connection, she emphasized the importance of capacity-building programmes in relation to the tracking of resources.

Mr LI Quanle (China) supported the global vaccine action plan and the establishment of a framework for monitoring, evaluation and accountability in line with the United Nations Secretary-General's Strategy for Women's and Children's Health. Implementation of the plan would be a lengthy process with many stakeholders, thereby presenting both opportunities and challenges. It was therefore imperative to strengthen information sharing between Member States and between regions, along with cooperation between all stakeholders. Information-sharing events for Member States

should be organized by the Secretariat. In addition, Member States should conduct studies on the feasibility of introducing one or more new or underutilized vaccines into their immunization programmes in the light of their disease burdens, vaccine availability and the progress made in research and development. The Secretariat should provide and publish technical guidance thereon. Moreover, in partnership with other international organizations, it should provide guidance to Member States on the evaluation of confidence in vaccinations among guardians of minors. Member States should use the extension of average life expectancy and child survival rates as indicators for the assessment of progress in implementing the global vaccine action plan, and should take steps to strengthen development of primary health care networks and to expedite the provision of essential medical services.

Professor NICKNAM (Islamic Republic of Iran), welcoming the WHO/UNICEF guidance for developing national immunization plans that were in line with the global action plan's strategic objectives, including a monitoring framework, emphasized the development of a data collection tool for that framework, which would facilitate self-assessment and the drafting of annual progress reports. As the monitoring framework was to be implemented over a 10-year period, it should be flexible enough to measure new technologies and innovations in addition to the indicators adopted. Financial commitments to the Decade of Vaccines should be the shared responsibility of all stakeholders, and the international agencies and development partners in particular should commit themselves to equitable funding for the transfer of vaccine production technology to all WHO's regions. Any new immunization programme should be sustainable and ensure equitable availability to all persons in need. A high-level meeting should be held to promote implementation of the global vaccine action plan and ensure the global commitment of all stakeholders to the Decade of Vaccines.

Dr SARMENTO P. DA COSTA (Timor-Leste) welcomed the holding of the first World Vaccination Week in 2012 and the initiative of the Regional Director for South-East Asia to have 2012 declared the Year of Intensification of Routine Immunization in that Region, which had enabled her country to identify key areas for increased routine immunization and develop relevant action plans. Seven vaccines had been administered in Timor-Leste up to mid-2012 and close collaboration with the Regional Office for South-East Asia, the GAVI Alliance and other stakeholders had made it possible to introduce a pentavalent vaccine in November 2012; however, many other important vaccines, such as those for pneumococcal infection and meningococcal meningitis, were still unavailable. The global vaccine action plan was a timely initiative that would serve to consolidate the implementation of the Global Immunization Vision and Strategy.

Mr CHONG CHEE KHEONG (Malaysia) supported the report as a whole, but expressed reservations about one strategic objective-level indicator, namely, "Presence of an independent technical advisory group that meets defined criteria". His concern was due to the fact that industry and associations were currently hiding behind nongovernmental organizations and pressuring his Government to introduce new vaccines without due consideration of the justification of their use. Those entities sought to influence public opinion through the media and made it seem that the Government was failing in its responsibility on health matters. That was cause for concern, although the indicator did include a reference to defined criteria.

Professor HALTON (Australia) said that Australia had a great deal of experience in the development and use of vaccines and was currently in the process of expanding its universal human papillomavirus vaccination programme for girls to cover boys in the relevant age group. She indicated that Australia had been pleased to work with colleagues in the region, and with partners such as the GAVI Alliance. She expressed strong support for the Decade of Vaccines. Bearing in mind the concerns that had been raised about the fracturing of systematic responses as a result of focusing on the Millennium Development Goals, she said that further consideration should be given to issues of coherence in respect of reporting and data standards, as developing countries did not necessarily have the capacity to produce data of the same standard as developed countries. The requirements needed to

be reasonable and achievable for all. She highlighted the importance of health system strengthening and vaccine supply. Efforts must be made to align the work of the global vaccine action plan with other organizational priorities as far as possible.

Dr VALVERDE (Panama) said that reducing infant mortality was a key concern of her Government. Panama had strengthened its national health plan and had developed a highly cost-effective vaccination strategy against, *inter alia*, poliomyelitis (including use of a hexavalent vaccine), hepatitis B (in a pentavalent vaccine), rotavirus, influenza, pneumococcal infection, human papillomavirus infection, varicella, and yellow fever. Acknowledging the work of WHO, UNICEF and other stakeholders on the issue, she urged them to look at the system for gathering information and updating data, as well as improvements that needed to be made. She supported the establishment of a working group of the Strategic Advisory Group of Experts on immunization that would review progress made in the implementation of the global vaccine action plan and consider the development and addition of indicators to measure equity in access to vaccines between countries and an indicator to monitor integration of immunization systems into broader health systems.

Dr VALLEJO (Ecuador) observed that vaccinations were cost-effective. Cuba supplied US\$ 5 million worth of vaccines to Ecuador each year. In the past year, that supply had included a liquid pentavalent vaccine formulation, enabling it to be used in the country for the first time. The two countries were collaborating on a technology transfer initiative that would enable Ecuador to begin producing its own vaccines in the near future. That showed that South–South cooperation was possible and could yield substantial benefits for the countries involved.

Ms REITENBACH (Germany),¹ commending the focus of the report on fine-tuning the goal-level and strategic objective-level indicators, expressed support for the updated definitions of those indicators. In some areas, such as the elimination of preventable diseases and immunization coverage for certain vaccines, the indicators were challenging even for developed countries. She supported in principle the proposals for monitoring commitments and resources for immunization at country level, but pointed out that the monitoring of financial data required better interministerial communication and the development of governance and general administrative capacity. Encouraging and harnessing such processes was often the objective of initiatives of other development partners, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance or the Commission on Information and Accountability for Women's and Children's Health. Applying the principles of development effectiveness was therefore of utmost importance. She welcomed the proposed indicator on domestic expenditures per person targeted, as it would serve to increase transparency with regard to developing countries' financial commitments. International comparison between developing and developed countries would, however, be difficult as health-system and vaccine costs varied widely. She requested more information from the Secretariat on the cost of the overarching global monitoring and reporting process.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland)¹ said that, as a framework for monitoring, evaluation and accountability had been developed under the global vaccine action plan, the next step should be renewed, sustained and concrete action. Moreover, at a time when the Decade of Vaccines secretariat had been scaled back, information should be provided on the Secretariat's future work on the plan, what resources were available for that purpose and how WHO was collaborating with Decade of Vaccines partners.

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

Mr BLAIS (Canada),¹ welcoming the progress made in operationalizing the global vaccine action plan, expressed support for the alignment between the framework for monitoring, evaluation and accountability and other existing mechanisms, such as the Commission on Information and Accountability for Women's and Children's Health. It was vital that inequality issues were addressed to ensure that immunization benefited all. He encouraged WHO and the GAVI Alliance to continue their close collaboration as they played complementary roles in that area.

Ms SMIRNOVA (Russian Federation)¹ said that the keys to successful implementation of the global vaccine action plan included general coordination of activities, monitoring and accountability, and strengthening of national immunization plans. The proposed targets and strategic indicators could be adopted as a basis for future work, subject to possible amendment at a later stage. It was necessary to update national immunization plans in accordance with the activities proposed under the plan and the relevant WHO/UNICEF guidelines.

Dr ATTAYA LIMWATTANAYINGYONG (Thailand),¹ expressing support for the proposed framework for monitoring, evaluation and accountability, agreed with the comment made by the member for the United States of America regarding the need for further clarification on indicators. Regarding the proposed target of the introduction of one or more new or underutilized vaccines in at least 90 low-income and middle-income countries, she said that the introduction of a new vaccine must be guided by factors such as disease burden, cost-effectiveness, long-term budgetary impact, programmatic and financial sustainability, cold-chain capacities to absorb new vaccines, and health systems' readiness to deliver vaccines equitably. Such factors should be reflected in the proposed framework as they would provide flexibility for countries that were not eligible for funding from the GAVI Alliance to make the best decision based on their national situation. With regard to the third and fifth strategic objective-level indicators, there was evidence to show that prices could be brought down by multiple sourcing of qualified vaccines; the global expansion of vaccine production capacities should therefore be a key strategy for ensuring vaccine security and achieving affordable prices. Governments increased public investment in immunization only when vaccine prices were affordable. In addition, there were several mechanisms in place that supported the production of affordable vaccines, such as patent pools, public-private production partnerships, differential pricing for segmented markets and regional level pool procurement.

Ms CHILDS (MSF International), speaking at the invitation of the CHAIRMAN, expressed concern that the proposed framework for monitoring, evaluation and accountability was not sufficiently ambitious in terms of bringing new vaccine delivery technologies to immunization programmes. Current tools were inadequate for reaching children who were disproportionately affected by vaccine-preventable diseases; vaccines required refrigeration, were difficult to transport and required trained health staff for administration. However, the framework called for the introduction of only one new platform delivery technology by 2020. In addition, the global vaccine action plan should give greater consideration to vaccine affordability. The cost of fully vaccinating a child had increased by 2700% since 2001 and was likely to increase further in the future. It was alarming that the framework contained no indicators on vaccine pricing.

Dr BUSTREO (Assistant Director-General), welcoming the suggestions for improving the proposed framework, said that, since the report had been issued, further operational definitions of indicators had been developed and the Secretariat was mapping available data sources. The indicators would be further refined on the basis of the Board's comments and the report would be revised for submission to the Sixty-sixth World Health Assembly in May 2013. Noting the comment on the need to enhance coherence between existing initiatives, she said that the global vaccine action plan should

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

facilitate further progress towards achieving Millennium Development Goals 4 and 5, as the introduction of new vaccines would have a significant effect on child mortality. It was envisaged that introduction of further vaccines, such as the human papillomavirus vaccine, would begin in many countries during 2013. The Health Assembly's adoption of the global vaccine action plan had given impetus to the work of the regional offices and Member States. The Secretariat would document achievements and work with Member States, for example to strengthen individual country capacity to track expenditure on immunization. That element was an integral part of health system strengthening and was linked to the work being done to strengthen accountability for women's and children's health.

The CHAIRMAN took it that the Board wished to take note of the report.

The Board noted the report.

The meeting rose at 13:15.

ELEVENTH MEETING

Friday, 25 January 2013, at 14:40

Chairman: Dr J. ST. JOHN (Barbados)

later: Dr Ren MINGHI (China)

later: Dr ST. JOHN (Barbados)

1. COMMUNICABLE DISEASES: Item 9 of the Agenda (continued)

Neglected tropical diseases: Item 9.2 of the Agenda (Documents EB132/19 and EB132/19 Add.1)

Dr MYINT HTWE (Myanmar), welcoming the report, said that he supported the draft resolution in principle. A simple and practical mechanism was needed to adapt country-level stakeholder interventions to individual country needs. The significant efforts made by Member States to reach consensus on the draft resolution should not be wasted; concrete action must be taken to implement the recommendations contained therein. Underscoring effective vector control and the concomitant need to ensure that vector-control specialists at the country level had sufficient technical capacity, he asked the Secretariat to support vector-control interventions as well as efforts to bolster specialist training. With regard to the actions listed in paragraph 16 of the report, the Secretariat should consider providing support to enable Member States that had not yet implemented those actions to do so; support could even be provided during the current biennium, with appropriate amendments to the programme of work. All action related to neglected tropical diseases should be clearly reflected in the programme of work, thereby allowing the necessary progress to be made.

Dr CESARIK (Croatia) acknowledged the importance of neglected tropical diseases in the light of global warming and increasing poverty, with concomitant lower standards of living and hygiene, which exacerbated the potential distribution of those diseases. In pursuance of the recommendations contained in WHO's road map, Croatia regularly undertook the following public health interventions: the provision of safe drinking-water, basic hygiene and sanitation, treatment and preventive chemotherapy, and effective vector control, with the consistent involvement of the veterinary sector. Following the detection of dengue haemorrhagic fever in Croatia in 2011 and human cases of West Nile fever in 2012, cooperation between the health system, biologists and veterinarians had made it possible to evaluate vector distribution and infection prevalence so that appropriate disinfection measures could be taken. Given the current rate of climate change, the Organization should concentrate on and allocate resources to increasing awareness of neglected tropical diseases and preventing their distribution within the European Region.

The CHAIRMAN, speaking in her capacity as the member for Barbados, recalled that her country had experienced a minor outbreak of dengue haemorrhagic fever in 2012. The detection of cases in Croatia demonstrated the effects of climate change on the distribution of neglected tropical diseases.

Dr ÁLVAREZ LUCAS (Mexico) affirmed that neglected tropical diseases were characterized by their association with poverty and climate change. Seven of the 17 neglected tropical diseases listed in the report affected Mexico, although most had been controlled and one, onchocerciasis, had nearly been eliminated. His country had made considerable progress in recent years in controlling neglected

tropical diseases, including dengue fever, rabies and leprosy, and he would gladly share that experience with other Member States and the Secretariat. Mexico was cooperating with the other countries of Central America in efforts to combat neglected tropical diseases, using WHO's road map. He recognized the relevance of the five public-health interventions set out in the road map, in particular preventive chemotherapy, case management and effective vector control. Prevention and control of neglected tropical diseases formed a basic element of universal health coverage and needed a multisectoral response and the involvement of experts. Implementation of the actions outlined in the report would enhance his country's ongoing efforts to reduce the impact of those diseases. He endorsed the draft resolution.

Mr KOLKER (United States of America) thanked the Secretariat for raising the profile of neglected tropical diseases. Global and regional cooperation was essential to their prevention and control and, to that end, three of his country's major government agencies were providing technical and research support to affected countries and the Secretariat. A recent example of such regional cooperation was the licensing the day before of a candidate vaccine against Chagas disease, developed in his country and proven to be safe and effective, to the Butantan Institute in Brazil, where a severe outbreak of the disease had recently occurred. He encouraged WHO to finalize and publish disease-specific guidelines for use by the global community, taking account of regional and national variations and epidemiology, for instance, and avoiding a "one-size-fits-all-neglected-tropical-diseases" approach. The programme budget should also be reviewed in order to ensure the staffing levels and programme funding needed to implement the actions recommended in the draft resolution and achieve the road-map's targets set for 2020. He encouraged active engagement between prevention and control strategies and the recommended focus on research for neglected tropical diseases outlined in the draft resolution proposed by the Consultative Expert Working Group on Research and Development (contained in document EB132/21).

He proposed two minor amendments to the draft resolution contained in document EB132/19: in paragraph 1, subparagraph (5)(a), the word "ensure" should be replaced by the word "provide" and in paragraph 2, subparagraph (3), the word "ensure" should be replaced by the word "promote". Although the amendments proposed by the member for Lithuania had not yet been formally submitted to the Secretariat, they had been acceptable to his delegation in discussions.

Dr GRABAUSKAS (Lithuania), speaking on behalf of the European Union and its Member States, fully supported the draft resolution but proposed some amendments. In the fifth preambular paragraph, the words "and across all relevant sectors" should be inserted after "integrated manner", and the words "but there are still many challenges" added after "Millennium Development Goals". In the sixth preambular paragraph, the words "while acknowledging the need to ensure its continuous availability and affordability" should be inserted after "neglected tropical diseases". In paragraph 1, subparagraph (2), the words "as appropriate" should be inserted after "to expand and implement" and the words "agreed by WHO and its partners" should be modified to read "agreed by all partners". He proposed adding a subparagraph (2)(b) to paragraph 1, to read: "integrating neglected tropical diseases control programmes to primary health care services and vaccination campaigns or existing programmes where feasible to achieve greater coverage and reduce operational costs." In paragraph 1, subparagraph (3) the words "and strengthen research" should be inserted after "prevention and control of neglected tropical diseases". In paragraph 1, subparagraph (5)(c), the words "health promotion and education" should be added after "basic sanitation". He would submit the proposals in writing.

Dr GONZÁLEZ FERNÁNDEZ (Cuba), recognizing the importance of all five public health interventions listed in the report, underlined the equally important role of effective vector control and the involvement of veterinary public health. Research had demonstrated that the most effective method of control involved a combination of interventions at the local level. He supported the draft resolution, to which he proposed the addition of a new subparagraph in operative paragraph 3, to read: "to encourage and support initiatives for the discovery and development of new diagnostics, medicines

and insecticides and to support operational research to increase the efficiency and cost-effectiveness of the interventions". He would submit his amendments in writing to the Secretariat.

Dr LUKONG (Cameroon), speaking on behalf of the Member States of the African Region, said that that Region bore a disproportionately high burden – some 50% of all cases worldwide – of neglected tropical diseases, giving rise to disabilities, malnutrition and even stigmatization, and affecting physical and educational development. Efforts had been focused on tackling the 13 diseases most commonly found in the Region, for which simple, effective and low-cost interventions existed, such as preventive chemotherapy. In recent years, there had been renewed efforts to control and eliminate neglected tropical diseases on a global scale through increased political commitment and funding at all levels as well as through multistakeholder cooperation, culminating in the adoption of the London Declaration on Neglected Tropical Diseases in January 2012. The Accra Call to Action, adopted in June 2012, had reinforced that Declaration at the regional level, calling on Member States to scale up national interventions rapidly. To date, 36 African countries had developed integrated multi-year plans to prevent and control neglected tropical diseases. Progress had been made – for example, the Region had achieved its leprosy target in 2005 – but greater prevention and control efforts were needed, especially at the regional level, together with better coordination among partners. In that regard, the decision to include the eradication of dracunculiasis as an impact goal in the draft twelfth general programme of work was commendable. In the main, the Region needed more resources, better integration mechanisms, greater community involvement, increased health system capacity and medicine supply, and additional support from the Secretariat. She endorsed the draft resolution, which would strengthen the commitment of all stakeholders.

Dr VALVERDE (Panama) affirmed that greater regional efforts were needed, especially in Central America, for the prevention and control of neglected tropical diseases that were a priority for her country. In cooperation with international stakeholders, Panama had implemented a programme to eradicate or control malaria in areas where the disease was still endemic. At a recent conference on tropical diseases and molecular parasitology (Panama, 2 and 3 August 2012), scientists had recognized the need for much greater international cooperation and the application of new technologies against malaria, leishmaniasis and dengue fever. In particular, new antimalarial agents were needed, given the increasing resistance of plasmodia to current medicines, and new strategies must be designed to meet the challenges posed by global climate change. She welcomed the recommendations contained in the report and supported the draft resolution, as amended by the member for Cuba.

Professor NICKNAM (Islamic Republic of Iran) said that neglected tropical diseases placed a disproportionately high burden on the countries affected. Lack of further action to prevent and control those diseases in developing countries could threaten the achievement of the health-related Millennium Development Goals and the post-2015 development agenda. Recognizing the link between neglected tropical diseases and poverty, WHO and its partners had made significant efforts to reduce factors that exacerbated poverty as an integral element of disease-control strategies. Among the remaining challenges were weak political commitment; insufficient resources for prevention and control programme implementation; paucity of research on neglected tropical diseases; and lack of appropriate medicines. Programmes to tackle neglected tropical diseases should be expanded by establishing more partnerships with development agencies; building overarching capacities, for example by strengthening health systems and surveillance models; and fostering the discovery and development of new diagnostics, medicines and pesticides.

Professor HALTON (Australia) commended the Secretariat's work on the prevention and control of neglected tropical diseases, especially in view of the related issues of social justice and equity. She supported the draft resolution but proposed several minor amendments. In, subparagraph 1 (1), the word "national" should be replaced by "country". In paragraph 2, a reference should be made to "sovereign governments" as being the entities primarily responsible for ensuring access to treatment

and other preventive measures. In view of the need to communicate the Organization's agenda to a global audience, why had the term "chemotherapy" been used in the draft resolution given its association with expensive cancer treatment and the possibility that it might therefore cause confusion?

Mr KLEIMAN (Brazil)¹ said that the intrinsic links between neglected tropical diseases and poverty underlined the need to strengthen national health systems and integrate health-related measures into social and economic policies aimed at eliminating extreme poverty. His country's efforts to tackle neglected tropical diseases included the discovery and development of new and improved medicines, laboratory diagnostics, vaccines and strategies. Monitoring of progress towards disease-related targets should be strengthened by means of a plan of action with a clear set of indicators. The draft resolution should include clearer and more direct language on research and development and production, including references to the Global Strategy on Public Health, Innovation and Intellectual Property and the recommendations of the Consultative Expert Working Group on Research and Development (document EB132/21). He would submit his proposed amendment in writing to the Secretariat.

Dr DARIN AREECHOKCHAI (Thailand),¹ endorsing the draft resolution, said that achieving the goals set out in the London Declaration on Neglected Tropical Diseases would require hard work and effective intersectoral cooperation, in particular concerning the environment, drinking-water and sanitation, and poverty. A lack of technical expertise in most countries that were endemic for the diseases was hindering implementation of national prevention and control programmes. To tackle that problem, the Secretariat should set up and maintain a roster of experts capable of providing technical support to Member States. The emphasis in the draft resolution on the need for sufficient and predictable funding was welcome as countries where neglected tropical diseases were endemic had limited resources, and, therefore, a realistic fund-mobilization strategy was needed. The work done by the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases could provide the foundation for mapping health product research and development needs. As suggested by the Consultative Expert Working Group on Research and Development, better control and prevention of neglected tropical disease and improved medicines for their treatment were needed.

Ms SMIRNOVA (Russian Federation) said that her Government supported the actions set out in the report for maintaining the progress already made and further reducing the global impact of neglected tropical diseases. Countries where those diseases represented a heavy burden must give top priority to strengthening national programmes to combat them through strategic planning, funding, prevention and control activities, and monitoring at all levels. Her Government had helped countries to strengthen their laboratory capacities by providing equipment, supplies, training and institutional support, allocating some US\$ 20 million for that purpose in the previous three years. She endorsed the draft resolution and had submitted in writing a proposal for amendment of paragraphs 2 and 3 to include references to vaccination and diagnosis.

Dr CICOGLA (Italy)¹ outlined some of the key factors relating to the prevention and control of neglected tropical diseases. Those included the magnitude of the problem; the solid technical understanding and the scientific evidence that formed the backbone of a well-defined and balanced road map and had guided and would continue to guide efforts in that area; the unprecedented progress made recently; the need to refine control strategies and make the best use of new technical tools and protocols and, above all, the fact that neglected tropical diseases disproportionately affected women and children, exacerbated poverty and hindered socioeconomic development. Those factors called for

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

broad endorsement of the draft resolution, backed by a commitment from countries endemic for neglected tropical diseases, donor communities and WHO.

Mr LE GOFF (France)¹ asked the Secretariat to confirm that the draft resolution covered the 17 neglected tropical diseases mentioned in its report.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, commended the Secretariat's leadership in the combatting of neglected tropical diseases. The pharmaceutical industry was actively engaged in that effort through its research and development activities and its medicine-donation programmes under which it had pledged to donate 14 000 million treatments for the control or elimination of nine major neglected tropical diseases by 2020.

The industry also collaborated with other stakeholders on strengthening health system capacities and carrying out research and development. Additional challenges, including improving sanitation, increasing access to safe drinking-water, capacity building, raising awareness, and strengthening health systems, must be met through commitments on the part of all stakeholders, especially governments.

Mrs TOWNSEND (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN and on behalf of the People's Health Movement, welcomed the draft resolution. As neglected tropical diseases were rooted in poverty, consideration must also be given to structural and other determinants of health in order to combat those diseases effectively. Member States should accord the same priority to those factors as that accorded to the five fundamental public health interventions set out in WHO's road map.

Partnerships, in which transnational pharmaceutical corporations played a major role, were the main vehicle for implementing efforts to combat neglected tropical diseases. Safeguards for managing conflicts of interest, which did not exist at present, must be built into the overall partnership design to prevent those corporations from serving their own interests. As the draft resolution failed to provide a precise mechanism to boost much-needed research and development targeting neglected tropical diseases, Member States should include in it the recommendations of the Consultative Expert Working Group on Research and Development, in particular that for a global coordination mechanism.

Ms CHILDS (MSF International), speaking at the invitation of the CHAIRMAN, welcomed the renewed attention being paid to neglected tropical diseases and the ambitious goals outlined in WHO's road map. However, some aspects of the work could be improved. For example, in some instances the road map focused solely on reduction of transmission, to the exclusion of case management. That approach was misguided: access to treatment for all patients affected by neglected tropical diseases must be ensured. The draft resolution should include a reference to the need for sufficient quantities of quality-assured, affordable medicines, whether through donations of medicines, which were important but could not meet all treatment needs, or by fostering the availability of affordably-priced products. It should also urge the Secretariat, Member States and their international partners to set a clear and specific research and development agenda for neglected tropical diseases with a view to stimulating innovation in a market that was not considered lucrative by the pharmaceutical industry.

Dr NAKATANI (Assistant Director-General) thanked speakers for their comments and proposed amendments to the draft resolution; a revised draft would be circulated later for the Board's consideration. He assured the representative of France that the resolution indeed covered the 17 diseases referred to in the report.

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

He agreed that vector control was important, remarking that vector control specialists were becoming rare professionals. That trend must be reversed, and accordingly the Secretariat was endeavouring to build country capabilities, including the training of entomologists. Dengue had been mentioned – that disease was spreading: in 2012, for example, Madeira had reported more than 1800 cases. The Secretariat was developing guidelines for its diagnosis, treatment, prevention and control. In the absence of any treatment or licensed vaccine at the current time, efforts were focusing on early outbreak detection and vector-control interventions. The member for Australia had proposed inserting in the draft resolution a reference to sovereign governments as being primarily responsible for ensuring access to treatment and preventive measures, yet the London Declaration on Neglected Tropical Diseases had made the point that no one organization or government could combat those diseases alone and that partnerships were needed to achieve the goals set out in the road map.

The allocation from the programme budget for neglected tropical diseases had been considerably bolstered by large donations of medicines by the pharmaceutical industry, amounting to between 800 million and 1000 million treatments per year. The need remained to explore means of delivering good-quality medicines to those in need, to supplement pharmaceutical company donations. With regard to the use of the term “preventive chemotherapy”, the Secretariat had been using the definition (document EB132/19, footnote to paragraph 4) for some time, also in the tuberculosis field; to change it might lead to confusion.

The Board took note of the report.

(For adoption of the resolution, see the summary record of the thirteenth meeting, section 3.)

2. HEALTH SYSTEMS: Item 10 of the Agenda

Substandard/spurious/falsely-labelled/falsified/counterfeit medical products: Item 10.1 of the Agenda (Document EB132/20)

Mr McIFF (United States of America), speaking on behalf of the Member States of the Region of the Americas, proposed that consideration of the item be deferred until Monday, 28 January, in order to give the six regional groups more time to deliberate on the composition of the steering committee and, in particular, its chairman.

Dr SHEKU DAOH (Sierra Leone), speaking on behalf of the Member States of the African Region, Professor HALTON (Australia) and Dr GRABAUSKAS (Lithuania), speaking on behalf of the European Union and its Member States, endorsed that proposal.

The CHAIRMAN said that she took it that the Board wished to postpone consideration of the item to Monday, 28 January 2013.

It was so agreed.

Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination: Item 10.2 of the Agenda (Documents EB132/21 and EB132/21 Add.1)

The CHAIRMAN drew attention to the draft resolution contained in the report of the open-ended meeting of Member States on the follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination (document EB132/21) and the related financial and administrative implications (document EB132/21 Add.1).

Dr VALENTIN (Seychelles), speaking on behalf of the Member States of the African Region, underlined the vital role of health research and development in tackling both neglected diseases and other diseases affecting developing countries and in providing timely, affordable and better responses to a wide range of health- and development-related challenges. Regional integration initiatives provided valuable support for research and development projects in Africa, but the health research and development capacities of African countries must be strengthened, particularly in relation to funding and coordination, in terms both of human resources and of structures and processes. The discussion on research and development, financing and coordination should be aligned with the discussions on the general programme of work, the programme budget and human resources. Adequate staffing and funding of the proposed global health research and development observatory should be ensured.

He looked forward to discussion of a well-structured international treaty on research and development, which would support both developed and developing countries in making significant progress. After careful examination, Member States in the Region gave their support to the draft resolution, but desired greater urgency by all partners in ensuring that the work envisaged therein was realized. They also urged Member States to make available the domestic resources needed to facilitate the implementation of timely action at a national level.

Dr DAULAIRE (United States of America) expressed support for the draft resolution, the text of which represented the culmination of years of hard deliberations by Member States, expert working groups, commissions and other stakeholders. He welcomed the consensus achieved during the open-ended meeting; the draft resolution represented the best outcome possible. It defined a clear approach for taking action to support increased research and development for diseases primarily affecting developing countries and the poor and provided a work plan for moving beyond lengthy dialogue to concrete global action. He supported submission of the draft resolution in its current form to the Sixty-sixth World Health Assembly for adoption. Sustained financial support would be crucial, especially in view of the resource-intensive nature of some of the recommended actions, such as the establishment of a global observatory. In that connection, he welcomed South Africa's early commitment to provide support and encouraged other Member States to do the same. His country looked forward to working actively with others on the issue.

Ms STIRØ (Norway) acknowledged the progress made in increasing research and development on diseases primarily affecting developing countries, but noted that much remained to be done. Norway accorded high priority to enhancing global health research and development and welcomed the practical recommendations of the Consultative Expert Working Group for rectifying the shortcomings of current incentive systems and the uneven distribution of global health research funds. Innovation and the development of new health products must address the health needs of developing countries; in 2013, her country would commit 0.01% of its gross domestic product to that end, in line with the recommendation of the Working Group. She concurred with the Working Group's finding that all countries, irrespective of their level of development, had a responsibility to contribute to increased investment in global health research and development. She welcomed the outcome reached by Member States during the follow-up meeting, which would serve as a solid platform for common action in the three interlinked areas of monitoring, coordination and financing for global health research and development. The strategic work plan laid out in the draft resolution defined concrete steps to be taken and provided a clear path for future action; she looked forward to participating in its further development. She welcomed the proposal to implement demonstration projects and hoped that the lessons learnt would encourage increased investment. She fully supported submission of the draft resolution to the Health Assembly for adoption.

Mr MIŠKINIS (Lithuania), speaking on behalf of the European Union and its Member States, said that Croatia, Turkey, the former Yugoslav Republic of Macedonia, Montenegro, Iceland, Serbia, Albania, Bosnia and Herzegovina, Ukraine, the Republic of Moldova, Armenia and Georgia aligned themselves with his statement. He welcomed the report and the draft resolution, which reflected the

balanced compromise and consensus reached by Member States at the open-ended meeting and should be submitted to the Health Assembly for adoption without reopening the agreed text for discussion. The European Union was committed to the implementation of the strategic work plan set out therein. While providing the basis for a long-term sustainable solution, the draft resolution would also allow Member States and the Secretariat to take immediate action. He welcomed the draft resolution's emphasis on enhancing national and regional capacities and initiatives and on effective coordination, including the implementation of demonstration projects. The proposed global health research and development observatory would play a key role in monitoring and analysing relevant information, but it should build on existing national and regional data collection mechanisms. Further efforts to systematize data collection and analysis should not stand in the way of immediate action. The review to be submitted to the Sixty-seventh World Health Assembly would help to identify remaining challenges and needs and thus to ensure long-term sustainable action. The European Union and its Member States were fully committed to advancing future work on global health research and development and encouraged all Member States to engage in a constructive and successful process.

Ms PENEVEYRE (Switzerland) supported the draft resolution and the incremental approach it recommended. Enhanced information on gaps and needs, which the global health research and development observatory should make more readily available, coupled with the prioritization and coordination of projects, would lead to a more efficient and targeted allocation of resources. The launching of demonstration projects would make it possible to test the effectiveness of coordination mechanisms. The Board should recommend that the Health Assembly adopt the draft resolution without reopening it.

Dr VALLEJO (Ecuador), speaking on behalf of the Member States of the Union of South American Nations, endorsed the report of the Consultative Expert Working Group, which provided timely solutions to a major challenge facing the national health systems, namely, how to incentivize innovations that could be translated into affordable technologies for combating diseases that disproportionately affected developing countries. The report reaffirmed that the current system of incentives for research and development, coordination and financing of health technologies was inadequate to meet the health needs of developing countries and tended to be driven by commercial rather than public health interests. During the open-ended meeting, Member States had come to the same conclusion. Nevertheless, it had proved difficult to reach consensus on what mechanisms should be adopted in order to improve coordination and increase resource flows for health innovation in developing countries. He noted with concern that some issues had remained ambiguous or unaddressed and that there was little correlation between the preambular and operative paragraphs of the draft resolution. It was therefore important to continue to devise strategies for coordination, priority setting and financing for health research and development that went beyond the proposals and actions envisaged in the draft resolution, which largely maintained the status quo.

He welcomed the idea of establishing a global health research and development observatory and the development of strategies for monitoring and collecting data on advances in, and obstacles to, health research and development. Given the importance of coordination and monitoring and of financial contributions to health research and development, he requested the Board to consider strengthening the wording of subparagraphs 4(5) and (6) of the draft resolution with a view to exploring coordination and funding strategies and fostering joint action. He requested the Board also to consider submitting the draft resolution to the Health Assembly in an open manner, in line with usual practice within WHO and the principles of democracy. The Health Assembly was WHO's supreme governing body and should be free to discuss whatever it liked.

Taking into account the need to ensure that discussions were conducted openly and that the actions expected of the Secretariat and Member States in the medium term were plainly stated, he proposed that subparagraph 4(7) should call on the Director-General to convene another open-ended meeting of Member States before the Sixty-eighth World Health Assembly in 2015. He hoped that

Member States would recognize that health research and development were crucial for equitable development and the well-being of individuals and communities.

Dr Ren Minghui took the Chair.

Ms DÁVILA CHÁVEZ (Mexico), welcoming the outcome of the open-ended meeting and endorsing the recommendation that the draft resolution should be forwarded to the Health Assembly for adoption, said that the agreements reached during the meeting represented a major step towards the implementation of an effective global strategy for accelerating research and development on neglected diseases. Some of the proposed areas for action were closely linked to activities to which Mexico was already committed, such as capacity building, technology transfer and manufacture of health products, as well as launching or strengthening national health research and development observatories. The agreements reached during the open-ended meeting would add value to her Government's policies and areas of work. It was to be hoped that they would also lead to exchanges of information and the creation of mechanisms for health technology assessment, application of results and generation of evidence for decision-taking and policy-making prioritizing research, as well as the formation of an early warning system that could identify new health technologies and products requiring further research before they were ready for marketing or for use in health systems. There was also a need to develop and finance applied health systems research on the management, effectiveness and social and financial impact of health interventions. She welcomed the proposals to establish a global health research and development observatory and to seek alternative funding sources.

Mr LIU Peilong (China) said that research financing and coordination mechanisms were undeniably important. He welcomed the report and supported submission of the draft resolution to the Health Assembly for adoption. However, he sought clarification of whether the proposal not to reopen discussion on the resolution referred to the Board or the Health Assembly. He was aware that the draft resolution was the result of arduous negotiations, but not all Member States had participated in the open-ended meeting. It was unusual for the Board to recommend that the Health Assembly adopt a resolution without further deliberation, and it might therefore be wise to allow it to decide for itself. Regarding the text itself, he proposed several friendly amendments, namely, that the words "and sharing" should be inserted between "monitoring" and "of relevant information" in subparagraph 2(3), and that "and share" should be inserted between "analyse" and "relevant information" in subparagraph 4(3). In addition, the words "and financing" should be inserted between "stakeholders" and "the implementation" in subparagraph 4(4).

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the report made it clear that current market mechanisms and publicly-funded research and development on the diseases that mainly affected developing countries were inadequate. As a result, many poor people were suffering and dying because they did not have access to health technologies, medicines, vaccines or effective diagnostic products. Neglected tropical diseases exemplified an area where funding for needed research was inadequate. A more energetic multilateral response was needed if the lives of millions of people were to be improved. The recommendations contained in the report could have a major impact on people living in developing countries and warranted serious consideration by all Member States, in particular the idea that their implementation should be monitored. He supported implementation of all the actions called for in the report in order to promote research and development, technology transfer and capacity building in developing countries and ensure the availability of affordable, high-quality medicines. He also supported the establishment of a global health research and development observatory and of mechanisms for setting research and development priorities.

He agreed with the members for Ecuador and China that the draft resolution should be discussed by all Member States during the Health Assembly. Such a discussion could enrich its content.

Mr HAZIM (Morocco) observed that, in operative paragraph 1 of the draft resolution, the Health Assembly was being recommended to endorse a strategic work plan which, according to the same paragraph, required further development. Coordination and financing of research and development should occur first and foremost at country level, where, in many cases, numerous different institutions and sectors were involved and funding was insufficient. Operative paragraph 2 of the draft resolution should therefore be amended to include wording requesting Member States to undertake institutional reforms aimed at improving the coordination of research and development and ensuring sustainable financing. The global health research and development observatory called for in the draft resolution was to build on national observatories, which would first have to be established in countries that did not already have them, and a commitment made to support them. The draft resolution should be amended accordingly.

Dr St. John resumed the Chair.

Dr DAULAIRE (United States of America) said that at the heart of the current debate was a question of governance of the Organization and of the process through which important agreements were reached and maintained. All Member States had been invited to attend the open-ended meeting, which had taken place from 26 to 28 November 2012. A wide range of issues had been debated over many hours, and a consensus draft resolution had finally been agreed in the early hours of the morning of 29 November. The resolution had resulted from a series of compromises and trade-offs and represented a package of agreements. His delegation had accepted the resolution, although the text contained many provisions that had not been to its liking, as a means of advancing towards the ultimate goal of more and better research and development and investment in diseases affecting the poor. The recommendations made by the member for Ecuador would reopen part of the package. If that were allowed to occur, inevitably the whole package would be reopened. It was to avoid such an eventuality that the open-ended working group had agreed to submit the draft resolution for consideration with the recommendation that it should not be amended. That recommendation had been carefully considered and discussed; it was not unique in the annals of the Organization: the Pandemic Influenza Preparedness Framework, which had also involved a highly contentious set of issues, had been submitted to the Health Assembly on similar terms.

He sincerely hoped that Member States would adhere to the agreements reached. Otherwise, it was questionable whether it was worth the time and effort of senior officials to travel around the world in order to discuss a specific set of issues only to find their agreement tossed out because someone did not like part of it. It was an important question of governance for the Board and the Organization as a whole, and he urged the Board to accept the consensus resolution as originally proposed. He would not oppose the minor wording changes proposed by the member for China, but would not want any part of the hard-won agreement to be reopened.

Mr BURCI (Legal Counsel), responding to a request for guidance from the CHAIRMAN, said that, from a legal point of view, the draft resolution before the Board had resulted from resolution WHA65.22, which had requested the Director-General to hold an open-ended meeting of Member States on certain topics to develop proposals or options relating to the report of the Consultative Expert Working Group to be presented through the Executive Board to the Sixty-sixth World Health Assembly. The practice of organizing an intergovernmental process that subsequently reported to the Health Assembly through the Board had been followed in the past, and in such cases the Board could make comments and bring them to the attention of the Health Assembly. The outcome of the work of the open-ended meeting had been requested by the Health Assembly for its later consideration, and as the supreme governing body of WHO it was certainly free to reopen discussion on the matter. He questioned, however, whether the Board had the legal authority to amend the draft resolution. "Through the Executive Board" did not mean that the Board could reopen a matter that had been discussed by the Health Assembly and was being resubmitted for discussion at a future Health Assembly. In the past, that formulation had been interpreted to mean that the Board could make

comments and present them to the Health Assembly in order to facilitate the latter's discussion of the matter. The Board might wish to bear in mind that practice.

The DIRECTOR-GENERAL said that she shared the Legal Counsel's understanding of the situation: the open-ended meeting of Member States had been tasked to do work by the Health Assembly and was reporting back to the Health Assembly. If it had been agreed that the matter should not be reopened, then no amendments, not even minor ones, should be accepted. The total package should go forward to the Health Assembly, where the full membership of the Organization could examine and discuss what had been agreed by the open-ended meeting. However, as the Legal Counsel had said, the Board was free to express its opinions, and the Secretariat stood ready to provide any necessary support for the discussion.

The CHAIRMAN said that it was clear that the Health Assembly had commissioned a product that it would discuss. That product, the draft resolution, passed through the Board, but while the Board could comment on it and its comments would appear in the record and be forwarded to the Health Assembly, the Board could not amend the resolution.

With the Board's acquiescence, she would invite the Chairman of the open-ended meeting to take the floor. He might wish to summarize the process of reaching consensus and to suggest that members place their comments on record but refrain from making any change to the draft resolution.

Dr REN Minghui (China) suggested that any Board members who wished to speak should be allowed to do so before the Chairman of the open-ended meeting took the floor.

Dr VALVERDE (Panama), welcoming the report of the open-ended meeting of Member States, said that the matter under discussion represented a particular challenge for health systems in developing countries. The current paradigm should be discussed openly with a view to catalysing international cooperation and fostering progress in health research and innovation to meet the needs of poor populations. She supported the draft resolution and the workplan outlined therein. At the same time, she believed that there was a need to continue discussing the issues covered in the report of the Consultative Expert Working Group. Financial support and joint efforts would be crucial for carrying out the work outlined.

Dr REN Minghui (China) stated that he had no intention of reopening the discussion on the draft resolution, but asked for clarification as to whether it was going to be discussed by the Health Assembly. He would refrain from making any amendments in the current session provided that he would have the opportunity to do so in that forum. Member States had the right to speak during the Health Assembly and could not be prevented from doing so. He suggested that the Board might wish to consider submitting any proposed amendments to the Secretariat in order to facilitate discussion during the Health Assembly.

Dr VIROJ TANGCHAROENSATHIEN (Thailand),¹ speaking in his capacity as Chairman of the open-ended meeting of Member States on the follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination, said that he had noted the suggestion made by the member for Ecuador regarding subparagraph 4(7) and understood the concerns underlying the amendments suggested by the member for China, which had emphasized the importance of sharing information. He pointed out that the purpose of the global observatory would be to generate and share evidence, so implicitly the idea of sharing had been included. The member for the United States of America had explained the difficulties and long hours involved in reaching

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

consensus on a package deal. The Health Assembly, having been unable to come to a decision on the matter the previous year, had entrusted the open-ended meeting with the hard work of reaching consensus, the result being the draft resolution, which represented the best compromise that could be achieved and provided a solid foundation for future work. He urged the Board to honour the outcome of the work of the open-ended meeting and to heed the strong recommendation made in paragraph 6 of the report not to reopen discussion on the text of the draft resolution.

Mr REALINI (Monaco)¹ expressed satisfaction with the encouraging outcome of the work of the open-ended meeting of Member States, and supported the draft resolution, which he hoped would be adopted by consensus by the Sixty-sixth World Health Assembly. The compromise it represented had been hard won, and reopening the discussion could undermine the fragile balance achieved in the agreement. He therefore endorsed the views expressed by the member for the United States of America and the explanations provided by the Legal Counsel and the Director-General.

Monaco supported research and development and provided funding for numerous projects aimed at combating diseases mainly affecting developing countries, including malaria, sickle-cell anaemia and bilharziasis. It would continue promoting research and development related to Type 1 and Type 2 diseases.

Dr MAKUBALO (South Africa)¹ said that the work of the Consultative Expert Working Group and the draft resolution would have far-reaching implications for making products available at affordable prices, as well as for improving the functioning of regulatory and research systems in order to facilitate technology transfer and training – the ultimate aim being to address health conditions in low-resource countries, including many of the diseases discussed by the Board during the current session. The draft resolution had been arrived at after lengthy consultations, and she was pleased that finally there was a basis for concrete action to improve the quality of life of millions of people in developing countries. That action should begin as soon as possible. She supported the recommendation that the draft resolution should be submitted to the Health Assembly for adoption and urged that WHO and other parties ensure that adequate resources were made available for its implementation.

Dr VALLEJO (Ecuador) said that the functioning of the Organization was at issue, and wished to ensure that the position of the Union of South American Nations was clearly understood. The Union was aware of the work that had been done, the progress made and the work proposed for the future, given the importance of coordination and monitoring, but he nevertheless requested the Board to consider strengthening the wording of subparagraphs 4(5) and (6) with a view to exploring coordination and funding strategies and fostering joint action. In addition, the Union wished to propose that the open-ended meeting called for in subparagraph 4(7) should be convened in 2015 rather than in 2016. The Union was in agreement with most of the text; it merely wished to strengthen some aspects of it. He pointed out that the Board would not be able to prevent a Member State reopening the discussion when the draft resolution was taken up by the Health Assembly. In the meantime, he acknowledged the need to reach agreement.

Mr ROSARES LOZADA (Plurinational State of Bolivia),¹ noting that his country's Constitution guaranteed its people access to medicines, said that his delegation had been involved in all work on the matters under discussion. The Consultative Expert Working Group had prepared a detailed analysis of the problems facing developing countries as a result of inadequate financing for health research and development and limited access to medicines for diseases that disproportionately affected developing countries. Existing, market-based approaches were not working and practicable

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

solutions were therefore needed. The actions proposed in the draft resolution were the result of difficult negotiations and were not as ambitious as he would have hoped. However, the draft resolution was a first step in an ongoing process. As proposed by the member for Ecuador, it should be evaluated at another open-ended meeting in 2015 with a view to strengthening efforts and launching new actions.

With regard to the pilot projects mentioned in subparagraph 2(5), priority should be given to the approaches deemed by the Consultative Expert Working Group to be the most feasible, such as milestone prizes and open collaboration approaches. The pilot projects should be guided by the principles identified by the Consultative Expert Working Group, namely, promotion of open-source innovation, consideration of research outcomes as public goods that could be used freely in other research, delinking of research costs from medicine prices, strengthening of research capacity in developing countries, monitoring of transparency in financing, and the circulation of clinical data in order to avoid their improper use. They should also explore new approaches to research that provided a sound alternative to market-based approaches.

He endorsed the views expressed by the members for China and Ecuador about the issue of reopening the discussion of the draft resolution and suggested that the legal implications of the recommendation by Member States at their open-ended meeting (document EB132/21, Annex, paragraph 6) should be carefully considered. The text to be submitted to the Health Assembly should be left open, and any Member State that so wished should be able to reopen the discussion.

Dr DAULAIRE (United States of America) said that he had noted with interest that the member for Ecuador had requested the convening of an open-ended meeting of Member States in 2015. However, if the outcome of the open-ended meeting that had taken place in November 2012 was to be reopened by the Board, there seemed little point in holding any further such meetings. Member States entered into negotiations openly and in good faith with the understanding that if an agreement were reached it would be respected. Hence, the Board had a clear choice to make: it could either accept the draft resolution and the report of the open-ended meeting or reject them and send nothing forward to the Health Assembly. It should be clearly understood that, if governance processes were to be maintained within WHO, they must be respected.

Ms STIRØ (Norway) said that her Government attached great importance to the matter under discussion. The compromise that had emerged from the open-ended meeting, in which her delegation had participated, had been difficult to reach and should be honoured. The open-ended meeting had been tasked with finding a way forward, which it had done, and the outcome of the negotiations should be forwarded to the Health Assembly. The Board's current discussion would be reflected in the report accompanying the draft resolution, but the latter should not be amended nor should discussion on the package deal agreed be reopened.

Mr MIŠKINIS (Lithuania), speaking on behalf of the European Union and its Member States, supported the views expressed by the members for the United States of America and Norway.

Mr TARIGAN (Indonesia)¹ commended the leadership of Dr Viroj Tangcharoensathien in chairing the open-ended meeting of Member States. Current research and development programmes and activities for addressing various global health issues, in particular health problems faced by developing countries, were insufficient. Many stakeholders and partners, particularly in the private sector, involved in the production of medicines had little interest in investing in such activities owing to a lack of incentives. Therefore, he strongly supported the efforts of the Consultative Expert Working Group to find new solutions to improve research and development activities in the health

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

sector. In particular, capacity building in, and technology transfer to, developing countries needed to be enhanced through joint agendas and priority setting. He supported efforts to strengthen global coordination in health research and development. Delinking of research and development costs from the price of medicines was essential, as were open approaches to research, development and innovation. Indonesia had already initiated several measures for implementing such approaches. A legally binding mechanism would be important for securing continued funding for research and development activities and he supported the idea of pooled funding at the global level. He also supported the establishment of a global health research and development observatory, as proposed in subparagraph 4(3) of the draft resolution.

Dr VALENTIN (Seychelles), speaking on behalf of the Member States of the African Region, said that the matter had been extensively discussed and consensus reached and, therefore, negotiations should not be reopened.

Ms PENEVEYRE (Switzerland) supported submitting the draft resolution to the Health Assembly for adoption without reopening it. The fact that it would be discussed by the Health Assembly safeguarded the sovereignty of Member States. Furthermore, as stated by the member for Norway, the views of Board members would be reflected in the record of the current meeting.

Professor HALTON (Australia) said that the issue was obviously a difficult one about which delegations felt strongly. It had been discussed extensively and in good faith at the national, regional and global levels, and the Board should give careful thought to how much time and energy should be spent continuing to debate it, bearing in mind that reopening discussion or launching additional international processes would not necessarily yield a better outcome and would only delay constructive action. She therefore supported the views expressed by the member for the United States of America and others on the need to move forward.

The DIRECTOR-GENERAL expressed the hope that the Board would accept that all views would be reflected in the record, but that the whole package negotiated by the open-ended meeting would go forward to the Health Assembly, which was the forum in which all 194 Member States could express their opinions. The Board could then continue with the rest of its work.

Mr PIPPO (Argentina),¹ highlighting the role of research and development in ensuring equitable access to medicines for diseases that disproportionately affected developing countries, observed that current mechanisms for fostering research and development were underpinned by competitive systems oriented towards monopolizing revenues. When profits were insufficient, commercial interest waned, leading to a dearth of research and new medicines. That problem had been acknowledged in several reports, including that of the Consultative Expert Working Group.

The draft resolution reflected the hard-won consensus that had been reached on some issues and in that sense it represented progress in the discussion on the issue. Nevertheless, he supported the position of the Union of South American Nations and the view expressed by the members for the Plurinational State of Bolivia, China and Indonesia. Consensus had been reached only in some areas and therefore the draft resolution provided only a partial solution, not a definitive response to the problem. Further discussions among Member States were needed in order to reach a final and definitive agreement. He was confident that progress could be made on matters relating to coordination and prioritization of research and development. The decision to establish a global health research and development observatory and the willingness to consider alternative approaches as recommended by the Consultative Expert Working Group showed that progress could be made. However, in order to reach a sustainable solution, Member States needed to continue holding formal discussions before 2015. He could not support the recommendation in paragraph 6 of the report of the open-ended meeting (document EB132/21, Annex) that the Board consider the draft resolution without

reopening it. Those delegations that had not participated in the discussions should have the opportunity to express their views in governing body meetings.

Dr HORI (Japan) supported the draft resolution and endorsed the views that the discussion should not be reopened. The hard-won consensus and the package deal produced by the open-ended meeting should be honoured. Increasing the resources for combating diseases predominantly affecting developing countries had been a key challenge for decades and much work remained to be done. The draft resolution represented a solid first step. He hoped it would be submitted to the Health Assembly without any modification.

Ms DÁVILA CHÁVEZ (Mexico) affirmed that the consensus reached during the open-ended meeting should be respected. As the representative of South Africa had pointed out, the draft resolution should be seen as the first step in an ongoing process. It was the Board's responsibility to transmit it to the Organization's supreme governing body, the Health Assembly, for further discussion in May.

Ms CHILDS (Médecins Sans Frontières International), speaking at the invitation of the CHAIRMAN, said that the report and draft resolution were disappointing. Member States were being asked to pass on, unopened, a weak resolution that was unlikely to change anything. The few elements in the text that could lead to concrete results needed clarification if they were to produce the desired results. For example, it should be clearly stated that the functions of the proposed health research and development observatory were to identify current and needed research and development and to engage Member States and experts in determining research and development priorities. The demonstration projects called for in the resolution could lead to new and improved financing mechanisms, but they must be used to implement key principles outlined in the report of the Consultative Expert Working Group, particularly that of delinkage. Even with those clarifications, however, the resolution would still be insufficient to address global research and development challenges. A more sustainable solution, in the form of a global research and development framework driven by Member States, was needed.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that the outcomes of the open-ended meeting demonstrated Member States' long-term commitment to address the shortcomings of the current innovation paradigm and to deliver tangible outputs. To that end, a mix of vision and pragmatism was needed. A systematic review of unmet research and development needs should be undertaken in order to gain a clear picture of gaps and priorities, which was essential if they were to be addressed. The establishment of a global health research and development observatory would be a useful means of identifying unmet needs. The members of his organization were currently engaged in research on Type 2 and Type 3 diseases, much of it collaborative, and stood ready to provide expertise in order to achieve the shared goals of facilitating innovation and access to medicines.

Ms DI GIROLAMO (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, noted that the report of the Consultative Expert Working Group had explicitly linked innovation in health research and development to the need for affordable access to the outcomes of such innovation. Its recommendations offered a paradigm shift in the form of a legally binding instrument to meet the unmet research and development needs of developing countries. The draft resolution represented a piecemeal approach to those recommendations and indeed seemed to ignore many of them. It did not clearly reflect the link between priorities, financing, coordination and access or key objectives and principles for ensuring innovation and access, nor did it conceive of the outcomes of publically funded research and development as global public goods. It was also unclear whether in the pilot projects the cost of research and development would be delinked from product prices. The recommendation in

paragraph 6 of the annex to document EB132/21 was worrying as it could prevent Member States from exercising their rights under WHO's Constitution.

Mr BALASUBRAMANIAM (Stichting Health Action International), speaking at the invitation of the CHAIRMAN, said that the draft resolution was disappointing for its lack of ambition and concrete commitments. It was indeed worrying that paragraph 6 of the open-ended meeting's report recommended adoption of the draft resolution by the Health Assembly without reopening it, particularly as it had been adopted in the early hours of the morning when representatives of only 25 Member States remained present and interpretation services had ended. A draft resolution adopted under those circumstances should not include such a far-reaching recommendation to the Board.

The only concrete commitment in the draft resolution was the call to establish a global health research and development observatory, which was a positive step. However, the mandate and structure of the observatory remained unclear. It should be made plain that it would perform two critical functions: mapping existing research and development resources and identifying priority areas in which research and development were needed. Furthermore, the draft resolution committed Member States to undertaking demonstration projects without providing further details. The report of the Consultative Expert Working Group had put forward key principles that should govern research and development in the public interest based on the concept of delinkage. The Working Group had evaluated and recommended five concrete proposals incorporating those principles. Those proposals should be operationalized through the pilot projects. The draft resolution did not adequately address the failings of the current research and development system or take account of the recommendations made by the Consultative Expert Working Group. He therefore urged the Board to reject the recommendation that the Health Assembly should adopt the resolution without reopening it so that a full discussion could take place within that forum.

The CHAIRMAN said that, in the absence of any further comments, she would take it that the Board wished to note the report. The comments made by Member States would be brought to the attention of the Sixty-sixth World Health Assembly.

The Board noted the report.

The meeting rose at 17:30.

TWELFTH MEETING

Saturday, 26 January 2013, at 09:40

Chairman: Dr J. ST. JOHN (Barbados)
later: Dr A. JAMSHEED MOHAMED (Maldives)

1. FINANCIAL MATTERS: Item 12 of the Agenda

Scale of assessments for 2014–2015: Item 12.1 of the Agenda (Documents EB132/28 and EB132/28 Add.1)

Dr THABET NASHER (Yemen), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, summarized the Committee's deliberations on the item (document EB132/43, paragraphs 27–33). The Committee had recommended that the Board propose that the Sixty-sixth World Health Assembly adopt the proposed scale of assessments (document EB132/28). Following consideration of the report on foreign exchange risk management (document EB132/28 Add.1), the Committee had recommended that the Board take account of the points that the Committee had raised in its discussion and that the Board consider whether to propose a draft resolution in respect of the currency of contributions (paragraph 8 of the report) for submission to the Sixty-sixth World Health Assembly.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) supported the proposal that some voluntary contributions should be paid in Swiss francs, as that would help to improve the Organization's finances. The United States dollar had depreciated by 34% over the previous decade and the Organization had incurred losses on that account. It was therefore reasonable to call for 50% of assessed contributions to be paid in Swiss francs.

Mr HAZIM (Morocco) said that the use of two different currencies for income and expenditure had led to a significant funding shortfall at a difficult time. The Organization should not seek a partial solution. Inviting Member States to pay half their assessed contributions in United States dollars and half in Swiss francs could expose them to increased currency risks and other complications. Instead of passing the problem on to Member States, account should be taken of the call for an overall solution made by the Independent Expert Oversight Advisory Committee. Recommending that the Health Assembly consider a resolution to denominate the programme budget and assessed contributions in Swiss francs would be the only way to guard against future risks. Finance ministers should also be consulted on the issue.

Dr REN Minghui (China) noted that China's assessed contribution had increased from 3.189% to 5.148%, making it the sixth largest contributor, despite United Nations reports identifying China as having more than 200 million poor people and putting it in 189th place in the poverty rankings. However, China would continue to support the United Nations and WHO in their leading role in the health sector and in strengthening national health systems, and had accordingly approved its assessed contribution for the biennium 2014–2015 and would endeavour to make additional voluntary contributions. He urged those States with reduced assessed contributions to make supplementary voluntary contributions.

Following careful analysis, he supported the Director-General's recommendation that 50% of assessed contributions be made in Swiss francs and 50% in United States dollars. In addition, he

proposed that the Secretariat circulate a questionnaire to Member States to determine their intentions with regard to split assessments, so that the Secretariat could better predict and manage exchange rate risks.

Ms BLACKWOOD (United States of America), recalling the full discussion during the previous week's meeting of the Programme, Budget and Administration Committee, agreed with the Director-General's split assessment proposal, which would help to reduce long-term currency exposure risks and mitigate the impact on those countries whose currencies closely tracked the United States dollar. She further recalled that the Committee had recommended that a draft resolution be prepared for submission to the Health Assembly, but Member States had not yet seen any such document. She asked how the Secretariat intended to proceed in that regard.

Professor HALTON (Australia) supported the outcome of the most recent meeting of the Programme, Budget and Administration Committee, noting that the Swiss franc was the fifth most traded currency worldwide. She too requested clarification about the text of the proposed draft resolution.

Dr MYINT HTWE (Myanmar) supported the Director-General's proposal and the proposal by the member for China. He encouraged the Board to consider the long-term perspective so as to avoid having to make repeated currency changes in the future.

Mr CORRALES HIDALGO (Panama) supported the conclusions of the Programme, Budget and Administration Committee and the proposed equal split in assessed contributions between Swiss francs and United States dollars as a way to mitigate the adverse impact of foreign exchange fluctuations. He also agreed to the application of the United Nations scale of assessments for the financial period 2014–2015. He also asked to see the text of the proposed draft resolution.

The CHAIRMAN, speaking in her capacity as the member for Barbados, said that, for small countries like hers, the split assessment would represent a considerable burden. Recalling that the idea of a threshold below which the split would not apply had been discussed by the Programme, Budget and Administration Committee, she emphasized that the draft resolution would have to specify all the details of any change. She also agreed with the member for Myanmar that the Board should give consideration to the long-term perspective.

Ms LANTERI (Monaco)¹ agreed with the Chairman. The split assessment would not be impossible for Monaco but could cause administrative problems in the national accounting system as one amount could appear as two mandatory contributions for the same organization in the same year. It was to be hoped that the text of the proposed draft resolution would provide clarification. As it appeared that the exchange rate risk was being passed on to Member States, she asked the Secretariat to look into the practice of other organizations in the United Nations system and private companies with a similar financing situation that had managed to limit long-term risks. She also noted that Member States that used the euro were at a disadvantage, owing to its recent depreciation.

She agreed with the scale of assessments for the biennium 2014–2015, while regretting that Monaco's assessment had increased by 300%.

The DIRECTOR-GENERAL said that there was no intention to shift the currency risk burden to Member States; rather, it was to be hoped that Member States could work with the Secretariat to manage the risk collectively, taking into account the Independent Expert Oversight Advisory Committee's recommendation to adopt a risk management culture and its advice to seek solutions for

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

the immediate, medium and long term. The split assessment proposal was designed not to make money but in the interest of fairness; the situation could be reassessed should there be significant changes in the value of the currencies involved.

The proposed draft resolution had not yet been prepared because the Secretariat had been waiting to take account of guidance from the Board. A draft resolution would be presented to the Programme, Budget and Administration Committee in May 2013, following further consideration of administrative arrangements, and of a minimum threshold for the split assessment. She thanked those Member States that made large contributions for bearing the burden of the change.

The CHAIRMAN took it that the Board wished to take note of the report. The Secretariat would be guided by the comments of the Board on foreign exchange risk management in preparing a revised report for the consideration of the Programme, Budget and Administration Committee before the Sixty-sixth World Health Assembly.

The Board noted the report.

The CHAIRMAN said that, in the absence of any objection, she took it that the Board wished to adopt the draft resolution on the scale of assessments 2014-2015 contained in document EB132/28.

The resolution was adopted.¹

2. MANAGEMENT MATTERS: Item 13 of the Agenda

Follow-up of the report of the Working Group on the Election of the Director-General of the World Health Organization: Item 13.1 of the Agenda (Document EB132/29)

The CHAIRMAN recalled that the Sixty-fifth World Health Assembly, in resolution WHA65.15, had decided to revise the process for the nomination and appointment of the Director-General. The Health Assembly had requested the Director-General to propose to the Board amendments to its Rules of Procedure. As the report prepared by the Secretariat contained specific proposals, she suggested that it should be considered section by section. Depending on the final outcome of the discussion, the Board might request the Secretariat to prepare a draft resolution for its consideration.

Mr BURCI (Legal Counsel) recalled that the Executive Board had begun its review of the process for the nomination and appointment of the Director-General at its 128th session. The Working Group on the Process and Methods of the Election of the Director-General of the World Health Organization that it decided to establish had held three sessions and had considered the overarching principles that should guide the nomination, election and appointment of the Director-General. After considering the report of the Working Group, the Health Assembly had adopted resolution WHA65.15, in which it had decided that due regard should be paid to the principle of equitable geographical representation and that, unless there were exceptional circumstances, the Executive Board should nominate three candidates for the Health Assembly's consideration. The Health Assembly had also revised the criteria that nominated candidates should fulfil. The Board was being asked to consider the following elements that the Secretariat had been requested to prepare: a draft code of conduct, a candidates' forum, tools to enhance the screening of candidates by the Executive Board, and amendments to the Rules of Procedure of both the Executive Board and the World Health Assembly in order to implement resolution WHA65.15.

¹ Resolution EB132.R6.

Code of conduct

Mr BURCI (Legal Counsel) said that the Joint Inspection Unit of the United Nations system had recommended that all organizations in that system adopt a code of conduct to establish best practices for the nomination and election of their executive heads. As no code of conduct currently existed for the election of executive heads in other organizations, the Working Group had drawn on national codes and other similar documents. A draft code of conduct, based on the Code of Conduct for the Nomination of the Regional Director of the Western Pacific Region of the World Health Organization, adopted by the regional committee in 2012, was contained in Annex 1 to the report. It was a non-binding code reflecting a political understanding of ethical principles and best practices for the process as a whole, with particular regard to the election campaign.

Mr McIFF (United States of America), speaking on behalf of the Member States of the Region of the Americas, welcomed the good progress made on the draft code of conduct for the election of a Director-General, particularly the clear rules regarding internal candidates, which reflected decisions taken by PAHO. He appreciated the potential benefit of the proposed candidates' forum, particularly if option (1) set out in paragraph 11 of the report were adopted, namely holding the forum two months in advance of the nomination by the Board, under a procedure similar to that used by ILO. The forum should promote participation and engagement by as many Member States as possible. He supported the proposals to amend the Rules of Procedure of the Executive Board and World Health Assembly, in line with the approach advocated in paragraph 27 of the report, and agreed with the proposal to consider the introduction of electronic voting. The core principles of the process, such as holding the election by secret ballot, should be protected.

Ms STIRØ (Norway), speaking on behalf of the Member States of the European Region, welcomed the proposals on a code of conduct, a candidates' forum and a standard form for the curriculum vitae of candidates, and agreed to the proposed amendments to the Rules of Procedure of the Executive Board and the World Health Assembly. She supported the proposal to investigate electronic voting and its associated costs, on the understanding that the Board and the Health Assembly would continue to come to a decision by secret ballot, as provided in Rule 52 and Rule 108 of their respective Rules of Procedure. She welcomed the idea of a single document on the overall election process, and said that the Board's comments on the proposals in the report should be reflected in a draft resolution that should be circulated before the end of the current session.

Dr VALENTIN (Seychelles), speaking on behalf of the Member States of the African Region and welcoming the report and the proposals therein, underlined the need to implement fully resolution WHA65.15. Referring to the revised criteria to be fulfilled by candidates for the post of Director-General set out in that resolution, he expressed concern that the proposed tools to enhance the application of the revised criteria made no reference to the application of the principle of equitable geographical representation. Given the value that his Region attached to that principle, he requested the Secretariat to prepare a concrete proposal on how its application could be facilitated.

The draft code of conduct, the adoption of which he supported, covered all the ethical issues raised by the Working Group and contained the principle of equitable geographical representation, but he asked how candidates would be expected to enforce that provision.

Professor HALTON (Australia) fully supported the draft code of conduct, noting that it was modelled on the adopted Code of Conduct for the Nomination of the Regional Director of the Western Pacific Region.

Mr BURCI (Legal Counsel) said that, regarding the concern expressed by the member for Seychelles, the Secretariat would welcome specific suggestions on how to address the issue of equitable geographical representation as part of the criteria.

Candidates' forum

Mr BURCI (Legal Counsel) recalled that the candidates' forum established by the Regional Committee for the Americas provided an in-house precedent, and the Working Group had also drawn on the experience of ILO and WIPO. As the Working Group had not had sufficient time to reach consensus on specific issues, the report by the Director-General contained options on timing, duration, format, the interactive process for questions and answers, participation, documentation and expected outcome. The Secretariat sought the Board's guidance.

Professor HALTON (Australia), recalling her experience of the process leading up to the election of the current Director-General, welcomed as prudent the proposal to allow two months or so between the Member States' interaction with the candidates and the actual election, and noted that the candidates' forum would ensure more equitable access to the candidates. Referring to the options for the process for questions and answers (paragraph 16 of the report), she strongly opposed the use of pre-set questions, which would allow candidates to prepare scripted answers and would not provide an indication of their ability to think on their feet. Furthermore, individual Member States, not just regional groups, should be allowed to ask questions, as the forum might be the only opportunity for some States to have access to the candidates.

Dr VALENTIN (Seychelles), speaking on behalf of the Member States of the African Region, supported the holding of the candidates' forum immediately before the Board's session (paragraph 11, option (2)), but said that the forum must remain discrete from the Board. With regard to the format of the forum, option (3) in paragraph 14 – allotting each candidate a certain amount of time for a presentation followed by a single question-and-answer session for all candidates – would provide maximum transparency and an opportunity to compare the candidates. A statement of the date, venue and participants would suffice as a record of the forum.

Dr AL-MARRI (Qatar) agreed with the member for Australia that candidates for the post of Director-General should be asked impromptu questions. The forum was not a school test in which candidates were asked to reply to questions placed in front of them. Candidates must have sufficient experience; if they were not already familiar with the work of the Organization, then they were unqualified for the position.

Dr REN Minghui (China) recognized the value of holding a dialogue with the candidates; allowing Member States to ask questions would enable them to gain a better understanding of their capacity and unique characteristics. Option (1) for the timing of the forum would provide more time for Member States to consult on the candidates before the nomination by the Board. Regarding the process for questions and answers, he considered that questions from any Member State should be allowed in order to ensure that the forum did not follow the same procedure as a formal Executive Board interview. A webcast in all the United Nations languages would ensure that Member States not represented on the Board could fully participate in the forum, ensuring broader coverage.

Mr McIFF (United States of America) supported the comments made by the member for Australia. The procedures for the candidates' forum should differ from those of the existing Executive Board interviews, so as to maximize engagement of Member States in the best and fairest way possible. He therefore favoured allowing individual Member States, not just regional groups, to pose questions. If there were to be any report or outcome document, it should take into account the stand-alone nature of the event, as noted by the member for Seychelles.

Ms STIRØ (Norway) said that the candidates' forum would be an important element of the new nomination and election process. With regard to its timing, she supported the option of holding the forum two months in advance of the nomination by the Board. Its duration would depend on the number of candidates, as there should be sufficient time for all questions to be answered and for

Member States to form an impression of the candidates. The forum should be open to all Member States and documentation should be provided in the form of the curricula vitae of the candidates. She agreed that the forum should be chaired by the Chairman of the Executive Board, and that a bureau should be tasked with finalizing the details, depending on the number of candidates.

Mr ASAOLU (Nigeria), emphasizing the importance of transparency, equity and equitable geographical representation in the nomination and election of the Director-General, supported option (2) for the timing of the candidates' forum.

Tools to enhance the effective application of the criteria for the nominated candidates; proposed amendments to the Rules of Procedure of the Executive Board

Mr BURCI (Legal Counsel) recalled that the Working Group had concluded that the initial screening of candidates by the Board under Rule 52 of its Rules of Procedure tended to be superficial, primarily because the Board lacked the necessary information to help it to decide whether candidates met the relevant criteria. The discussions of the Working Group revealed a desire for more information but also the fact that, as candidates' curricula vitae were presented by Member States as part of an intergovernmental process, not by the candidates themselves in an individual capacity, the sovereignty of Member States should be respected. Therefore, the Secretariat proposed that a standard form be introduced for the curriculum vitae or a questionnaire be used in addition to the curriculum vitae, so as to facilitate a comparative assessment of the candidatures; that tool was already used by some regional committees.

Turning to the proposed amendments to the Rules of Procedure of the Executive Board, he said that Rule 52 needed to be amended because of the decision taken by the Health Assembly that, henceforth, the Board would nominate three candidates to the Health Assembly instead of one. The proposed amendments were contained in Annex 5 to the report and explained in paragraphs 27–31 of the same document. The Health Assembly had decided that existing procedures, such as shortlisting, interviewing and secret ballot, should be maintained. The report proposed modalities to be followed in the voting until three candidates remained. The proposed rule change in Annex 5 also reflected option (1) of the two options on the timing of the candidates' forum, which would require a change in the calendar and therefore a change in the deadlines set by the Rules of Procedure, whereas option (2) would not.

Dr REN Minghui (China) supported the proposed consideration of electronic voting, in line with what was being used in ILO.

Dr VALENTIN (Seychelles), speaking on behalf of the Member States of the African Region and supported by Dr AL-MARRI (Qatar), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that he recommended the use of both the standardized curriculum vitae and a questionnaire to facilitate the Board's assessment of the candidates. Those tools were effective in assessing professional qualifications and ensuring gender balance, but they would not guarantee observance of the principle of equitable geographical representation, and he requested the Secretariat to develop a tool that respected that principle.

The revised criteria for assessing candidates rested on three pillars, namely, professional qualifications and integrity, equitable geographical representation, and gender balance, as set out in resolution WHA65.15, paragraph 1(f). He therefore proposed amending paragraph 6 of Rule 52 of the Board's Rules of Procedure (document EB132/29, Annex 5) to read "The Board shall decide, by a mechanism to be determined by it, paying due regard to equitable geographical representation and gender balance, on a short list of candidates."

Mr McIFF (United States) agreed with the spirit of the amendment proposed by the member for Seychelles but averred that it would need further analysis. Under the amendments proposed by the Secretariat, Board members would be aware of the region of origin of each candidate, and it was not clear what contribution the proposed amendment would make to the screening process.

Professor HALTON (Australia) agreed that the three pillars of professional merit, equitable geographical representation and gender balance were important. Having all the proposed rule changes together in a single document would facilitate their analysis. She wondered how the proposal by the member for Seychelles for the creation of a “tool” could be implemented without placing limitations on the action of the Board.

Ms LANTERI (Monaco)¹ agreed with the comments made by the members for the United States of America and Australia; a comprehensive document setting out all the selection criteria agreed upon by the Board could serve as a manual for the election process.

Mr OSEI (Ghana)¹ said that the amendment proposed by the member for Seychelles was based on resolution WHA65.15, which unambiguously mandated the Secretariat to ensure the use of the revised criteria for the nomination of candidates. The proposed standard form for curriculum vitae (document EB132/29, Annex 4) adequately sought evidence of the principles of professional integrity and competence and gender balance, but would not assist the Board in implementing the principle of equitable geographical representation. He would seek advice from his capital regarding the nature of the tool to be adopted for that purpose.

The CHAIRMAN emphasized that more guidance was needed from Member States before a tool could be created to promote equitable geographical representation.

Proposed amendments to the Rules of Procedure of the World Health Assembly

Mr BURCI (Legal Counsel) recalled that the Health Assembly had decided that the Director-General should be appointed by a clear and strong majority. There needed to be a change in the Rules of Procedure to implement that decision, particularly as there were to be three candidates nominated by the Board. The challenge was to obtain a clear and strong majority while avoiding a deadlock if no candidate received such a majority. The proposed solution was to apply a sliding majority, starting from a high majority of two thirds in the first ballot if there were three candidates, and moving to a progressively lower majority if there were a deadlock in the subsequent ballots and possibly a vote by simple majority as a last resort.

The CHAIRMAN emphasized that, if there were no clear majority, there would still have to be an appointment, and she encouraged the Board to consider a practical proposal.

Professor HALTON (Australia) supported the proposal for a sliding majority. There was a need to be practical if a single candidate were to be elected from the three nominees. Although a clear and strong majority was preferable, fifty plus one was still a majority.

Dr REN Minghui (China), recalling previous experience in other organizations where voting procedures had not led to a result, supported the proposal that had been explained by the Legal Counsel.

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

Dr VALENTIN (Seychelles) proposed adding a Rule 70*bis* to the Rules of Procedure of the World Health Assembly, which would read “The Director-General of the World Health Organization shall be elected by a clear and strong majority of members present and voting.” In addition, all references to “two-thirds majority” in the proposed amendment to Rule 108 should be replaced by “clear and strong majority”.

He emphasized that the initial screening of candidates should be maintained, and any amendments to the Rules of Procedure of the Executive Board should also maintain the references to the shortlisting, voting and interviewing of candidates.

Professor HALTON (Australia), supported by Ms LANTERI (Monaco),¹ sought clarification from the Legal Counsel as to how the requirement of a “clear and strong majority” could be implemented.

Mr ASAOLU (Nigeria) reminded the Board that, although it might be difficult to find a definition for “clear and strong majority”, resolution WHA65.15 contained that wording, with no reference to a two-thirds majority. He therefore supported the amendment proposed by the member for Seychelles.

Mr OSEI (Ghana)¹ agreed with the comments by the member for Nigeria. The Health Assembly had decided upon the need for a “clear and strong majority”, and the Executive Board did not have the mandate to reopen the discussion of that language. It should be left to the Health Assembly, as the plenary body of the Organization, to decide on its meaning on the day of the election.

Mr McIFF (United States of America) agreed with the two previous speakers that it was necessary to give effect to resolution WHA65.15. However the term “clear and strong majority” had been a matter of intense discussion in the Health Assembly. The Secretariat’s proposal, as outlined by the Legal Counsel, provided a practical means to give effect to that language. He agreed with the member for China that Member States needed to be able to elect a Director-General whom they could all support; the proposal for a sliding majority was therefore sensible. He did not support the proposal of the member for Seychelles as it would add confusion to the process.

Dr AL-MARRI (Qatar), speaking on behalf of the Member States of the Eastern Mediterranean Region, expressed support for the amendments proposed by the member for Seychelles.

Professor HALTON (Australia) said that the Board needed to focus its discussion on how to give practical effect to the intent of resolution WHA65.15. It was true that the resolution referred to the need for a “clear and strong majority”, but regardless of whether Board members liked the Secretariat’s proposal, their task was to establish an unambiguous rule. The proposal by the member for Seychelles could leave the Organization paralysed if there were no clear outcome to the election of a Director-General. WHO should learn from the experiences and practices of other organizations in order to avoid deadlock.

The DIRECTOR-GENERAL said that a lack of clarity in the relevant Rules of Procedure could give rise to lengthy debate and a divisive deadlock on the day of an election. Clear guidance was therefore needed from Board members on how to operationalize the concept of a “clear and strong majority”. That meant that the required majority should be quantified in percentage terms. She requested clarification from the Member States of the African Region of the rationale behind its proposal.

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

Ms STIRØ (Norway) said that the amendments proposed by the Secretariat were a sensible and practical interpretation of the term “clear and strong majority”. The proposed text also established clear procedures to be followed no matter what circumstance arose in the election of a Director-General.

Ms LANTERI (Monaco)¹ said that the election of a Director-General was fundamental for the Organization. Monaco strongly supported resolution WHA65.15. If WHO was to remain a strong organization, any person elected to lead it needed a definitive majority and enough support for their legitimacy not to be called into question. The Secretariat had been asked to operationalize that aspiration and the proposal put forward was based on a combination of current practices at WHO and those of other organizations. She supported the process proposed in the report, which was reasonable and would give full legitimacy to the election of a Director-General.

Ms SY (Senegal), wanting to clarify the intention of the amendment proposed by the member for Seychelles, said that, as the Secretariat had proposed to remove the reference to the election of the Director-General in Rule 70, the purpose of the proposed new Rule 70*bis* was to ensure that the Rules of Procedure of the World Health Assembly contained a clear reference to the need to elect a Director-General with a clear and strong majority. That proposal did not detract from the Region’s support for the amendments put forward by the Secretariat but was intended to give practical effect to the term “clear and strong majority”. She added that the proposal was not intended to replace the Secretariat’s proposed amendments to the Rules of Procedure of the World Health Assembly but to add to and strengthen them.

Mr McIFF (United States of America), welcoming the clarification provided by the member for Senegal, noted the broad support among Board members for the proposed changes to Rule 108, which reflected the recognition among all regions that the status quo, i.e. a simple two-thirds majority, was no longer appropriate. A two-thirds majority would remain the desired objective, but the proposed new Rule set out clear procedures to be followed in the event that such a majority could not be achieved.

Ms STIRØ (Norway) said that she was willing to consider the addition of the proposed new Rule 70*bis*, on the understanding that the wording of Rule 108 proposed by the Secretariat would not be further amended. She suggested that the new Rule 70*bis* should include a reference to Rule 108.

Ms OSUNDWA (Kenya)¹ said that the implementation of any resolution needed to be consistent with its wording; much time had been spent coming to an agreement on the phrase “clear and strong majority” and, rather than reopen discussions on what it meant, further negotiations should be undertaken at the Sixty-sixth World Health Assembly, as by that time governments would have been able to provide further guidance on the matter.

Mr OSEI (Ghana)¹ said that it would not be desirable for the Health Assembly to have to define what was meant by a “clear and strong majority” on the day of an election, and for that reason the Board needed to come to an agreement on the matter. In his view, removing the reference to the election of a Director-General in Rule 70 meant that it was not viewed as a decision requiring a two-thirds majority, although he acknowledged that his interpretation might be incorrect. He underscored the need to quantify the proportion of votes needed under the proposed amendments, but pointed out that the reference to a two-thirds majority in the proposed amendment to Rule 108 seemed to reflect the status quo, inasmuch as a candidate who obtained a two-thirds majority in the first ballot would be elected. If a sliding scale was the preferred option, the reference to a two-thirds majority should be changed and another percentage should be agreed upon.

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

Professor HALTON (Australia) suggested that the Secretariat, in refining its proposals to the Health Assembly, should distinguish between the ideal of a two-thirds majority and a situation where a deadlock in voting must be resolved. A separate section could be drafted on the mechanism needed to break a deadlock.

Mr BURCI (Legal Counsel) noted the growing consensus that the issue could not be resolved by the Board at the current session and that members wanted more time to reflect on the different interpretations of the term “clear and strong majority” and on possible ways to give it operational effect in the Rules of Procedure. If the Board agreed, the current discussions could be reflected in a number of alternative proposals to be submitted to the Health Assembly by the Secretariat.

He clarified that it was proposed to delete the reference to the election of a Director-General in Rule 70 because that subject, together with the suggestion of a sliding scale, would be taken up in the proposed revised text of Rule 108. He noted that there was agreement on the need to capture the intended meaning of “clear and strong majority” as well as to avoid the risk of paralysis over such an important matter. The Secretariat would conduct further work on those points for the submission of proposals to the Sixty-sixth World Health Assembly.

The CHAIRMAN drew attention to the suggested action to be taken by the Board in relation to the two general points on which action by the Board was requested (paragraph 38 of the report).

Mr BURCI (Legal Counsel), outlining the two points, said that the first concerned a proposal to introduce a system of electronic voting in the Health Assembly which would, among other things, help to cut considerably the amount of time required to appoint the Director-General under the new procedure. The Board was asked to authorize the Secretariat to investigate options for electronic voting facilities and their related costs, before reporting to the Health Assembly on the matter. The second point concerned a proposal to consolidate in a single document all the details of procedures related to the election of a Director-General, which had evolved over the years and were scattered among several documents.

Professor HALTON (Australia) expressed firm support for the two proposals.

Mr AGHAZADEH KHOEI (Islamic Republic of Iran), referring to the first point, said that, although in principle he supported the idea of introducing an electronic voting system, the Secretariat should be asked to ensure that the system would have all the necessary safeguards to avoid hacking or the leaking of results, and to preserve secrecy of the ballot.

He also expressed support, in principle, for the second point, but said that it was not the right time to ask the Secretariat to produce a consolidated document, since the discussion of the proposed process for electing a Director-General had not yet been completed.

The DIRECTOR-GENERAL, responding to comments on the whole subject, first assured the member for the Islamic Republic of Iran that the consolidated document on the process for electing a Director-General would not be produced without approval by the Health Assembly. On the electronic voting system, she said that consultations would be held with other organizations that already used such a system, *inter alia*, to discover whether they had experienced any problems with security breaches. The Secretariat would report back to the Health Assembly on those consultations and seek further guidance from Member States on whether such a system would be desirable.

She recognized the existence of a consensus on the code of conduct but noted that there were differing views on the timing of the candidates' forum. She further noted that there had been agreement on the proposed standard form for the curriculum vitae of candidates. It was not clear, however, how the three principles of merit, geographical representation and gender were to be put into practice; it was important to ensure that those principles did not become a hierarchical set of criteria, but it was for Member States, and not the Secretariat, to decide how they should be taken into consideration in the assessment of candidates. Member States could use the candidates' forum to

assess the competence and abilities of the individuals concerned and she confirmed that the forum could be recorded and presented as a webcast so that those Member States that were not able to attend could securely access the webcast in order to view the proceedings before a vote took place at the Executive Board. She did not want to commit the Secretariat to producing a report on the forum, as such a report could be subject to interpretation. Providing a webcast only would ensure the necessary transparency and objectivity.

The Secretariat would continue to work in the run-up to the Health Assembly to provide different options to Member States for their consideration on how to operationalize the term “clear and strong majority”. In the meantime, a draft resolution would be drawn up for the Board’s consideration at a later meeting.

The CHAIRMAN took it that the Board wished to defer further discussion on the item until a draft resolution was made available, on the understanding that the amendments to the Rules of Procedure of the Executive Board would be adopted by the Board, while the decisions on other topics would be submitted to the Health Assembly for its consideration.

It was so agreed.

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

Evaluation: update, and proposed workplan for 2013: Item 13.2 of the Agenda (Document EB132/30)

Dr THABET NASHER (Yemen), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, recalled the Committee’s deliberations on the item (document EB132/43, paragraphs 43–46). The Committee had recommended that the Board take note of the report contained in document EB132/30.

Dr Jamsheed Mohamed took the Chair.

Dr MYINT HTWE (Myanmar) expressed support for the evaluation-related activities of the Organization, including the preparation of a handbook on WHO’s evaluation practices, the Organization-wide inventory and especially the use of findings. The results of the evaluation findings should be the Organization’s reference point. Clear-cut evaluation criteria for specific topics should be included in the handbook and evaluations must not be carried out simply for their own sake, given their costs and the staff time required.

The selection of evaluation team members, who should be competent and free from conflict of interest, must be unbiased in order to ensure the quality, utility and integrity of the findings. Any evaluation team should also have a multidisciplinary membership.

He requested the Secretariat to include an additional column in the Annex to the report, indicating the approximate cost of the evaluations carried out in 2012 and due to be carried out in 2013. It would also be beneficial to establish evaluation units within the regional offices, using existing staff members and based on regional needs.

Regarding the reference in the report to the submission of workplans to the Board for approval through the Programme, Budget and Administration Committee, he asked whether that applied only to evaluations initiated at headquarters, or whether evaluations done by the technical units of the country and regional offices were also concerned.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that an analysis of the proposed transitional workplan set out in the Annex to the report showed that 26 of the 85 planned and ongoing evaluations for 2012 and 2013 related to the Region of the Americas, with eight specifically for Argentina. What was the reason for that and why was no evaluation foreseen in the Eastern Mediterranean or European Region?

Dr DE ASSUNÇÃO SAÍDE (Mozambique), speaking on behalf of the Member States of the African Region, welcomed the comprehensive report on developments in the area of evaluation at all levels of the Organization and, in particular, the work on the WHO evaluation practice handbook. The African Region had been involved in many of the evaluations, some of which were still in progress. However, the nature of some of those evaluations had been questioned; the final reports on such activities should specify whether they were classed as evaluations, studies or reviews.

He noted that the African Region was not included in the activities planned for 2013. Moreover, no indication was given as to how the performance of the Office of Internal Oversight Services would be assessed at the end of the current biennium, so as to inform the workplan for the biennium 2014–2015.

Dr LAHTINEN (Finland)¹ emphasized both independent evaluation, as a tool to make WHO a modern and effective organization, and the transparency of the results of future evaluations.

Mr WEBB (Office of Internal Oversight Services) said that the reporting process was transitional, with his office collecting information on what had been done in 2012 and what was planned for 2013 before implementation of the evaluation policy that had been approved in May 2012. Many of the issues that had been raised by speakers on the transitional 2013 workplan would provide input for the reporting process in relation to the work of fully implementing the policy in 2014 and 2015.

The WHO evaluation practice handbook would provide guidance on the criteria for inclusion of new items in the Organization-wide workplan and that would apply not only to evaluations initiated at headquarters but to centralized and decentralized evaluations throughout the Organization. It also would give guidance on the selection of evaluation team members, who should be free of conflict of interest and have the appropriate sectoral experience and competencies in evaluation.

Regarding the cost of evaluations, all information that had already been collected would be included in the inventory that would be published on the evaluation pages of the WHO web site. The inventory would be updated over time as more information was received.

Responding to comments from the member for Cuba, he said that information from the Eastern Mediterranean and European regions had been received too late for inclusion in the report, but would be made available during the year. Regarding the situation in Argentina, he said that the Organization did not have that level of information, but he would ascertain whether the relevant evaluation reports could be made available.

Turning to the comments made by the member for Mozambique, he said that the inventory had been the result of a self-reporting process and had not yet been subjected to quality control in order to ensure that all elements were categorized in accordance with the new policy. Some elements of the quality control process would draw on the evaluation network, which would include technical experts from the regions and headquarters. The Office of Internal Oversight Services would itself be evaluated by the Independent Expert Oversight Advisory Committee.

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

Mr CORRALES HIDALGO (Panama) said that, like the member for Cuba, he wished to learn more about what had given rise to the situation in Argentina regarding evaluation.

Mr WEBB (Office of Internal Oversight Services), in reply, said that he would request more information on the situation in Argentina from the coordinator for evaluation in the Regional Office for the Americas.

The CHAIRMAN took it that the Board wished to note the proposed transitional workplan contained in Annex 1 to document EB132/30.

It was so agreed.

Independent Expert Oversight Advisory Committee: Item 13.3 of the Agenda

- **Membership** (Document EB132/31)
- **Terms of reference** (Document EB132/32)

The CHAIRMAN said that the Board was invited to consider the proposal to appoint Mr Farid Lahoud (Lebanon) as a member of the Independent Expert Oversight Advisory Committee in place of Dr Shamshad Akhtar (Pakistan) and to review and approve the revised terms of reference of that Committee.

Mr ASAOLU (Nigeria), speaking on behalf of the Member States of the African Region, endorsed the appointment of Mr Farid Lahoud and expressed appreciation to the Secretariat for the careful selection process. Mr Lahoud would contribute greatly to the work of the Committee and his appointment demonstrated that all regions were blessed with experts with the appropriate skills to carry forward the work of WHO. He encouraged the Secretariat to apply a similar procedure, based on fostering trust, cooperation, and equitable geographical representation, when filling similar vacancies in the future.

The terms of reference could be amended after an evaluation of the Independent Expert Oversight Advisory Committee. He supported the amendments proposed to subparagraph 2(c) of the terms of reference as well as the insertion of a new subparagraph 2(h), but recommended that approval of the insertion of new subparagraphs 2(d) and (e) be deferred until the performance review referred to in subparagraph 2(h) had been completed.

Ms BLACKWOOD (United States of America) said that, as the Committee had been in existence since 2009, it was appropriate that it had reviewed its own terms of reference, in line with best practices. The Committee had proposed various amendments, which her country found acceptable, including more explicit oversight of the Secretariat's activities on internal audit, evaluation and investigation, and the provision of technical advice on the selection criteria for key positions relating to audit and oversight.

The DIRECTOR-GENERAL agreed with the member for Nigeria that it was reasonable to defer approval of the proposed new subparagraphs 2(d) and 2(e) until after the review process under the proposed new subparagraph 2(h) had been completed, especially as the External Auditor referred to in the proposed subparagraph 2(d) had only recently been appointed.

Mr RUSH (United Kingdom of Great Britain and Northern Ireland),¹ referring to the membership of the Independent Expert Oversight Advisory Committee, requested clarification: would the roster of candidates be expanded before the next few members were selected and appointed to the Committee or was the intention to draw on the current roster when filling those positions? It would be useful to know when a call for candidates had last been made in order to determine whether a new call should be issued.

Regarding the terms of reference, he agreed with the member for Nigeria that there was no reason for haste in confirming all the proposed amendments, but said that it should be within the remit of the Committee to provide a certain level of impartial advice to the Director-General and the Board, without there being a risk of encroaching on the mandates of either of the two. The provision of such advice was a good practice already followed in other organizations and he supported the amendments proposed by the Committee.

Dr JAMA (Assistant Director-General) said that two options were available: either new members of the Independent Expert Oversight Advisory Committee could be selected from the existing roster of 18 candidates or a fresh call could be made to expand the roster. The latter would incur costs to the Organization. He added that the current roster had been compiled, at the request of the Board, in 2012.

The DIRECTOR-GENERAL asked the representative of the United Kingdom whether the roster had been compiled sufficiently recently for any new members of the Committee to be selected from it or whether the roster was to be expanded.

Mr RUSH (United Kingdom of Great Britain and Northern Ireland)¹ expressed the view that new members should be selected from the existing roster but added that that was a matter for the Board to decide.

Ms BLACKWOOD (United States of America) agreed that it seemed reasonable to draw on the existing roster rather than issue a call to expand it, and asked whether an explicit decision on the matter was required from the Board.

The DIRECTOR-GENERAL said that the agreement of Board members was important and took it that, based on the comments made, the Board was in favour of new members being appointed from the current roster.

Mr ASAOLU (Nigeria) expressed his agreement in principle, as long as it promoted equitable geographical representation; if that could not be guaranteed, the roster should first be expanded before appointing new members.

The CHAIRMAN took it that the Board wished to appoint Mr Farid Lahoud (Lebanon) as a member of the Independent Expert Oversight Advisory Committee for the remainder of the term of Dr Shamshad Akhtar (Pakistan).

It was so decided.²

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

² Decision EB132(2).

The CHAIRMAN further took it that the Board agreed to revise the terms of reference of the Independent Expert Oversight Advisory Committee, accepting the proposed new wording for subparagraph 2(c) and the insertion of a new subparagraph (f) concerning the proposed performance review, under paragraph 2 of the terms of reference, but deferring a decision on the insertion of new subparagraphs 2(d) and (e) until the provisions of new subparagraph 2(f) had been fulfilled.

It was so agreed.

The CHAIRMAN asked the Board to accept the proposal that the Secretariat draft a resolution to capture those agreed actions.

It was so agreed.¹

The meeting rose at 12.30.

¹ Resolution EB132.R12.

THIRTEENTH MEETING

Monday, 28 January 2013, at 09:10

Chairman: Dr J. ST. JOHN (Barbados)

1. TRIBUTE TO THE MEMORY OF DR HIROSHI NAKAJIMA, FORMER DIRECTOR-GENERAL OF WHO

The DIRECTOR-GENERAL said that it was her sad duty to inform the Board that Dr Hiroshi Nakajima, the fourth Director-General of WHO, had died after a brief illness. Following a career in neuropharmacology research, Dr Nakajima had joined the Organization in 1974, where he had helped to develop the concept of essential medicines. He had served as Regional Director for the Western Pacific from 1978 to 1988, and as Director-General from 1988 to 1998. Many of the Organization's most successful programmes and initiatives owed a great debt to his efforts, including the directly observed treatment, short-term (DOTS) approach to tuberculosis; the use of vector control and bednets to prevent malaria; the development of the Integrated Management of Childhood Illness initiative; and the expansion of the global programme for childhood immunization. In every case, what had mattered most to him had been the impact on people's lives. An additional achievement had been the launch of the world health report series, which had had a significant impact. One of Dr Nakajima's greatest passions had been to see poliomyelitis defeated and WHO's current efforts to that end were a tribute to his memory. Dr Nakajima was survived by his wife and two sons. He would be sorely missed.

The Board stood in silence for one minute.

The CHAIRMAN said that Dr Nakajima had left an undeniable legacy to WHO as it pursued its ultimate goal of health for all.

Mr OKADA (Japan)¹ expressed his deepest sympathy to the family of Dr Nakajima and thanked the Director-General and the Board members for their condolences. Dr Nakajima had begun his career in neuropsychiatric research, and scientific research had remained his passion throughout life. He would be remembered by all for his contribution to the field of global public health, and by his countrymen in particular, as the first Japanese head of a United Nations agency, inspiring many of them to pursue international careers.

Mr DAULAIRE (United States of America) said that Dr Nakajima had embodied the ideals of the Organization and had always helped Member States that were most in need of support.

Professor HALTON (Australia), speaking on behalf of the Member States of the Western Pacific Region, said that Dr Nakajima had made a significant contribution as Regional Director for the Western Pacific, representing the interests of the diverse communities in the Region with distinction and flair.

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

Dr REN Minghui (China) said that as Regional Director for the Western Pacific, Dr Nakajima had made a significant contribution to the reform of the Chinese health sector and had helped to improve coordination between his country and WHO.

Dr VALENTIN (Seychelles), speaking on behalf of the Member States of the African Region; Professor NICKNAM (Islamic Republic of Iran); Ms DÁVILA CHÁVEZ (Mexico); Dr VALVERDE (Panama); Dr REYNDERS (Belgium), speaking on behalf of the Member States of the European Region; Dr THABET NASHER (Yemen), speaking on behalf of the Member States of the Eastern Mediterranean Region; Dr HISHAM ABDULLAH (Malaysia); Dr JAMSHEED MOHAMED (Maldives), speaking on behalf of the Member States of the South-East Asia Region; and Dr SARMENTO P. DA COSTA (Timor-Leste) also expressed their condolences.

2. **WHO REFORM** (Documents EB132/5, EB132/5 Add.1, EB132/5 Add.2, EB132/5 Add.3, EB132/5 Add.4, EB132/5 Add.5, EB132/5 Add.6, EB132/5 Add.7, EB132/5 Add.8, EB132/5 Add.9, EB132/43, EB132/INF./2, and EB132/INF./3) (continued from the tenth meeting, section 1)

The CHAIRMAN, referring to the informal meeting held on Saturday, 26 January 2013 to discuss the non-paper on WHO reform distributed at the Board's tenth meeting on Friday, 25 January, asked what progress had been made.

Professor HALTON (Australia) replied that solid progress had been made. Consensus had been reached on all the issues up to those relating to the Rules of Procedure. The group would reconvene later that same day.

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

3. **COMMUNICABLE DISEASES:** Item 9 of the Agenda (continued)

Neglected tropical diseases: Item 9.2 of the Agenda (Documents EB132/19 and EB132/19 Add.1) (continued from the eleventh meeting, section 1)

The CHAIRMAN drew attention to the revised draft resolution on neglected tropical diseases that incorporated amendments proposed by Board members.

The Executive Board,
Having considered the report on neglected tropical diseases,¹

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

The Sixty-sixth World Health Assembly,
PP1 Having considered the report on neglected tropical diseases, and recalling the previous World Health Assembly resolutions listed therein;

¹ Document EB132/19.

PP2 Recognizing that increased national and international investments in prevention and control of neglected tropical diseases have succeeded in improving health and social well-being in many countries;

PP3 Noting the WHO's roadmap to accelerate the work to overcome the global impact of neglected tropical diseases and the subsequent London Declaration on Neglected Tropical Diseases endorsed by a community of partners;¹

PP3bis Acknowledging the linkages and mutual supportiveness control and elimination of Neglected Tropical Diseases and the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property; [Brazil, Cuba]

PP3ter Recognizing the importance of considering the recommendations of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination (CEWG) for the identification of potential solutions regarding international, regional and national efforts to prevent, control and eliminate NTDs; [Brazil, Cuba]

PP4 Acknowledging that expansion of activities to prevent and control neglected tropical diseases will need adequately-resourced national programmes functioning within effective health, education and other sectors in order to provide for an uninterrupted supply and delivery of quality-assured commodities and services;

PP5 Realizing that current approaches to prevention and control of neglected tropical diseases, when implemented in an integrated manner **and across all relevant sectors, [EU]** are highly effective and contribute to stronger health systems and the achievement of health-related Millennium Development Goals, **but there are still many challenges; [EU]**

PP6 Appreciating the generous contribution of pharmaceutical companies in donating sufficient quantities of quality-assured essential medicines for the prevention and treatment of neglected tropical diseases, **while acknowledging the need to ensure its continuous availability and affordability; [EU]**

PP7 Recognizing the contribution of bodies in the United Nations system, intergovernmental and nongovernmental organizations, academic institutions and civil society;

PP8 Recognizing the diversity of neglected tropical diseases, their causative agents and relevant vectors and intermediate hosts, epidemic potential (such as for dengue, Chagas disease, human rabies of canine origin, and leishmaniasis), morbidity, mortality and associated stigmatization,

1. URGES Member States:

- (1) to ensure ~~national~~ **country [Australia]** ownership of neglected tropical disease prevention, control, elimination and eradication programmes;
- (2) to expand and implement, **as appropriate, [EU]** interventions against neglected tropical diseases in order to reach the targets agreed by ~~WHO and its all~~ **[EU]** partners in the London Declaration on Neglected Tropical Diseases and set out in WHO's roadmap for accelerating work to overcome the global impact of neglected tropical diseases by:
 - (a) ensuring that resources match national requirements and flow in a sustainable manner as a result of thorough planning and costing of prevention and control activities and detailed analysis of associated expenditures;

¹ Respectively, *Accelerating work to overcome the global impact of neglected tropical diseases: a roadmap for implementation*. Geneva, World Health Organization, 2012 (document WHO/HTM/NTD/2012.1) and the *London Declaration on Neglected Tropical Diseases*. London, 30 January 2012 (available at: http://search.who.int/search?q=london+declaration&ie=utf8&site=default_collection&client=_en&proxystylesheet=_en&output=xml_no_dtd&oe=utf8; accessed 22 October 2012).

- (b) enabling improvement of the management of the supply chain, in particular through forecasting, timely procurement of quality-assured goods, improved stock management systems, and facilitating importation and customs clearance;
- (bbis) integrating Neglected Tropical Diseases control programmes to Primary Health Care services and vaccination campaigns or existing programmes where feasible to achieve greater coverage and reduce operational costs; [EU]**
- (c) ensuring appropriate programme management and implementation through the development, sustenance and supervision of a cadre of skilled staff (including other sectors than health) at national, district and community levels;
- (3) to advocate predictable, long-term, international financing for control of neglected tropical diseases, to enhance and sustain national financial commitments, including resource mobilization from sectors other than health, and to strengthen capacity for prevention and control of neglected tropical diseases, **strengthening research, [EU]** in order to accelerate implementation of the policies and strategies designed to achieve the targets set by the Health Assembly in various resolutions related to specific neglected tropical diseases as well as in the roadmap and the London Declaration;
- (4) to strengthen national capacity for monitoring and evaluation of the impact of interventions against neglected tropical diseases;
- (5) to devise plans for achieving and maintaining universal access to and coverage with interventions against neglected tropical diseases, notably:
 - (a) to ~~ensure~~ **provide [USA]** prompt diagnostic testing of all suspected cases of neglected tropical diseases and effective treatment with appropriate therapy of patients in both the public and private sectors at all levels of the health system including the community level;
 - (b) to implement and sustain coverage with preventive chemotherapy¹ of at least 75% of the populations in need, as a prerequisite for achieving goals for disease control or elimination;
 - (c) to improve coordination for reducing transmission and strengthening control of neglected tropical diseases through provision of safe drinking-water, basic sanitation, **health promotion and education, [EU]** vector control and veterinary public health;

2. CALLS upon WHO's international partners, including intergovernmental, international and nongovernmental organizations, financing bodies, academic and research institutions, civil society and the private sector;

(1) to support Member States as appropriate; [Australia]

- ~~(1)~~ **(a) to assist** to ensure **[Australia]** sufficient and predictable funding to enable the targets for 2015 and 2020 to be met and efforts to control neglected tropical diseases to be sustained;
- ~~(2)~~ **(b) to harmonize [Australia]** the provision of support to countries for implementing a national plan based on WHO-recommended policies and strategies and using commodities that meet international quality standards;
- ~~(3)~~ **(c) to ensure promote [USA, Australia]** universal access to preventive chemotherapy, and **diagnostics, [Russian Federation]** case management, and

¹ Preventive chemotherapy means large-scale preventive treatment against helminthiases and trachoma with safe, single-dose, quality-assured medicines.

vector control and other prevention measures, as well as effective surveillance systems;

(4) (2) to encourage initiatives for the discovery and development of new diagnostics, medicines, **vaccines, [Russian Federation] and pesticides and biocides, improved tools and technologies and other innovative instruments for vector control and infection prevention [EU]** and to support operational research to increase the efficiency and cost-effectiveness of interventions **taking into account the Strategy and Plan of Action on Public Health, Innovation and Intellectual Property and the Consultative Expert Working Group on Research and Development: Financing and Coordination (CEWG) report and specific recommendations; [Brazil, Cuba]**

(5) (3) to collaborate with WHO in order to provide support to Member States in measuring progress towards and accomplishing their goals of elimination and eradication of selected neglected tropical diseases;

3. REQUESTS the Director-General:

(1) to sustain WHO's leadership in the drive to overcome neglected tropical diseases;

(2) to support the development and updating of evidence-based norms, standards, policies, guidelines and strategies **and research [EU]** for prevention, control and elimination of neglected tropical diseases in order to chart a course for reaching the related targets set in resolutions of the Health Assembly;

(3) **to develop a Plan of Action and indicators [Brazil, Cuba]** to monitor progress in achieving the targets for neglected tropical diseases set in WHO's roadmap for accelerating work to overcome the global impact of neglected tropical diseases,¹ and to provide support to Member States in their efforts to collect, validate and analyse data from national surveillance systems;

(4) to provide support to Member States to strengthen human resource capacity for prevention, ~~and~~ control **and diagnostics [Russian Federation]** of neglected tropical diseases, including vector control and veterinary public health;

(5) **that encourages and supports initiatives to discover and obtain new diagnostic tools, medicines and insecticides, and supports operational research to increase the efficacy and cost-effectiveness of interventions; [Cuba]**

(5bis) to report to the Sixty-eighth ~~seventh~~ [EU] World Health Assembly on progress towards the elimination and eradication of targeted diseases, through the Executive Board.

Dr GRABAUSKAS (Lithuania), speaking on behalf of the European Union and its Member States, proposed that preambular paragraph 3~~ter~~ be deleted for three reasons: the Board had not discussed it at the tenth meeting of the current session; no agreement on it had been reached by the Consultative Expert Working Group on Research and Development; and it was not directly relevant to the control of neglected tropical diseases. Similarly, at the end of subparagraph 2(2), the words following "Innovation and Intellectual Property" should be deleted. At the beginning of subparagraph 3(3), the words "to develop a Plan of Action and indicators" should be deleted, since the same words had already been included in both the roadmap for accelerating work to overcome the global impact of neglected tropical diseases and the workplan of the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases. Subparagraph 3(5) should also be deleted as the principle contained therein had already been mentioned in subparagraph 2(2).

¹ *Accelerating work to overcome the global impact of neglected tropical diseases: a roadmap for implementation.* Geneva, World Health Organization, 2012 (document WHO/HTM/NTD/2012.1).

Mr McIFF (United States of America), supporting the amendments put forward by the member for Lithuania for paragraphs PP3^{ter} and 2(2), proposed further that in subparagraph 2(1)(a) the word “ensure” be replaced by “provide”.

Mr GONZÁLEZ FERNÁNDEZ (Cuba) endorsed the draft resolution as amended.

Professor HALTON (Australia), expressed her support for the proposed amendments and further proposed that at the beginning of subparagraph 3(5) the words “that encourages and supports” be replaced with “to encourage and support”.

The draft resolution, as amended, was adopted.¹

4 HEALTH SYSTEMS: Item 10 of the Agenda (continued)

Substandard/spurious/falsely-labelled/falsified/counterfeit medical products: Item 10.1 of the Agenda (Document EB132/20) (continued from the eleventh meeting, section 2)

Mr McIFF (United States of America), speaking on behalf of the Member States of the Region of the Americas, commended the progress made at the First Meeting of the Member State mechanism on substandard/spurious/falsely-labelled/falsified/counterfeit medical products, and thanked the Government of Argentina, His Excellency Ambassador Orjiako of Nigeria and the Secretariat for their leadership and support in that connection. The meeting had demonstrated Member States’ ability to work together on tackling the complexities of those medical products and supply chains and in focusing on the serious public health implications of those products for patients and consumers worldwide. Another encouraging sign was that the regional groups had recently agreed on the 12 vice-chairpersons of the steering committee. It was incumbent on the regional groups to maintain momentum by rapidly choosing the steering committee chairperson, who must be fully committed to the mechanism and able to ensure continuity with previous work.

He urged the steering committee to convene a one-day meeting of the mechanism shortly before the Sixty-sixth World Health Assembly in order to finalize the draft workplan, which should list priorities and be action oriented in order that the work be focused and yielded tangible benefits. He supported Brazil’s offer to chair the open-ended working group whose establishment to identify the actions, activities and behaviours that resulted in substandard/spurious/falsely-labelled/falsified/counterfeit medical products had been decided at the First Meeting, and urged that arrangements be made to ensure that the group would complete its work in not longer than six months. That work should not preclude the Member State mechanism from undertaking activities in other priority areas identified in the workplan. There should also be creative intersessional work. The mechanism provided a new opportunity for collaboration to resolve complex issues, for instance by strengthening the integrity of the supply chain and continuing to build regulatory capacity.

Ms PENEVEYRE (Switzerland), speaking on behalf of the Member States of the European Region, said that progress during the first meeting of the Member State mechanism had been slower than expected – not even a workplan had been agreed upon. The open-ended working group should be convened quickly, in order to ensure progress within the agreed time frame. The region called upon all Member states to nominate appropriate technical experts for the working group. The steering committee, which should be inclusive and transparent and work closely with the regions, must be set up before the Sixty-sixth World Health Assembly in order to give it an opportunity to finalize the workplan to be implemented by the Secretariat, making use of existing structures as much as possible.

¹ Resolution EB132.R7.

Dr GRABAUSKAS (Lithuania), speaking on behalf of the European Union and its Member States, agreed with the previous speaker that not enough progress had been made at the first meeting of the Member State mechanism; the failure to finalize a workplan was particularly regrettable. A successful mechanism should work towards a common understanding of the scale of the problem; enable Member States to share information on incidents and new methodologies, criteria and tools for data collection and analysis, at least across regions; and address issues of supply chain integrity, control and monitoring through exchanges of experience and information. In addition, it should focus on health; allow all relevant partners to contribute to and/or collaborate on specific issues, while managing potential conflicts of interest; and avoid duplicating the work of other organizations working in the field. At the same time, WHO should continue its efforts to strengthen information exchanges, communication, education and awareness-raising among national regulatory authorities. Failure to make progress in combating substandard/spurious/falsely-labelled/falsified/counterfeit medical products would undermine WHO's credibility in the drive to ensure the quality, safety and efficacy of medicines.

Dr VALVERDE (Panama) said that the large amount of substandard/spurious/falsely-labelled/falsified/counterfeit medical products on the international market was a global problem, rather than one affecting only low-income and developing countries. Her country had a national medicines policy based on a seven-point workplan, covering: access to medicine; the quality, efficacy and safety compliance of medical products; the rational use of medicines; research; human resources; intellectual property; and evaluation of the policy itself. The progress made in finalizing the workplan, structure, governance and meetings schedule for the Member State mechanism was encouraging, but it was essential that funding sources in addition to the WHO programme budget be found for it, its transparency ensured, and conflicts of interest avoided.

Dr SHEKU DOAH (Sierra Leone), speaking on behalf of the Member States of the African Region, said that substandard/spurious/falsely-labelled/falsified/counterfeit medical products wasted badly needed resources and threatened public health. The Region was particularly concerned about the proliferation of such products, which was due largely to poorly resourced and ineffective regulatory authorities, and inadequate collaboration and cooperation among multisectoral agencies involved in regulation, inspection and law enforcement.

Unfortunately, implementation of national, regional and global measures had failed to curb the ever-growing menace of those medical products. He therefore welcomed the outcome of the first meeting of the Member State mechanism and urged swift follow-up action. In that connection, resources and technical support were needed in order to strengthen medicines regulatory authorities in the Region; provide timely and adequate funding to the Member State mechanism; and maintain the efforts of the African Union to establish an African Medicines Regulatory Agency. Member States were also encouraged to prioritize action against substandard/spurious/falsely-labelled/falsified/counterfeit medical products by building their national medicines regulatory capacities and quality-control services, and by engaging agencies and partners skilled in legal and law enforcement issues.

Mr JIN Song (China) said that his Government had stepped up its efforts to counter substandard/spurious/falsely-labelled/falsified/counterfeit medical products and enhance international cooperation in that area. China supported WHO's leading and coordinating role in that field and welcomed the creation of the Member State mechanism as a demonstration of the international community's resolve. The first meeting of the mechanism had been a good starting point but much remained to be done, in particular, finalization of the workplan and establishment of a steering committee. China had submitted its candidacy for the Vice-Chairperson for the Western Pacific Region and would continue to participate in the drafting of a detailed work programme. Any measures or programmes adopted should take into account existing regulations on medical products in Member States, and should promote a mechanism of international coordination that was relevant to regional realities, efficient and easy to implement.

Mr AGHAZADEH KHOEI (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, regretted that the first meeting of the Member State mechanism had not been able to complete its work. The workplan of the Member State mechanism should focus on the following actions: technical support to national regulatory authorities, including assistance in identifying gaps in national legislation; building surveillance systems in order to track all medical products from production to consumption by means, for instance, of labelling and mass serialization data metrics; sharing surveillance system information among Member States, with WHO's support in fostering uniform standards and best practices; and increasing public awareness of activities, actions and behaviours that resulted in substandard/spurious/falsely-labelled/falsified/counterfeit medical products.

Dr AMMAR (Lebanon) fully supported the structure, governance and future actions proposed for the Member State mechanism. Member States must not, however, lose sight of how the global health system functioned; enhancing national capacities in order to control the integrity of the supply chain and promote "good distribution practices" should be regarded as an integral part of strengthening the health system as a whole. Substandard/spurious/falsely-labelled/falsified/counterfeit medical products not merely posed a technical problem but struck at the heart of efforts to ensure access to health services and good-quality, affordable medical products. Quality control and pricing of pharmaceutical products, as well as promotion of the use of generic medicines and knowledge transfer for local manufacturing should all be regarded as essential components of work against substandard/spurious/falsely-labelled/falsified/counterfeit medical products.

Professor HALTON (Australia) expressed great regret that the work had not advanced further; solutions to outstanding issues must be found. Substandard/spurious/falsely-labelled/falsified/counterfeit medical products were not simply a public health issue but were also a threat to health security: the consequences for individuals who purchased counterfeit or substandard medicines, sometimes at great cost, should not be underestimated; such behaviour was, moreover, potentially very dangerous for the global health community, particularly in terms of increasing antimicrobial resistance. She supported the work done thus far by the Member State mechanism, which would need to adopt a multisectoral approach that involved national regulators and national authorities in order to combat organized crime.

Dr AZODOH (Nigeria) acknowledged that the widespread problem of substandard/spurious/falsely-labelled/falsified/counterfeit medical products had grown to such an extent that effective coordination and cooperation were needed at the international level if regional and country measures were to be effective. She therefore called for more efforts on the part of Member States to enable the new Member State mechanism to begin its work.

Nigeria had taken various measures to combat substandard/spurious/falsely-labelled/falsified/counterfeit medical products. It had revised its anti-counterfeiting legislation in order to secure the supply chain and deter potential offenders more effectively, and would be launching new guidelines for the distribution of medicines in February 2013. It had recently adopted a new national pharmacovigilance policy and was using advanced technologies, including a hand-held detection device, to detect substandard/spurious/falsely-labelled/falsified/counterfeit medical products. Such measures had helped to reduce drastically the circulation of those medical products in Nigeria. A WHO survey in 2008 of the quality of selected antimalarial medicines circulating in six countries of sub-Saharan Africa had identified a failure rate of 64%, although tests by the National Agency for Food Administration and Control had shown that that rate had decreased by some 40% in 2012. Other efforts had included participation in a survey sponsored by WHO to determine the prevalence of counterfeit medicines; establishment of a federal taskforce on substandard/spurious/falsely-labelled/falsified/counterfeit medical products, and contributions to regional and international cooperation. Nigeria had much experience to share.

The Member State mechanism should focus on building strong and effective partnerships in order to strengthen oversight activities in Member States. It should also concentrate on matters concerning public health and should not confuse its work with the protection of intellectual property.

Mrs LANTERI (Monaco)¹ said that Member States were aware that rapid progress was necessary after the first meeting of the Member State mechanism in Buenos Aires. Monaco was a candidate for the steering committee of the Member State mechanism, which, it was to be hoped, would hold its first meeting as soon as possible and in accordance with the timetable set out in the Annex to document EB132/20. The proposed programme budget 2014–2015 should contain an element on substandard/spurious/falsely-labelled/falsified/counterfeit medical products.

Mrs ESCOREL DE MORAES (Brazil)¹ attached great importance to the Member State mechanism, which should be able to pursue public health objectives without linking its activities to intellectual property enforcement or commercial interests. The mechanism should strive to ensure the integrity of the supply chain and improve information exchange between regulators. Any remaining differences between Member States would be resolved once the mechanism had demonstrated its relevance to public health. The mechanism should begin its work by identifying behaviours and actions to be prevented and controlled. Because it was technically oriented and managed by Member States, the mechanism had the potential to attract broad interest and be financially sustainable. As measures to fight counterfeit medicines were already in place at the country level, the mechanism's main challenge would be to reach agreement at the global level. She proposed that the mechanism be renamed "the Mechanism of Buenos Aires" in consideration of its origin.

Mr KOTALWAR (India)¹ said that affordable, innovative and accessible medical products were needed in order to grapple with many of the health problems of low-income countries and poor populations. That could be achieved by supporting health system strengthening, with a focus on facilitating transfer of technologies; promoting access to affordable, good-quality, safe and effective medical products; and promoting health systems research.

India exported medicines to more than 200 countries and had about 8000 drug manufacturing units and 800 000 retail outlets. In 2012, the Secretariat had assessed India's regulation system against international bench marks and found it to be functional. India's efforts to ensure the quality, safety and efficacy of all pharmaceutical products had yielded results: categories of drugs of compromised quality accounted for about 0.2% to 0.4% of all medicines produced in India.

He welcomed the progress made by the Member State mechanism at its first meeting. India was fully committed to participating in the mechanism, which should hold a meeting before the forthcoming Health Assembly in order to finalize its workplan. India supported the appointment of Brazil as chairperson of the open-ended working group, welcomed the vice-chairpersons nominated by the regional groups and looked forward to early consensus on the selection of the chairperson. Good-quality, safe and effective medicines must be ensured through a process that was separate from commercial or intellectual property issues.

Mr PIPPO (Argentina)¹ said that Member States could not allow the health of their citizens to be compromised by substandard/spurious/falsely-labelled/falsified/counterfeit medical products. His Government had hosted the first meeting of the Member State mechanism. The mechanism's structure, which combined a steering committee with precisely defined functions and plenary meetings, was a solid institutional arrangement that should ensure the participation of all Member States. Although its workplan had not yet been finalized, the mechanism had set itself some important tasks, including work on identifying actions, activities and behaviours that resulted in substandard/spurious/falsely-labelled/falsified/counterfeit medical products. Work under the first three parts of the workplan would

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

begin in 2013, with a focus on detection technologies; building the capacities of regulatory authorities; and communication, education and awareness raising. He thanked Brazil for suggesting a new name for the mechanism.

Mr RUSH (United Kingdom of Great Britain and Northern Ireland)¹ welcomed the mechanism's successful efforts in Buenos Aires to set out its modalities and establish its workplan. Regrettably, no further progress had been made at that time. The steering committee should, therefore, meet soon so that the work could move forward swiftly, and should provide a forum that would help to build trust for those Member States that continued to have concerns about the work of the mechanism. The subject of substandard/spurious/falsely-labelled/falsified/counterfeit medical products was a public health issue in which WHO's involvement was essential. He supported the remarks of the member for Australia with regard to antimicrobial resistance, which was one of the gravest threats to health in the twenty-first century.

Dr DARIN AREECHOKCHAI (Thailand),¹ welcoming the report, underlined the need to put public health, not intellectual property or trade considerations, at the centre of work to define and combat unqualified medicines. The Secretariat and Member States should be encouraged to play a greater role in improving the world's medicine quality and supply. Thailand looked forward to participating fully in the activities identified by the mechanism and encouraged Member States to strengthen their own preparedness in parallel by strengthening and building the capacities of national and regional regulatory authorities and quality-control laboratories, and improving cooperation and collaboration among national and regional authorities.

Mr BESANÇON (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN and also on behalf of the World Medical Association, the International Council of Nurses, the World Federation for Physical Therapy and the World Dental Federation, which together formed the World Health Professions Alliance, affirmed that the issue of substandard/spurious/falsely-labelled/falsified/counterfeit medical products lay within the scope of WHO's work and should be considered from a public health perspective. He welcomed the first task chosen by the Member State mechanism, namely to identify the actions, activities and behaviours that resulted in such medical products, as well as the opportunity to collaborate with the Secretariat by providing data and technical support. The World Health Professions Alliance endorsed the Organization's policy and practices with regard to disclosure of potential conflicts of interest. The Member State mechanism could benefit greatly from the involvement of the health care professionals under its umbrella, especially in many of the activities set out in the workplan contained in document EB132/20 (Appendix 2).

Mrs TOWNSEND (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 and the Third World Network, expressed concern that, in various international organizations, there was a tendency to associate the subject of quality of medicines with intellectual property protection and enforcement. WHO should make it clear that the two subjects must be considered separately, and should stop using the word "counterfeit".

The efforts of the open-ended working group would, it was to be hoped, throw light on the question of the actions, activities and behaviours that resulted in substandard/spurious/falsely-labelled/falsified/counterfeit medical products. The work of the Member State mechanism and the open-ended working group should be supported by concrete, verifiable evidence, and the pilot project to establish a global surveillance and monitoring system should be based on sound data and guided by the principle of transparency. The Member State mechanism would be focusing not only on the quality, safety and efficacy of medical products, but also on access to affordable medicines and, in that regard,

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

it should be kept in mind that high prices were one reason that medicines of compromised quality were produced. The mechanism should not be an exclusive forum for regulatory authorities but should encourage the participation of policy-makers.

Dr KIENY (Assistant Director-General) thanked Board members for their commitment to eliminating substandard/spurious/falsely-labelled/falsified/counterfeit medical products from the supply chain worldwide. The Secretariat stood ready to facilitate the Member State mechanism and to organize the first meeting of the 12 vice-chairpersons of the steering committee before the Health Assembly in May 2013. It would provide as much support as possible to Member States in undertaking the activities on which they had decided, and do its best to support the fund-raising efforts of the steering committee in order to accelerate progress in that key area.

The CHAIRMAN said that, as there were no further comments, she took it that the Board wished to take note of the report. The views expressed by Member States would be taken into account by the steering committee in planning for future activities.

It was so agreed.

Universal health coverage: Item 10.3 of the Agenda (Document EB132/22)

Mrs DÁVILA CHÁVEZ (Mexico) endorsed the report and welcomed the progress made towards universal health coverage. Her country was committed to achieving that goal, which was only possible with the requisite vision, commitment and political will. Universal health coverage comprised provision of two interrelated components: needed health services and financial risk protection. The principles of equity and quality must underlie the provision of health care services to the whole population. Many challenges still had to be met, including improved collection and analysis of information and statistics. Universal health coverage was not an end in itself, but a means to improving the quality of life for all, and it should be included, together with appropriate targets and indicators, as a priority objective on the post-2015 development agenda.

Mr HAZIM (Morocco), speaking on behalf of the Member States of the Eastern Mediterranean Region, expressed appreciation of the progress reported, reflecting in particular the Organization's efforts to provide technical support to Member States in assessing the performance of their health systems, with a view to formulating a fair and sustainable health financing strategy. Before being transmitted to the Sixty-sixth World Health Assembly, however, the report should be expanded to include contributions from all Member States in order to serve as a reference document, first for mobilizing additional international support during the forthcoming United Nations debate on the post-2015 development agenda and, secondly, for assisting advocacy of universal health coverage to decision-makers.

Two challenges would have to be overcome in order to achieve universal health coverage. First, non-discriminatory access to health services must be facilitated for all, especially persons with limited incomes, and that required a strong and effective health system delivering equitable, accessible and quality services. Secondly, universal access to equitable financing mechanisms must be provided for all social groups in order to protect individuals against financial burdens and risks. Countries with substantial health needs due to demographic and epidemiological shifts could be hindered from achieving universal health coverage in a timely manner unless they received technical and financial support from WHO and other development partners as part of a joint action plan.

Health financing policies and strategies must reflect the current situation. In order to secure sustainable health systems financing, Member States that had not yet achieved universal health coverage must step up their efforts to do so by establishing channels for comprehensive and lasting political dialogue with all health stakeholders in the interest of making health a government priority. In that regard, the situation in countries where there had been civil unrest and political turmoil was a catalyst insofar as health for all was among the key demands of the citizens in those countries.

Dr DAULAIRE (United States of America) said that his Government had been proud to support universal health coverage through its sponsorship of the United Nations General Assembly resolution 67/81 on Global health and foreign policy with its promotion of universal health coverage. With regard to its domestic agenda, the Affordable Care Act sought to expand access to health care services to the 30 million American citizens who were currently living without coverage. Achieving universal coverage was primarily the responsibility of national governments, although WHO could play a powerful advocacy role and provide needed technical support.

The goal of universal health coverage could serve as a unifying element in the debate on the post-2015 development agenda, provided that it was accompanied by clear health targets, supported by evidence-based interventions. The targets should focus on making additional efforts to achieve the current health-related Millennium Development Goals. Noncommunicable diseases, and prevention as a key to achieving and maintaining universal health coverage, should be included in the debate.

Dr JAMSHEED MOHAMED (Maldives) welcomed the Organization's leadership and Member States' commitment to strengthening universal health coverage. The regional strategy on universal health coverage, endorsed by the Regional Committee for South-East Asia at its 65th session, would guide efforts to achieve evidence-based, equitable and efficient health systems with a focus on primary health care. At that session, Member States had emphasized the importance of public funding in ensuring social protection. Expenditure on pharmaceuticals represented a major portion of out-of-pocket payments in the Region owing to the dependence on imported pharmaceuticals, extensive use of costly branded medicines, low volume requirement and geographical dispersion, the latter of which added to the cost of the medicines at local level. His Government was exploring possible ways of reducing the cost of pharmaceuticals through, for example, greater use of generic medicines and bulk procurement of pharmaceuticals. He urged the Secretariat to continue providing support to smaller Member States in managing supply chains and setting up bulk purchasing mechanisms for quality-assured medicines.

His country had launched a universal health insurance scheme in 2012, ensuring availability of basic health care packages to all, with telemedicine service provided to various islands. Care delivery remained an extremely difficult goal to achieve, however, owing to the dispersed nature of the country's islands and its high dependency on expatriate health care workers.

Universal health coverage should be included in the post-2015 development agenda where it would help to maintain current achievements and to stimulate efforts to meet the challenge of out-of-pocket expenditure and reduce health-related inequalities.

Dr PE THET KHIN (Myanmar) said that the Organization should continue to coordinate arrangements for forums at which Member States could exchange their experiences in implementing universal health coverage, and to send experts to support them in meeting their needs. Consideration might be given to classifying experts according to their specific skills, given the broad scope of universal health coverage. At the country level, governments needed to develop effective policies and strategies to deal with different aspects of universal health coverage.

The plan of action referred to in resolution WHA64.9 had been finalized and it behoved each country to implement the plan according to its own needs. Health financing was, however, only one factor and must be considered in tandem with the other challenges involved in achieving universal health coverage, some of which were beyond the purview of health ministries. It might be necessary to bolster advisory committees at country level and to build the capacities of staff involved in universal health coverage activities. WHO's support in that regard would be welcome.

Ms STIRØ (Norway) said that universal health coverage had been established in her country as a result of a strong and shared political will that had its roots in the 1950s and 1960s and the belief that it was the state's responsibility to provide universal access to health services. The health coverage scheme in Norway was based on principles of solidarity and collective responsibility: every citizen contributed based on ability, and received health services based on need.

Universal health went hand-in-hand with health system strengthening. To that end Norway had developed a broad-based system encompassing promotion, prevention, diagnostics, access, treatment and rehabilitation. Achieving equity was an ongoing challenge and a cornerstone of her Government's health policy. She favoured the inclusion of universal health coverage in the post-2015 development agenda; debate on the subject should focus on availability, quality, financing and organization, and be guided by a rights-based approach.

Dr LOUME (Senegal), speaking on behalf of the Member States of the African Region, said that universal health coverage was the foundation on which equal access to health care was built. With its two components of coverage – needed health services and financial risk protection – universal coverage helped to reduce poverty and was the practical expression of health equity and the right to health. Some countries in the Region had adopted universal health coverage policies while others had expressed the desire to do so. The Secretariat had provided support to some countries in developing health system financing strategies.

The Region's Member States had reached different stages of social and economic development and had differing needs for external support. Progress towards universal health coverage in the Region could be accelerated by analysing the extent of universal health coverage, elaborating and revising policies and strategies for health systems financing through a multistakeholder process, and analysis of progress in implementing policies and using feedback to refine those. WHO must advocate making universal health coverage a priority to high-level health care officials.

Dr AMMAR (Lebanon) paid tribute to WHO for its role in building awareness of the importance of health system strengthening among policy-makers, which had led to sounder policies and better resource allocation, and in pinpointing the critical issues related to human resources and financing, and the causal link between out-of-pocket health payments and poverty. Many countries still needed support in meeting the challenge of managing health care provision and financing by the private sector. Emphasis should be placed on stronger regulatory capacity, performance-based contracting, and partnerships with non-profit-making nongovernmental organizations, especially in prevention and primary care. Another particularly challenging question, from the financing point of view, was how to involve the informal sector.

He reaffirmed support for the inclusion of universal health coverage as an overarching goal in the post-2015 development agenda.

The CHAIRMAN, speaking as the member for Barbados, affirmed the contribution of nongovernmental organizations, which in her country were required to enter into contracts that included guarantees of quality.

Dr GRABAUSKAS (Lithuania), speaking on behalf of the European Union and its Member States, said that Croatia, the former Yugoslav Republic of Macedonia, Montenegro, Iceland, Serbia, Albania, Bosnia and Herzegovina, Ukraine, the Republic of Moldova, Armenia and Georgia aligned themselves with his statement. He concurred with the emphasis in the report on universal health coverage for better health and approved the list of components set out (paragraph 6). More information would be welcome on the results of and future plans for the Secretariat's technical and policy support to Member States in the field of universal health coverage. At the country level, universal health coverage should be regarded as a basic health policy priority and, to ensure the sustainability of the efforts made, it should also figure prominently in national and international development policies. Achieving universal health coverage required the development of relevant indicators for monitoring health systems; multisectoral collaboration between ministries of health, finance, labour and social affairs; and cross-sectoral public health policies that dealt with the determinants of health. A minimum set of services would not suffice: national health systems had to respond to the needs of all people, especially the poor and marginalized.

Universal health coverage was crucial to the attainment of the Millennium Development Goals and, as recommended in United Nations General Assembly resolution 67/81, should be considered for

inclusion in the post-2015 development agenda. It was the key to health equity and to ensuring the right to health, for example in relation to noncommunicable diseases, HIV/AIDS and sexual and reproductive health.

Dr VALVERDE (Panama) affirmed Panama's commitment to achieving universal health coverage and its related benefits, namely providing health equity, ensuring the right to health and reducing poverty. Its many components included universal access to health services, essential medicines and health products; a sufficient supply of motivated health workers available locally; and information systems that provided timely information for decision-making. Increased government health spending was crucial to the long-term sustainability of universal health coverage. She urged Member States to introduce universal health coverage to prevent the poorest members of society from suffering financial ruin, and favoured its inclusion in the post-2015 development agenda.

Dr SHI Guang (China) said that universal health coverage had become a key health reform goal for China; in addition, access to better health care was a core priority of its 2020 social and economic development plan. Universal health coverage should be included as an overarching health goal in the post-2015 development agenda, and all efforts to attain that goal should take full account of differences in national health systems and political, economic, social and cultural environments. More work must be done to define the components of universal health coverage more clearly and to develop measurable and comparable frameworks and indicators for evaluation. Moving towards universal health coverage was a holistic process, requiring multisectoral collaboration under the leadership of national governments. The report should mention that governments had primary responsibility for achieving universal health coverage and should recommend that Member States facilitate the process by introducing relevant laws, regulations and policies.

Dr SARMENTO P. DA COSTA (Timor-Leste) said that her country's Constitution guaranteed the right to health and medical care. Her Government was committed to the establishment of universal, free-of-charge, national health coverage, consistent with its resources and as required by law. Rather than adopting approaches favoured in other Member States, such as health insurance, health taxation and private-sector benefits, it had allocated the necessary resources from the national budget to provide a full range of services at the primary, secondary and tertiary levels. The national health system nevertheless needed strengthening, and a financing system had to be set up to relieve the burden on the State; approaches used in other countries might serve as a good model in that regard.

Dr VALLEJO (Ecuador) said that his country had been progressively moving towards universal health coverage, granting it priority in the 2008 Constitution and its national welfare plan. His Government, convinced of the importance of sustainable health system financing, had invested US\$ 7000 million in the system over the previous five years, attaining in 2011 the highest level of health spending in Latin America. Strategies had been implemented to ensure the availability of essential medicines and to tackle the shortage of health workers.

Public health systems should take account of the social, economic and environmental determinants of health, and provide universal access to services of equal quality. The greatest challenge for the international development agenda was to set clear, carefully-selected, quantifiable and measurable goals for the attainment of universal health coverage, and he urged the Secretariat to redouble its efforts in that direction. The WHO/World Bank ministerial-level meeting on progress towards universal health coverage, scheduled to be held in Geneva (18 and 19 February 2013), would be crucial to determining the goals of the post-2015 development agenda.

Dr HEMMATI (Islamic Republic of Iran) said that all Member States must make universal health coverage a policy priority in order to prevent the rise in health care costs from impeding progress towards equitable access to quality health care and undermining the post-2015 development agenda. The Secretariat should provide support to governments in assessing their health coverage situation, identifying bottlenecks and drawing up, with the participation of all concerned parties, a

suitable health financing policy. During the process, attention should be paid to, inter alia, the identification of vulnerable groups in need of support; development of health care benefits packages and a cost-sharing model; reform of financing structures and resource management; and development and use of clinical guidelines. Global solidarity was vital to achieving universal and non-discriminatory access to advanced diagnostics, technologies, health information and knowledge.

Dr FEISUL IDZWAN MUSTAPHA (Malaysia) said that his country had achieved universal health coverage by providing universal access to an extensive network of public health facilities and services. The sustainability of the system was nevertheless threatened by increasing private sector involvement in health care, medical technology, an ageing population, human resources issues especially in underserved areas, and the growing burden of noncommunicable diseases, particularly for primary care. He reiterated the call to include universal health coverage and noncommunicable diseases in the post-2015 development agenda. His country would continue to rely on the support and expertise of WHO and other international agencies, and was eager to exchange experience with other Member States.

Dr UDVAL NATSAG (Mongolia) said that progress towards universal health coverage had been made, but significant challenges remained for low-income and middle-income countries, including a lack of national expertise in setting targets for universal health coverage and financial risk protection; financial shortfalls making it difficult to attain the average level of per capita health expenditure estimated by the High-level Taskforce on Innovative International Financing for Health Systems; and difficulty in reducing the overall level of out-of-pocket payments. To support Member States in meeting those challenges, the Secretariat should work with them to develop guidelines on universal health service coverage and financing packages.

Dr THABET NASHER (Yemen) suggested that, in view of the criticism levelled at WHO for failing to achieve the goal of health for all by the year 2000, the goal of achieving universal health coverage should be broken down into a series of medium-term targets for the post-2015 period. It would be interesting to know how the interplay of existing initiatives and funding agencies shaped universal health coverage goals for the future. The Member States of the Eastern Mediterranean Region were concerned about the extent to which the complex emergency situations in several of their countries would hinder efforts to achieve universal health coverage.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that most countries regarded health as a constitutional human right for all citizens, yet that right could not be exercised without universal health coverage and an appropriate distribution of wealth at the national and international levels. According to international funding agencies, the distribution of wealth in the Region of the Americas was among the most unequal in the world. The problem concerned all government sectors, not just that dealing with public health. Social and economic equity were crucial to sustainable development, which in turn depended on broad health coverage at the national level. Cuba had a single, regionalized health system that provided primary care to the entire population. The system was linked with all the other public sectors which, in accordance with government policy, were obliged to provide support to it. Organizations such as WHO provided technical and theoretical support, but universal health coverage depended first and foremost on the political will of each individual state.

Dr HORI (Japan)¹ said that Japan, which had introduced a national health insurance scheme to ensure universal access to essential health care services more than 50 years ago, acknowledged the importance of setting the achievement of universal health coverage as a shared goal for the entire global health community. Working towards that goal called for ongoing efforts to improve the quality

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

of health care, implement the Organization's plan of action, and obtain and sustain domestic funding. Japan was ready to cooperate with WHO in its efforts to facilitate progress towards universal health care at all levels, and would continue participating in bilateral and regional cooperation for health.

Dr ATTAYA LIMWATTANAYINGYONG (Thailand),¹ endorsing the views of the members for Maldives, Myanmar and Timor-Leste, commended the Secretariat's plan of action, in particular because it set out to support Member States in their efforts to achieve universal health coverage in accordance with the specificities of their own national health systems, and emphasized capacity-building at the national and regional levels. To achieve universal health coverage, South-South cooperation was needed as well as hands-on experience rather than theoretical debate; a good model was the universal health coverage network established as a platform for learning and experience-sharing by the Association of Southeast Asian Nations Plus Three.

In order to sustain the momentum of regional- and international-level policy dialogue, she suggested the elaboration of a three-year strategic dialogue plan. In the meantime, the next step was to organize a policy forum, technical briefings and side meetings for experience-sharing in parallel with the Sixty-sixth World Health Assembly.

Dr HENG (Singapore)¹ observed that a strong consensus had emerged globally on the importance of achieving universal health coverage, owing to its potential social and economic benefits. WHO and other stakeholders were to be applauded for their tireless advocacy efforts at the national level, which had culminated in the adoption in 2012 of United Nations General Assembly resolution 67/81 on Global health and foreign policy. Nevertheless, the road to achieving universal health coverage was complex and each country must tailor its own approach. Even countries like his own that already had universal health coverage should continue striving to improve the quality of coverage and effectiveness of care, and to ensure that it remained sustainable and affordable.

He recognized the powerful unifying force of the concept of universal health coverage, but stressed that it was not an end in itself. He agreed with the emphasis placed on identifying evidence-based indicators within a concise and transparent framework to measure progress, and with the need to integrate universal health coverage into the noncommunicable disease campaign. The question was whether universal health care could be guaranteed in the face of current demographic and epidemiological changes or whether steps should be taken to reduce the risk by promoting healthy lifestyles, investing in cost-effective preventive care and mobilizing sufficient public and private funds to meet present and future health care needs.

Mr PIPPO (Argentina)¹ said that achieving universal health coverage meant guaranteeing the right to health, which called for improvements in living conditions, and efforts to tackle the determinants of health. The best way to achieve universal health coverage was through national health systems, financed by general revenues and providing services free of charge, without co-payments. Such models had proven to be sustainable, even in the face of economic downturns and rising health costs. In Argentina, health coverage was guaranteed for all through voluntary or compulsory medical insurance schemes or, in the case of the most vulnerable groups, free access to essential medicines, vaccines and treatment, thereby helping to promote their health and, indirectly, to redistribute wealth. In recent years, there had been a decrease in the share of family income spent on health costs. Much remained to be done, in both his country and the many countries struggling to maintain fair and equitable health systems, and that required the commitment of all Member States and the support of the Secretariat at headquarters and regional office levels.

Mr SEN (Turkey)¹ said that the link between universal health coverage and sustainable development had recently been acknowledged at the international level in the form of United Nations

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

General Assembly resolution 67/81, of which his country had been a sponsor. Universal health coverage contributed to and benefited from sustainable development and provided a means of measuring its progress.

Turkey had been making progress towards universal health coverage, as indicated by health outcomes, financial protection and use of core health services, for nearly a decade. The government's determined efforts to adopt appropriate health policies and to tackle the determinants of health had yielded reductions in mortality, morbidity and disability as well as achievement of health-related Millennium Development Goals. Achieving universal health coverage was a broad goal which called for strong advocacy and long-term engagement and merited a place in the post-2015 development agenda. All Member States should be encouraged to engage in constructive work and collaboration with WHO on that challenging task.

Miss WILLARD (International Federation of Medical Students Associations), speaking at the invitation of the CHAIRMAN, agreed that universal health coverage, underpinned by human rights and equity, should be an overarching goal in the sustainable development agenda. Notwithstanding the progress to date, all stakeholders had to make even greater efforts to establish solid and structured management and governance in order to reach the most vulnerable and neglected groups not adequately served by the millennium development project. That would require new, effective and coordinated approaches to tackling problem areas; continuous evaluation of their risks, benefits, relevance and the ethical considerations to which they gave rise; concerted and sustained global support for basic research; and the building of sustainable green economies. A unifying framework, backed by multisectoral, interagency collaboration, and strong national health systems adapted to each country's specific circumstances were also important.

Mrs PARISOTTO (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN and on behalf of the People's Health Movement, welcomed WHO's growing interest in including universal health coverage as a strategic priority within the sustainable development framework. Furthermore, efforts to achieve universal health coverage should be part of a larger, comprehensive strategy that included both social and structural determinants of health. She expressed concern, however, that the term "universal health care" had been replaced by "universal health coverage", which suggested reliance on an insurance-based model. The risk was that universal health coverage would perpetuate the selective primary health care approach driven by market forces, which could lead to the dismantling of the public health system. She suggested a return to universal health care through the establishment of organized, accountable systems that provided high-quality, comprehensive primary health care services.

Another concern was that the focus on service delivery might divert attention from efforts to tackle the determinants of health and to foster grass-roots participation in shaping health services. The global financial crisis and the ongoing privatization of public services were giving rise to growing health inequalities, both within and between countries. She called upon Member States to uphold the fundamental principles of comprehensive, publicly financed, health systems capable of guaranteeing equal access to all.

Ms BAUMGARTEN (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, regarded universal health coverage as a core priority requiring the active support of all stakeholders and as crucial to the realization of the right to health. Health was not a commercial commodity that only some could afford; nor was it a gift that governments could choose to bestow on their citizens or not. Universal health coverage was an obligation.

Her organization was working with WHO to foster civil society support for the universal health coverage goal at the country level, and to determine how efforts to attain it could be equitable from the outset. Given the concern over the vagueness of the concepts under discussion, she urged WHO to work not just on health financing systems but also on definitions and clarifications of the terms involved.

It was unfortunate that some countries regarded only “significant” or “catastrophic” direct payments as a problem. For the poor, rising food prices meant that even the smallest fee or co-payment could make crucial preventive care and treatment unaffordable. The principle of free-at-delivery health services should apply to all, and that required a commitment on the part of rich to pay their fair share through pooling mechanisms or taxation.

She called on all those working on specific diseases or health services to incorporate the principle of universal health coverage into their work.

Dr KIENY (Assistant Director-General), welcoming the support expressed for universal health coverage, agreed that health system strengthening should serve as a platform for universal health coverage. Accordingly, the Secretariat would do its best to combine work on health system strengthening with promotion of universal health coverage. She agreed also that priority should be accorded to the development of indicators and targets, as well as to technical support and capacity-building. She had noted the endorsement of the exchange of information and best practices as a means of enabling countries to build on the achievements of others and to identify the bottlenecks in their own systems. She had also taken note of the suggestions for using the Sixty-sixth World Health Assembly as a platform to promote universal health coverage, the interest expressed in the WHO/World Bank ministerial-level meeting on universal health coverage to be held in February 2013, and the suggestion for organizing a policy forum and a technical briefing. The report would be strengthened before being submitted to the Health Assembly in May with, for instance, information about the outcome of WHO’s technical support to countries. It would also provide the guidance requested by the member for Mongolia on financial options and packages.

Cross-sectoral cooperation was the key to universal health coverage, which many speakers considered to extend well beyond the health sector. As to how the three levels of the Organization would help to support the engagement of Member States, the Secretariat saw a crucial role for country offices in the work on health systems and universal health coverage, and every effort was being made to strengthen the capacity of those offices to support countries to engage in cross-sectoral policy dialogue. The Secretariat would shortly be holding a meeting for staff from regional offices and headquarters to define the concept of universal health coverage and elaborate the strategy for its promotion and for supporting country offices in implementing it locally. Headquarters and regional offices would also be defining indicators and a monitoring framework, and providing platforms, such as the International Health Partnership Plus and the Providing for Health network, to foster national dialogue with government, civil society, donors and partners. Technical support packages would be designed for regional offices to adapt to local needs; regional offices would also be responsible for helping country offices to assimilate the necessary knowledge so as to be able to provide support to governments.

One of the main reasons for transforming the earlier concept of universal health care was to underscore that it was not just a matter of therapy and treatment but also a question of promotion, prevention, rehabilitation and palliative care; the concept of universal health coverage would embrace the entire continuum.

The Board noted the report.

The meeting rose at 12:30.

FOURTEENTH MEETING

Monday, 28 January 2013, at 14:40

Chairman: Dr J. ST. JOHN (Barbados)

1. **HEALTH SYSTEMS:** Item 10 of the Agenda (continued)

The health workforce: advances in responding to shortages and migration, and in preparing for emerging needs: Item 10.4 of the Agenda (Document EB132/23)

Mr ASAOLU (Nigeria), speaking on behalf of the Member States of the African Region, welcomed WHO's efforts not only to raise awareness of the health workforce crisis, but to develop a response to an issue that was undermining health outcomes, in particular in the African Region. The WHO Global Code of Practice on the International Recruitment of Health Personnel ought to make a difference. In November 2012, the Regional Committee for Africa had endorsed a road map that could contribute to the development and implementation of guidelines for the retention of health workers.¹ However, enormous challenges remained as the regional health workforce crisis involved a broad range of financial and technical issues as well as migration.

All possible steps should be taken to improve the situation in Africa. A more comprehensive strategy should be developed to respond to the needs of the labour market and transform the education and training of health workers at all levels. Both South–South and North–South cooperation should be promoted for health workforce development and retention, and he supported the establishment of a special training fund in developing countries to redress the negative effects of migration and achieve universal health coverage by 2015. Africa needed more health workers than ever before, and WHO should lead the efforts to mobilize the resources necessary to augment the training and improve retention of health workers in Africa. The health workforce issue should remain a critical component of the post-2015 development agenda and be addressed in WHO's twelfth general programme of work.

Dr VALLEJO (Ecuador) said that the shortage of health personnel in his country had been exacerbated by the large number of citizens who had emigrated to other countries as a result of the financial crisis that had begun in 2001. To respond to the shortage, his Government had launched a plan in 2012 offering financial and economic incentives for health professionals to return to the country and resume work in the health service; legislation had been strengthened and the salaries of specialized physicians and nurses had been increased. Other actions had included the establishment of a global database of professionals and the launch of external competitions. Agreements had been signed with universities for the provision of international scholarships and for the training of professionals in areas of special expertise needed by the country. Postgraduate fellowship agreements were in force with Cuba, and some 200 Cuban professionals were working in Ecuador to compensate for shortages of national staff.

International cooperation was essential to remedy the shortage of health professionals, and Ecuador undertook to send reports on its progress in that regard to PAHO, WHO headquarters and the Ibero-American Network on Migration of Health Professionals.

¹ Resolution AFR/RC62/R3.

Dr GRABAUSKAS (Lithuania), speaking on behalf of the European Union and its Member States, said that Croatia, the former Yugoslav Republic of Macedonia, Montenegro, Iceland, Serbia, Albania, Bosnia and Herzegovina, Ukraine, the Republic of Moldova, Armenia and Georgia aligned themselves with his statement. Despite the progress made in implementing the WHO Global Code of Practice on the International Recruitment of Health Personnel, much remained to be done, particularly with regard to the establishment of designated national authorities. Only in the European Region had 80% of Member States established such authorities.

Human resources were essential for the achievement of universal health coverage, in particular in low-income countries. However, the economic crisis had exacerbated pressures on health workers globally and staff shortages had prompted an increase in cross-border recruitment of health professionals in many countries. An action plan approved in April 2012 by the European Union to help Member States to enhance health workforce sustainability supported the implementation of the Code. A joint action on European health workforce planning and forecasting that sought to improve migration data in the European Union and develop guidance on cooperation in implementing the Code would be launched soon with the involvement of up to 19 participating countries and WHO as a collaborating partner.

The health workforce crisis was a global, multidimensional challenge, and a balance should be struck between national and global interests. Commitment from all countries was essential, as was the need to anticipate health workforce needs. Countries should strive to involve all relevant sectors in devising national policies and measures to ensure a sustainable health workforce.

Mr HAZIM (Morocco), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that migration of health workers was a serious issue for the majority of both source and destination countries in the Region. The flow of internally displaced persons and cross-border refugees, who included health workers, created a huge burden on the health systems and also had socioeconomic repercussions.

The States of the Cooperation Council for the Arab States of the Gulf and Libya were destination countries and attracted the highest number of migrant health workers from other countries in the Region and from India and the Philippines. Their obligations to those workers and to the source countries were highlighted in the WHO Global Code of Practice on the International Recruitment of Health Personnel. Afghanistan, Iraq, Morocco, Pakistan, Somalia, South Sudan, Sudan and Yemen faced a severe shortage of human resources for health, and in the source countries of the Region the health workforce situation was even more desperate.

With respect to the development of nursing and midwifery in the Region, a strategy had been formulated for the period 2012–2020, in line with the Strategic Directions for Strengthening Nursing and Midwifery Services, and was being used as a framework for the preparation of national action plans. He favoured the pursuit of multilateral negotiations under the Code to strengthen support and assistance to educational institutions in source countries with the aim of increasing the number of health graduates, including nurses and midwives, and ensuring continued support for the Region's Member States in developing their national action plans for nursing and midwifery.

Ms PENEVEYRE (Switzerland), recalling that Switzerland had submitted its report on implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel in 2012, expressed concern that so few other countries had done so. Consideration should be given to the reasons for the poor response and to possible changes to be made for the next reporting cycle in 2015. The Secretariat should have made better use of the responses received, and she asked whether a report would be made to the Health Assembly in accordance with Article 9.2 of the Code, and requested clarification of the next steps to be taken. She also asked what action would be taken to encourage information sharing on the basis of the national reports submitted. She favoured the continuation of close cooperation between WHO and OECD with a view to monitoring trends and remedying the scarcity of data on health workforce migration referred to in paragraph 15 of the report. Work on the Code should be appropriately reflected in the proposed programme budget 2014–2015.

Dr JAMSHEED MOHAMED (Maldives) acknowledged the importance of the WHO Global Code of Practice on the International Recruitment of Health Personnel and welcomed the focus on human resources for health in Health Assembly resolutions adopted in 2011. There was a need for better national and international data on the health workforce, including data on workforce migration and future needs, and he drew attention to the need for a long-term health workforce plan. Strengthened regulatory systems and greater collaboration between governments and regulatory authorities were also necessary to deal with the increasing number of applications from persons with forged certificates and documents for clinical posts in the developing world.

Currently, more than 80% of the workers in the Maldivian health system, particularly doctors, were expatriates, many using the Maldives as a stepping stone to work in other parts of the world that offered better opportunities and salaries. The high turnover made it difficult to train staff to deal with specific national health needs and prevalent diseases. Moreover, frequent service disruptions hampered efforts to maintain universal health coverage and improve quality of care. In order to promote the achievement of universal coverage, WHO should develop renewed approaches to the health workforce crisis, with a particular focus on countries like his own that faced ever-increasing costs and lacked capacity to train health professionals in many areas.

Mr SANNE (Norway), noting that designated national authorities had been established in fewer than half of WHO's Member States, said that the Secretariat should have allocated significantly more resources to follow up the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel. In its work with the Global Health Workforce Alliance, Norway would focus on the role of high-income countries and their contribution to the global health workforce crisis, and would be hosting a second conference on the impact of the financial crisis on health systems in the European Region in Oslo in April 2013, in collaboration with the Regional Office for Europe. He encouraged all Member States to attend the Third Global Forum on Human Resources for Health due to be held in Brazil in November 2013.

The Secretariat should analyse the reasons for the low level of reporting on implementation of the Code in 2012. Implementation of resolutions related to health personnel should be given greater priority in WHO, consistent with the efforts to match plans and budgets with governing body priorities. Better use should be made of regional and country offices to support Member States' implementation of such resolutions with a view to achieving universal health coverage.

Dr DAULAIRE (United States of America), welcoming the informative report, expressed disappointment that only 48 countries, including his own, had reported on implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel in 2012. He was concerned that the national reporting instrument was too broad to support the effective monitoring of migration trends. He also requested clarification of how the elimination by WHO of all full-time posts occupied by staff implementing Code-related activities would affect WHO's future work and cooperation with partners on those activities.

The United States was anxious to continue cooperating with WHO to achieve the objectives of the Code. It remained fully committed to a portfolio of health system strengthening and health workforce training. Measures were being taken at the national level to increase medical school and nursing school enrolment. The United States also continued to support training opportunities for health care workers globally through its HIV/AIDS-related development assistance, in particular in Africa. The Peace Corps would be launching a global health service corps in 2013, aimed at strengthening African medical and nursing schools.

Professor HALTON (Australia) welcomed the report and agreed that efforts should be made to maintain momentum and ensure that the WHO Global Code of Practice on the International Recruitment of Health Personnel was properly implemented. Self-sufficiency was a goal to which Australia aspired. However, it took a long time to train health personnel, and clear domestic policies and instruments must be put in place. The work on strengthening the health workforce required focus

and real data, and close collaboration with OECD could be beneficial to prevent duplication and to leverage resources available elsewhere.

The CHAIRMAN, speaking as the member for Barbados and referring to the issue of national policies, said that in her own country health policies were determined by the civil service ministry outside the health framework; they were sometimes obstructive and were imposed on the health sector without consultation. Efforts were currently being made to change that situation at the Caribbean Community level, with a view to initiating a dialogue with governments that would pave the way for policy input to be provided to the relevant departments.

Mrs ESCOREL DE MORAES (Brazil)¹ said that the report made a valuable contribution to the debate on universal health coverage. A skilled, well-trained and motivated workforce was essential in order to improve service delivery and in the interests of cost-effectiveness. A broader analysis of the situation with regard to workforce requirements and migration patterns must take into account respect for human rights and access to the best possible education and training in health. The Third Global Forum on Human Resources for Health scheduled to be held in Recife, Brazil, in November 2013 would provide an opportunity to explore workforce issues from the standpoint of their impact on essential interventions and health services, and to identify the changes required to achieve universal health coverage. She encouraged Member States and international and civil society organizations to participate actively in the Forum.

Ms WISEMAN (Canada)¹ said that her Government recognized the collaborative efforts and contributions of WHO and its partners in addressing the global challenges associated with the international migration of health personnel. Canada had designated a national authority responsible for exchanging information and had worked with other stakeholders in order to meet the reporting requirements set out in the WHO Global Code of Practice on the International Recruitment of Health Personnel. It had taken steps to increase the domestic supply of health professionals and establish policies for ethical recruitment. The ongoing monitoring of the international migration of health personnel was essential and she encouraged other Member States to establish national authorities, complete the national reporting instrument, and support global efforts to address global shortages of health personnel.

Ms WISKOW (International Labour Organization) commended the report and welcomed the progress made in implementing the WHO Global Code of Practice on the International Recruitment of Health Personnel. Given the voluntary nature of the Code, the designation of national authorities in 81 countries was encouraging, and it was to be hoped that more countries would join the reporting system. However, the fact that 35 of the 48 reports submitted had originated from the European Region highlighted the need to give other regions greater support in following up on recommendations of the Code. ILO continued to work with WHO and ensured, through its tripartite constituency, that the voices of health workers, employers and governments were heard; the national report of the Philippines, for instance, was the result of a multistakeholder dialogue supported by the ILO project on promoting decent work across borders. Ensuring a sufficient number of qualified health workers was essential for universal health coverage. Multidimensional responses were required, including investment in the health sector and public services so as to retain a qualified and motivated health workforce, in particular in the area of nursing and midwifery. ILO stood ready to continue to work with the Secretariat and its Member States on health workforce issues, which should be taken into account in the WHO reform process.

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

Mr BESANÇON (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN and also on behalf of the World Medical Association, the International Council of Nurses, the World Confederation for Physical Therapy and the World Dental Federation, which, together with the International Pharmaceutical Federation, formed the World Health Professions Alliance, welcomed the progress made in documenting and reporting health workforce shortages and migration. The health workforce crisis was global and multidimensional, and comprehensive planning should be encouraged at the national level to ensure that a competent health workforce was able to respond to health system needs, including those relating to the post-2015 agenda. Greater interprofessional collaboration was also important in preparing for emerging needs and delivering universal health coverage.

The Alliance would welcome the opportunity to collaborate with the Secretariat in providing additional data and analysis, and in outlining strategic directions to strengthen the services provided. The national reporting instrument should be extended to cover health professionals other than physicians and nurses, and agreements similar to the one on strategic directions for strengthening nursing and midwifery services for the period 2011–2015 should be developed for other health professionals, such as pharmacists, dentists and physiotherapists.

Dr KIENY (Assistant Director-General), responding to comments, said that the number of reports received since the preparation of the report had increased from 48 to 51. Some low-income countries had also nominated focal points and submitted reports. The Secretariat would provide more detailed information for the Health Assembly, analysing rates of response and would put forward suggestions for increasing the participation of Member States in the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel. Regional platforms could help to increase the number of responses, and WHO would use international forums to appeal for increased participation. Noting that reports had been received from 31% of Member States represented on the Board, she urged Board members to encourage their governments to nominate a focal point and submit a report.

Regarding the points raised by the member for Switzerland, she said that the Secretariat would look into the possibility of closer collaboration with OECD. Although the work under the Code had been included in the proposed programme budget, funding was not assured. In response to the questions raised by the member for the United States regarding staffing, she said that four technical officers in headquarters and six technical officers at the regional offices were working on the implementation of the Code. WHO was trying to adopt working practices to facilitate cross-cutting work on matters relating to health systems.

She thanked Brazil and Thailand for their leadership in the area of human resources for health. The Third Global Forum on Human Resources for Health to be held in Brazil in November 2013 would be followed by a Prince Mahidol Award Conference on the training of health workers, to be held in Thailand in January 2014. She trusted that many Board members would take part in those important events.

The Board took note of the report.

eHealth and health Internet domain names: Item 10.5 of the Agenda (Document EB132/24)

The CHAIRMAN drew attention to a draft resolution on eHealth standardization and interoperability proposed by Mauritania and Myanmar, which read:

The Executive Board,
Having considered the report on eHealth and health Internet domain names,¹

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

The Sixty-sixth World Health Assembly,

PP1 Recalling resolution WHA58.28 on eHealth;

PP2 Recognizing that information and communication technologies have been incorporated in the Millennium Development Goals;

PP3 Recognizing that the Regional Committee for Africa adopted resolution AFR/RC60/5 on eHealth in the African Region and that the 51st Directing Council of PAHO adopted resolution CD51/13 on eHealth and has approved the related strategy and plan of action;

PP4 Recognizing that the secure, effective and timely transmission of personal data or population data across information systems requires adherence to health data standards and related technology standards;

PP5 Recognizing that, to improve care, and increasingly engaging patients in their own care, as appropriate, it is essential to make appropriate use of information and communication technologies in order to offer quality health services, support sustainable financing of health care systems and promote universal access;

PP6 Recognizing that the lack of seamless exchange of data within and between health information systems hinders care and leads to fragmentation of health information systems, and that improvement in this is essential to realize the full potential of information and communication technologies in health system strengthening;

PP7 Recognizing that, through standardized electronic data, health workers can gain access to fuller and more accurate information about patients in electronic form at the point of care, pharmacies can receive prescriptions electronically, laboratories can transmit test results electronically, imaging and diagnostic centres can send high-quality digital images, researchers can carry out clinical trials and analyse data with greater speed and accuracy, public health authorities can receive electronic reports on vital events in a timely manner, and implement public health measures based on the analysis of health data and individuals can gain access to their personal medical information which supports patient empowerment;

PP8 Recognizing that advances in medical health care, coupled with an exponential increase in the use of information and communication technologies in the health sector and other related fields including environment, have brought about a need to collect, store and process more data about patients and their environment in multiple computer and telecommunication systems;

PP9 Recognizing that the electronic collection, storage, processing and transmission of personal health data requires adherence to the highest standards of data protection;

PP10 Recognizing that the electronic transmission of personal data or population data using health information systems based on information and communication

¹ Document EB132/24.

technologies requires adherence to health data and technology standards in order to achieve secure, timely and accurate exchange of data for health decision-making;

PP11 Emphasizing that scientific evaluation of the impact on health care outcomes of health information systems based on information and communication technologies is necessary to justify strong investment in information and communication technologies for health;

PP12 Highlighting the need for national eHealth strategies to be developed and implemented, in order to provide the necessary context for the implementation of health data standards, and in order that countries undertake regular, scientific evaluation;

PP13 Recognizing that it is essential to ensure secure online management of health data given their sensitive nature and to the increase trust in eHealth tools and health services as a whole;

1. URGES Member States:

(1) to consider, as appropriate, options to collaborate with relevant stakeholders, including national authorities, relevant ministries, and academic institutions, in order to draw up a road map for implementation of health data standards at national and subnational level;

(2) to consider developing, as appropriate, policies and legislative mechanisms linked to an overall national eHealth strategy, in order to ensure compliance in the adoption of health data standards by the private sector and the donor community;

2. REQUESTS the Director-General, within existing resources:

(1) to provide support to Member States, as appropriate, to integrate the application of health data standards and interoperability in their national eHealth strategies through a multistakeholder and multisectoral approach including national authorities, relevant ministries, and academic institutions;

(2) to provide support to Member States, as appropriate, in their promotion of the full implementation of health data standards in all eHealth initiatives;

(3) to provide guidance and technical support, as appropriate, to facilitate the coherent and reproducible evaluation of information and communication technologies in health interventions, including a database of measurable impact and outcome indicators;

(4) to promote full utilization of the network of WHO collaborating centres for health and medical informatics and eHealth for research, development and implementation;

(5) to report regularly through the Executive Board to the World Health Assembly on progress made in the implementation of this resolution.

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

1. Resolution: eHealth standardization and interoperability

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): 10

Organization-wide expected result(s): 10.7

How would this resolution contribute to the achievement of the Organization-wide expected result(s)?

It would strengthen country health information systems by supporting the provision of timely, reliable, and accurate data for decision-making.

<p>Does the programme budget already include the products or services requested in this resolution? (Yes/no) 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) Five years (covering the period 2013–2017)</p> <p>(ii) Total: US\$ 2.25 million (staff: US\$ 750 000; activities: US\$ 1.50 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). Total: US\$ 250 000 (staff: US\$ 200 000; activities: US\$ 50 000)</p> <p>Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant. All levels of the Organization.</p> <p>Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no) 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) 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. One staff member (0.5 full-time equivalent).</p>
<p>4. Funding</p> <p>Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no) Yes.</p> <p>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.</p>

The CHAIRMAN also drew attention to a draft decision on Internet domain names related to health proposed by Belgium on behalf of the European Union and its 27 Member States, which read:

The Executive Board, at its 132nd session,
Having considered the report on eHealth and health Internet domain names,¹

RECOMMENDS to the Sixty-sixth World Health Assembly the adoption of the following decision:

The Sixty-sixth World Health Assembly,

PP1 Recalling resolution WHA1.133 governing the use of the name, acronym and emblem of WHO by third parties;

PP2 Recognizing that secure online management of all personal health data is essential to ensure public confidence in eHealth and in health services as a whole;

PP3 Recognizing that maintaining trust among Internet users requires the definition of criteria to register Internet domain names related to health, in the view of safeguarding a transparent, lawful and quality online health environment, and preventing the development of illicit markets of medicines, medical devices and unauthorized and otherwise inappropriate medical services;

PP4 Underlining that WHO, exercising its essential function as the directing and coordinating authority in the field of international public health, has a role to play in conveying to the appropriate bodies, including to the Internet Corporation for Assigned Names and Numbers (ICANN) and relevant United Nations agencies, legitimate health concerns regarding the allocation and use of Internet domain names related to health;

PP5 Underlining in this context the necessity to protect the name and acronym of the World Health Organization (WHO) against its registration by third parties as part of their Internet domain names,

1. Requests the Director-General:

(1) to continue working with the appropriate entities, including ICANN and relevant United Nations system agencies in the protection of the names of intergovernmental organizations;

(2) to convey to them the necessity of ensuring that the allocation and use of the internet domain names related to health will not result in compromising public health objectives and public confidence in the online health environment;

(3) to continue protecting the name, acronym and emblem of the WHO, including against its registration and misuse by third parties as part of their internet domain names;

(4) to report to the Board at its 133rd session and, as appropriate, subsequent sessions.

The CHAIRMAN pointed out that, in the introductory part of the draft decision, the words “RECOMMENDS to the Sixty-sixth World Health Assembly the adoption of the following decision: The Sixty-sixth World Health Assembly” should be deleted.

Professor HALTON (Australia), noting that the draft decision was dated that day, 28 January, which was a public holiday in Australia, said that she had been unable to consult with the relevant ministries and would not be in a position to comment on the text. The more timely submission of proposals would facilitate their consideration.

She could support the adoption of a resolution on eHealth standardization and interoperability, but proposed insertion of the words “health care providers” after “relevant ministries” in subparagraph 1(1). In subparagraph 1(2), the words “private sector” could be replaced by “public and private sectors, as

¹ Document EB132/24.

appropriate”; and in subparagraph 2(1), after “relevant ministries” and subject to possible editorial improvement by the Secretariat, the words “relevant private sector parties” could be inserted.

Dr CUYPERS (Belgium), speaking on behalf of the European Union and its Member States, expressed support for the draft resolution, but proposed that a footnote referring to the participation of regional economic integration organizations be added after “URGES Member States”. The words “as well as to ensure the privacy of personal clinical data” should be added at the end of subparagraph 1(2). In subparagraph 2(4), the words “to support Member States” should be added after “eHealth”, and the word “implementation” should be replaced with “innovation in these fields”.

Recognizing the opportunities and challenges associated with the development of a quality online health environment, the European Union had proposed the draft decision on Internet domain names related to health. It supported the expansion of trusted Internet domain names related to health, provided that they were managed in a way that did not compromise public health. The ongoing process of assignment of top-level Internet domain names related to health must aim at protecting eHealth users and at maintaining a lawful health environment. The Internet should not become a haven for unauthorized medical services, such as the promotion of sales of falsified medicines and the illicit use of personal health data. WHO, as the directing and coordinating authority in the field of global health, was entitled to protect public health objectives in the allocation of Internet domain names related to health. Its name and acronym should be protected against registration and misuse by third parties.

The CHAIRMAN expressed regret that the heavy agenda of the Executive Board had prevented the European Union from submitting the draft decision until that day.

Dr MYINT HTWE (Myanmar) welcomed the information on regional activities and eHealth trends and progress provided in the report. The work of the WHO Global Observatory for eHealth was extremely beneficial to Member States, and he called for continued action to ensure that the Observatory was dynamic, comprehensive and responsive to the needs of Member States. Full use should be made of WHO collaborating centres in conducting capacity-building activities at country level, in particular in developing countries in the context of the National eHealth Strategy Toolkit. He emphasized the importance of eHealth standardization and interoperability, which contributed to the delivery of quality health-care and preventive-care services through appropriate use of information and communication technologies. The full potential of those technologies should be harnessed to meet the specific requirements of individual countries through capacity-building activities, particularly in terms of developing the analytical capability of health professionals working at different levels of the health care delivery system, which would have multiple benefits for programmes all across the WHO domain. He strongly recommended that budgetary provision be made in the country-level workplan to fund such activities and to promote and expand eLearning networks, in particular for the developing countries. In view of the above considerations, Myanmar was sponsoring the draft resolution.

Mr SKOTHEIM (Norway), referring to the seventh preambular paragraph of the draft resolution, proposed that the words “can send” before “high-quality digital images” and “can receive” before “electronic reports” should be replaced by “have access to”. He also proposed the addition of a new subparagraph 2(6), to read: “to promote, in collaboration with relevant international standardization agencies, harmonization of eHealth standards”.

Ms PENEVEYRE (Switzerland) said that, although the potential benefits of information and communication technologies for the health sector were considerable, steps must be taken to contain dangers such as the misuse of personal data. She welcomed the fact that the draft resolution requested the Director-General to provide support to Member States in developing mechanisms to enhance eHealth. Switzerland shared the European Union’s concern that domain names related to health should be used in a manner consistent with public health interests, and encouraged the Secretariat to continue

to convey that concern to the competent authorities. WHO should continue its efforts to protect its name and acronym from use as domain names on the Internet.

Dr DAULAIRE (United States of America) said that health information technology could improve efficiency within the health care system and expand access to affordable and high-quality services for all individuals. He supported the draft resolution as amended by the members for Australia, Belgium and Norway. Welcoming the information provided on the issue of Internet domain names, he expressed support for appropriate measures to protect the names of intergovernmental organizations, including WHO, from third party registration. Referring to subparagraph 24(b) of the report, he requested further information on how the questions raised in 2003 by the Executive Board regarding an international organization owning and managing a domain name from a legal, financial and operational standpoint had been addressed. He noted with satisfaction that WHO had attended a recent meeting of the Governmental Advisory Committee of the Internet Corporation for Assigned Names and Numbers (ICANN) and made the case for the “.*health*” domain to be operated in the global public interest. However, the United States would be wary of WHO’s engagement to pursue possible safeguards to protect health-related domain names since its oversight capability was limited and such engagement could create future liabilities for the Organization.

He had some concerns about the draft decision, which had been circulated only that morning and which, although well-intentioned, appeared rushed. WHO did not own the word “health” and thus had no special claim to regulate it or establish rules for it, which was what the draft decision appeared to suggest. His Government’s experts had not had time to review the text, and he suggested that the Secretariat should prepare a paper on the issue for consideration by the Sixty-sixth World Health Assembly.

Dr AMMAR (Lebanon), speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed the informative report, which made it clear that WHO would have to act quickly to protect its name, acronym and emblem and ensure that the “.*health*” domain name was not used in a manner that was detrimental to public health. Given that no consensus had been reached on ownership of that top-level domain, the draft decision was a good compromise and should be supported. He supported the draft resolution as amended by the members for Australia, Belgium and Norway.

Dr MATCHOK-MAHOURI (Chad), speaking on behalf of the Member States of the African Region, welcomed the report and the progress made in the area of eHealth since the adoption of resolution WHA58.28 in 2005. The Internet was a key tool for health education, capacity building, research and health networks, and information and communication technologies should be integrated further into national health mechanisms for the exchange of factual data. However, many African countries did not have the capacity to investigate Internet fraud and the unlawful sale of pharmaceutical products. Noting that national policies and measures of protection should in all cases be relevant to the common challenges at the international level, he drew attention to the particular challenges faced by the African Region, which included the digital divide, limited knowledge in the area of eHealth, weak leadership and coordination, a lack of human and financial resources, and shortcomings in the monitoring and evaluation system. Member States in the Region were committed to implementing resolution AFR/RC60/R3 on eHealth solutions in the African Region. They supported the initiative to collaborate with intergovernmental organizations and, noting the increase in the unauthorized use of Internet domain names, encouraged the African Union to contact the Internet Corporation for Assigned Names and Numbers with a view to developing appropriate policies to protect names and emblems of intergovernmental organizations on the Internet.

Dr CUYPERS (Belgium) said that the comments that had been made about the timing of the proposal submitted on behalf of the European Union were unfair. The original intention had been to incorporate the proposed decision in the text proposed by Mauritania and Myanmar. The discussion of that text had not taken place until the end of the previous week because of a delay in the arrival of one of the proponents; following that discussion, which had also involved the members for Australia and

the United States, the European Union had decided to table a separate proposal on the morning of Saturday, 26 January. The European Union was aware of the discussions that had been held on the timing of the submission of documents and fully supported more diligence in that matter. Noting that Rule 5 of the Rules of Procedure of the Executive Board provided that documents for the session should be dispatched not less than six weeks before the commencement of a regular session, he pointed out that the report (document EB132/24) was dated 11 January. He understood the concerns expressed by the member for Australia, and was prepared to show flexibility. However, action on the important topic under discussion should be taken in the coming months.

Dr WIRANPAT KITTIHARAPHAN (Thailand)¹ welcomed the draft resolution. She encouraged WHO to play an active role in the global governance structure for new top-level domains in order to protect the global public interest and prevent the misuse of eHealth by commercial interests. Member States should develop and strengthen their national strategies and plans, with support from the Secretariat. The establishment of monitoring and evaluation systems was essential in order to measure progress in the implementation of the national eHealth strategic plans.

Dr DAULAIRE (United States of America) expressed appreciation of the flexibility shown by member for Belgium, and suggested that the Health Assembly, in May 2013, might consider incorporating some of the issues relating to domain names into the proposed draft resolution.

Professor HALTON (Australia) supported the approach suggested by the member for the United States. The draft decision raised two issues: the protection of WHO's name and other attributes and the broader issue of domain names on which the advice of experts was needed. The two issues should be considered in combination.

Dr CUYERS (Belgium) pointed out that the process being implemented by the Internet Corporation for Assigned Names and Numbers regarding top-level domains would be completed in April 2013, before the Sixty-sixth World Health Assembly. It might therefore be desirable to proceed with the draft decision before the closure of that process.

The DIRECTOR-GENERAL explained that the Internet Corporation for Assigned Names and Numbers was currently reviewing applications for new top-level domain names, including *“.health”*. WHO – like its fellow organizations in the United Nations system, as expressed at a recent CEB meeting – was anxious to protect its name, acronym and emblem, but there were limits to its capacity to manage a top-level domain name and it had concerns about the potential related liability of the Organization. She stressed that the Secretariat could not take a decision to apply for the domain name *“.health”* without the approval of Member States, but the latter should be made aware of the consequences of such a decision. She recognized the timeline of April 2013 for a decision on those domains. WHO and other intergovernmental organizations were engaged in discussions with the Internet Corporation for Assigned Names and Numbers, which understood their concerns in relation to the need to protect their names against use by other entities, especially – in the case of WHO – against advertisers who made false or misleading claims about pharmaceutical products. She noted that the Internet Corporation for Assigned Names and Numbers would have mechanisms to address liabilities arising from its authorization of the use of domain names. In that connection, she pointed out that the Secretariat was already fulfilling the requests made in subparagraphs 1(1) and 1(3) of the draft decision and was acting as a conduit between the relevant bodies and Member States in a process of information sharing, in line with the request contained in subparagraph 1(2). Regardless of whether elements of the draft decision were incorporated in the draft resolution, the broader issues relating to eHealth and health Internet domains would have to be discussed by the Health Assembly.

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

Mr BESANÇON (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, said that his organization was committed to ensuring that Internet-based pharmacies were legal entities that complied with all applicable pharmaceutical regulations and that medicines sold over the Internet were safe and legitimate. It was working with the National Association of Boards of Pharmacy in the United States of America to develop a “.*pharmacy*” top-level domain name in order to offer patients around the world the opportunity to access legally established web-based pharmacies that were approved to deliver medicines in their country and met the quality criteria for pharmacy practice and patient safety. As a result, the use of the “.*pharmacy*” domain name would provide a more secure certification of reliability than logos, which could easily be copied or falsified. He appealed for the Secretariat’s support for his organization’s initiative.

Professor GEISSBUHLER (International Medical Informatics Association), speaking at the invitation of the CHAIRMAN and on behalf of the International Federation for Medical and Biological Engineering, said that the rapid deployment of eHealth posed challenges related, inter alia, to the interoperability of systems, the secure exchange of information together with the protection of stakeholder privacy, and the development of transparent and trustworthy mechanisms for the reuse of health data for health system management and research and development. Concerted efforts were required nationally and internationally to develop and implement interoperability frameworks and standards in collaboration with WHO and other stakeholders. Special attention should be given to the existing burden of health data reporting; WHO should try to make such reporting more efficient by using available eHealth technology and methods. Health-related Internet top-level domain names should be managed with a focus on public health interests; his organization was concerned that the current process managed by the Internet Corporation for Assigned Names and Numbers might not fulfil that objective and therefore recommended that further consultations should be organized under the leadership of WHO.

Ms BERGER (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN and on behalf of Health Innovation in Practice and the Democratising Global Health coalition, expressed concern that, to date, all the applications that had been made for the “.*health*” top-level domain name had come from commercial entities that planned to sell use of the domain name on a wholesale and auction basis. Such an approach could mean that private interests would be placed ahead of the public interest. The Internet was an essential tool for access to health information and it was crucial that users were able to access evidence-based, quality-controlled information from trusted sources. Consequently, the “.*health*” domain must be guided by the public interest and based on agreed principles that would ensure its reliability and trustworthiness. She urged the Secretariat and Member States to work with the Internet Corporation for Assigned Names and Numbers, its Governmental Advisory Committee and relevant institutions to ensure that the domain was managed in the interests of global public health.

Dr CUYPERS (Belgium) said that, if the Secretariat was able to confirm that it would take steps to protect the “.*health*” domain name, he could agree to defer discussion of the draft decision to the Sixty-sixth World Health Assembly.

The DIRECTOR-GENERAL said that WHO was in discussion with the Internet Corporation for Assigned Names and Numbers with a view to protecting the “.*who*” domain name. WHO did not want to be allocated the “.*health*” domain name as it did not have the capacity to manage the process and liabilities of owning a domain name. However, she agreed with the concerns expressed by Member States, particularly with regard to private entities applying for that domain name. WHO would urge the Internet Corporation for Assigned Names and Numbers to understand the public health consequences and to allocate the “.*health*” domain name in accordance with public health principles. However, it was the prerogative of that body to allocate domain names and WHO could therefore only advocate a decision; it could not ensure that the decision was made. She sought guidance about how to proceed with the draft decision.

Dr KIENY (Assistant Director-General) welcomed the proposed amendments to the draft resolution. Clarifying subparagraph 24(b) of the report, she explained that the Universal Postal Union had set a precedent for the principle of a United Nations body owning and administering a top-level domain name, as was indicated in paragraph 19. However it was not the intention of WHO to apply for the “.*health*” domain name. The Internet Corporation for Assigned Names and Numbers had received some 1930 applications for a large number of different top-level domain names and it was only just starting to review those applications. As a result, the review process might take longer than expected. The rules and procedures for the process were unclear. To date, four applications for the “.*health*” domain name had received the highest number of negative comments on the comments section of the Corporation’s web site. She welcomed the agreement to postpone discussion of the draft decision, which would allow time for further consultations.

Professor HALTON (Australia) asked whether the draft decision would be taken up again by the Board or by the Health Assembly.

Dr CUYPERS (Belgium) said that it should be taken up by the Sixty-sixth World Health Assembly at the same time as the draft resolution proposed by Mauritania and Myanmar.

The CHAIRMAN took it that the Board wished to adopt the draft resolution with the agreed amendments.

The resolution, as amended, was adopted.¹

2. MANAGEMENT MATTERS: Item 13 of the Agenda (continued)

Real estate: Item 13.4 of the Agenda (Document EB132/33)

Dr THABET NASHER (Yemen), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, recalled the Committee’s deliberations on the item (document EB132/43, paragraphs 47–50). The Committee had noted that the Secretariat would provide updated information to the Committee at its meeting in May 2013.

Dr Ren Minghui took the Chair.

Ms PENEVEYRE (Switzerland) said that, as one of the governing bodies, the Board was responsible for ensuring that WHO’s premises complied with security requirements and were not exposed to serious environmental risks. Not much funding was currently available for real estate-related issues and she noted with concern that the sum of US\$ 10 million for the sustainable financing mechanism had not yet been appropriated. It was important to provide regular and long-term sustainable funding to the Real Estate Fund. It was also important to develop a long-term real estate strategy, as recommended by the Joint Inspection Unit of the United Nations system.

Professor HALTON (Australia) said that it was vital to find a sustainable mechanism to fund the Capital Master Plan; that issue should be considered part of the financing dialogue. It was likely that real estate would always be an underfunded area even though it was important to have the right people in the right place at the right time. The documents on WHO reform had indicated that there were costs

¹ Resolution EB132.R8.

associated with a human resource-intensive organization such as WHO. The real costs had to be acknowledged. She urged Member States to consider how to resolve the real estate funding issue.

Ms HERNÁNDEZ NARVAEZ (Mexico) said that the Capital Master Plan should be considered in conjunction with the efforts made by the Secretariat to review long-term operational costs and efficiencies. Therefore, she requested that future analyses include viable options for the renovation of WHO premises. Several innovative mechanisms could be used for the redistribution of office space and were also relevant to the ongoing reform in the area of human resources. She encouraged the Secretariat to take into account all operational reforms relating to the human resource deficit with a view to ensuring long-term sustainable financing.

Dr JAMA (Assistant Director-General), acknowledging that WHO's real estate funding requirements were not being met and that no sustainable funding was available, said that, although resolution WHA63.7 had authorized the Director-General to transfer up to US\$ 10 million from the Member States' non-assessed income to the Real Estate Fund if it had not been used at the end of a biennium, it had not yet been possible to do so. It might be possible to appropriate some of the assessed contributions, but it was unclear how much could be made available as those contributions were fully used at the current time. The Organization's real estate would be in significant jeopardy if sustainable funding was not ensured in the future. The Secretariat would work to develop a new strategy for consideration by the governing bodies in May 2013. He welcomed the suggestion that the issue should be included in the financing dialogue.

The CHAIRMAN took it that the Executive Board wished to take note of the report.

The Board noted the report.

Dr St. John resumed the Chair.

Reports of committees of the Executive Board: Item 13.5 of the Agenda

• **Standing Committee on Nongovernmental Organizations** (Document EB132/34)

The CHAIRMAN invited the Board to consider the draft resolution and draft decision contained in the report.

Mr KOLKER (United States of America), referring to paragraph 3 of the draft resolution, said that it was his understanding that the Global Health Council had appointed a new Board of Directors and was being reconstituted; it was therefore premature to terminate relations with that entity.

Dr VALLEJO (Ecuador), noting that the most recent meeting of the Standing Committee on Nongovernmental Relations had been attended by only three of its five members (including Ecuador and the United States of America), asked whether the other members of the Committee were in favour of the proposal made by the member for the United States at that meeting to defer any decision on terminating relations with the Global Health Council to the Board's next session. He could accept the proposal.

Dr JAMA (Assistant Director-General) said that, if the Board agreed to the proposal, the reference to the Global Health Council in paragraph 3 of the draft resolution would be moved to the draft decision on the review of nongovernmental organizations in official relations with WHO.

The resolution and decision, as amended, were adopted.¹

- **Foundations and awards** (Document EB132/35)

Dr A.T. Shousha Foundation Prize

Decision: The Executive Board, having considered the report of the Dr A.T. Shousha Foundation Committee, awarded the Dr A.T. Shousha Foundation Prize for 2013 to Dr Mohammad-Reza Mohammadi (Islamic Republic of Iran) for his significant contribution to public health in the Islamic Republic of Iran, particularly in the area of child and adolescent psychiatry. The laureate will receive the equivalent of 2500 Swiss francs in United States dollars.²

Léon Bernard Foundation Prize

Decision: The Executive Board, having considered the report of the Léon Bernard Foundation Committee, awarded the Léon Bernard Foundation Prize for 2013 to Dr Teng Shuzhong (China) for the significant contribution he has made to health training and health care services in the region of Fenghuang, Hunan Province, China. The laureate will receive 2500 Swiss francs.³

The CHAIRMAN said that the Léon Bernard Foundation Committee had requested the Secretariat to propose draft criteria or guidelines for the assessment of the work done by the candidates for the Prize, for consideration by the Committee at its next meeting. The Committee had also recommended that consideration be given to mobilizing additional resources to ensure the continuation of the award.

In the absence of any objection, she took it that the Board agreed to the request and recommendation.

It was so agreed.

The CHAIRMAN said that the Committee had unanimously decided to propose to the Executive Board that Article 2 of the Statutes of the Léon Bernard Foundation should be revised by replacing the term “social medicine” with “primary health care”.

In the absence of any objection, she took it that the Board agreed to the proposed revision.

It was so agreed.

Sasakawa Health Prize

Decision: The Executive Board, having considered the report of the Sasakawa Health Prize Selection Panel, awarded the Sasakawa Health Prize for 2013 to Professor No-yai Park (Republic of Korea) who has been instrumental in improving the quality of public health centres and health staff education, particularly in the area of maternal and child care nursing in the Republic of Korea. The laureate, as an individual, will receive US\$ 30 000.⁴

¹ Resolution EB132.R9 and decision EB132(9).

² Decision EB132(3).

³ Decision EB132(4).

⁴ Decision EB132(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 2013 to Dr Laila Ali Akbar Bastaki from Kuwait who is being honoured for her outstanding contribution to the research and management of genetic disorders, and the increased delivery of health services in Kuwait. The laureate will receive US\$ 15 000.¹

The CHAIRMAN said that the Panel had requested the Secretariat to work with representatives of the Founder to prepare a proposal to revise the financing mechanism of the Prize for consideration by the Panel at its next meeting, with a view to submitting any proposed revision of the Statutes to the Executive Board at its next session.

In the absence of any objection, she took it that the Board agreed to the request.

It was so agreed.

State of Kuwait Prize for Research in Health Promotion

Decision: The Executive Board, having considered the report of the State of Kuwait Health Promotion Foundation Selection Panel, awarded the State of Kuwait Prize for Research in Health Promotion for 2013 to Dr Wang Guiqi from China for his significant contribution to early detection and treatment of oesophageal cancer, one of the most common forms of cancer in China, particularly in high-risk rural areas. 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 Public Health for 2013 jointly to Dr An Dong from China for his dedication and outstanding contribution made to public health in the Province of Ghizhou, China, and to the Diabetes Society of Maldives for its success in creating public awareness on diabetes, making health promotion interventions for the prevention of diabetes and other noncommunicable diseases in the Maldives, and for the training of local staff to offer counselling and eventual treatment. The laureates will each receive US\$ 50 000.³

3. STAFFING MATTERS: Item 14 of the Agenda (continued)

Statement by the representative of the WHO staff associations: Item 14.2 of the Agenda (Document EB132/INF./1)

Dr SADANA (representative of the WHO staff associations), summarizing key issues from the statement contained in document EB132/INF./1, drew particular attention to the grave concerns of the staff associations regarding the proposed changes to the Staff Rules related to appointment policies, in particular the phasing out of continuing appointments and changing the right to reassignment

¹ Decision EB132(6).

² Decision EB132(7).

³ Decision EB132(8).

entitlement from five to ten years of service. Those changes were proposed to be applied to future and current staff as of February 2013, despite repeated assurances from management that existing staff would not be affected by the proposed changes. That meant that long-serving staff members' contracts could be terminated with only three months' notice; as international civil servants, they had no institutional or national unemployment insurance or other social security benefit that could provide a financial cushion during the transition to another job. Other concerns included the reduction in the overall participation of women in WHO's workforce and the possible negative effects the proposed changes could have on female staff; the high proportion of experienced staff members that were due to retire within the next 10 years; the increased expectations and workload placed on the Organization despite the reduction in staff numbers; and the need to create an enabling environment for staff. The staff associations asked the Board to consider deferring any endorsement of the proposed changes to the Staff Rules to its next session in May 2013 so that further discussion of the issues could take place.

Mr KOLKER (United States of America), acknowledging the lack of predictability in the current employment system, said that his country did not support the recommendation by the staff associations to postpone the changes to the Staff Rules until the 133rd session of the Executive Board in May 2013. Those changes were an important part of the internal reform process, particularly the suggestions set out in the document entitled *The future of financing for WHO*, such as a more flexible hiring policy that was more accessible to external candidates and encouragement of rotation of technical staff between WHO and domestic institutions. He expressed the hope that the staff associations would continue to engage constructively with WHO management in order to bring about further reforms and improvements.

Ms HERNÁNDEZ NARVAEZ (Mexico), noting the concerns expressed by the representative of the WHO staff associations, said that her country nevertheless supported the revision of human resources policies in order to introduce flexibility into current contractual arrangements. Such changes were consistent with the Organization's needs and also took account of the current financial constraints. The changes would enable WHO to respond effectively to changing or emergency situations.

Dr JAMA (Assistant Director-General) said that the proposed changes had been elaborated over the past two years in consultation with staff members, regional offices, Member States and the Director-General. Increasing the Organization's capacity to recruit external candidates was essential. With regard to the issue of renewal of the Organization, every 10 years WHO saw about 30% of its staff retire and had accordingly already established plans and systems to ensure that retiring staff were replaced in a timely manner. The reduction in staff numbers had been implemented on the basis of a thorough consultative process between the staff associations and management, and the Secretariat was better placed to cope with existing financial constraints. Steps had been taken to minimize the risks to and liability of Member States and the Organization. The proposed changes were being made in the best interests of the staff and the Organization.

The DIRECTOR-GENERAL, noting the difficulties that staff members had endured during the past two to three years, expressed deep appreciation to them and thanked them for their understanding. The Member States were making efforts to be fair to staff by pursuing the WHO reform process and seeking to establish a financing dialogue, subject to Health Assembly endorsement, in order to ensure greater predictability of funding and the matching of resources to the important work done by the Organization. WHO's management was committed to managing the Organization properly and ensuring that it was not overextended in terms of financial liability. Management's dialogue with the staff associations was an important mechanism whereby both sides sought to reconcile their differences and achieve a "win-win" outcome. Some of the staffing changes had been demanded by Member States and therefore had to be implemented; others had been introduced in order to respond to the financial uncertainty faced by the Organization.

The Board took note of the statement by the representative of the WHO staff associations.

Human resources: annual report: Item 14.3 of the Agenda (Documents EB132/38 and EB132/38 Corr.1)

Dr THABET NASHER (Yemen), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, recalled the Committee's deliberations on the item (document EB132/43, paragraphs 51–60). The Committee had recommended that the Board take note of the report.

Mr KOLKER (United States of America) commended the well-documented and substantive annual report and welcomed the information that the Global Roster for Heads of WHO Country Offices had proven to be a success and that an administrative roster was being prepared. Given the need to ensure flexibility in contract arrangements, consideration could be given to creating rosters of experts for temporary or short-term contracts that could be used to match the programmatic needs of the Organization at any given time. He urged that further attention should be given to addressing the shortcomings that had been identified in the informal internal justice mechanism, with a view to streamlining rules and procedures consistent with due process. It would also be useful to know how many cases had been resolved through the informal process and how many had been referred to the formal system.

Dr CUYPERS (Belgium) said that, although the report in its current format was useful, it could not be used as a strategic management tool. The Programme, Budget and Administration Committee had formulated suggestions to increase the value of the report as such a tool. It was important that future reports include financial data on staffing and a forecast of the financial implications of proposed decisions or changes in strategy.

Ms PENEVEYRE (Switzerland) welcomed the introduction of a web-based database to monitor staff members' health, which was referred to in the report (paragraph 34), and said that future reports on human resources should include information on that subject. She also welcomed the information regarding contracts that did not carry staff member status, which would enable Member States to monitor and understand the costs and benefits of such contracts. In addition, she expressed appreciation of the statement made by the representative of the staff associations; it was one of the responsibilities of the Board to listen to the concerns of the staff. At the same time as efforts were made to stabilize and consolidate the sustainability of WHO funding sources, in human resource terms it was important to balance the flexibility needed to implement reform against the stability needed to attract and retain specialist staff members. It was therefore essential to continue the dialogue between WHO management, the staff associations and the members of the governing bodies.

Dr MATCHOK-MAHOURI (Chad), speaking on behalf of the Member States of the African Region and welcoming the updated and comprehensive data included in the report, expressed concern that the staff reduction measures, despite yielding financial savings, were having a negative impact on technical cooperation with Member States. Staff cuts also affected the morale and motivation of those who remained in their posts, potentially amplifying feelings of uncertainty in the work environment. He noted with concern that the staff employed in priority programmes were paid with funds from voluntary contributions, as such contributions were frequently not made in a predictable or timely manner. In addition, 20% of professional category staff in the African Region were due to retire within the next five years. The aforementioned concerns carried the risk of a decrease in operational capacity and performance in the face of an ever-growing demand for technical support from Member States. He therefore encouraged the Secretariat to continue the efforts already under way in the areas of contract reform, easing of the recruitment process, alignment of new recruitment with forthcoming retirements, expansion of the mobility and rotation policy, and improvement of the system of incentives, bonuses and sanctions. Steps should also continue to be taken to ensure a proper balance in respect of geographical representation, gender, age and flexibility.

The DIRECTOR-GENERAL said that staffing costs represented more than half the Organization's expenditure; as WHO was a knowledge-based, technical organization, it was to be expected that those costs would be high. At the same time, the Secretariat was looking for ways to be more efficient and effective. The Secretariat had tried to provide a comprehensive overview of the human resources situation, but would continue to seek to improve the annual report, taking into account the suggestions of Member States, particularly with regard to the provision of more detailed information on financing and a full-time equivalent breakdown of the staffing profile, so as to enable the report to be used as a strategic management tool.

The Board noted the report.

The meeting rose at 17:30.

FIFTEENTH MEETING

Monday, 28 January 2013, at 18:40

Chairman: Dr J. ST. JOHN (Barbados)

1. STAFFING MATTERS: Item 14 of the Agenda (continued)

Report of the International Civil Service Commission: Item 14.4 of the Agenda (Document EB132/39)

The Board noted the report.

Amendments to the Staff Regulations and Staff Rules: Item 14.5 of the Agenda (Documents EB132/40, EB132/40 Add.1 and EB132/43)

The CHAIRMAN drew attention to the two amended draft resolutions contained in document EB132/43 and their financial and administrative implications for the Secretariat, were they to be adopted, in document EB132/40 Add.1. The views of the Programme, Budget and Administration Committee with regard to the item were set forth in paragraphs 62–69 of document EB132/43. The Committee had recommended that the Board adopt the two draft resolutions, as amended.

Mr KOLKER (United States of America) welcomed the proposed changes to the Staff Rules, which were a useful first step to meet WHO's changing staffing needs. They would also strengthen the Secretariat's ability to respond to the serious criticisms made by the Joint Inspection Unit,¹ which had identified major flaws in the current human resources management systems and processes. Significantly more changes were needed to correct those failings.

Continuing appointments must correspond to the long-term requirements of the Organization. It was a matter of serious concern, for example, that 700 staff (10% of the Organization's entire workforce) who were working on poliomyelitis eradication in the African Region would have their contracts converted from fixed into continuing appointments, even though the programme was scheduled to end within five years and the skills it needed were expected to change significantly in the next two years. The Secretariat must stop or limit the conversion of those staff contracts in the regions and at headquarters. An independent study on the financial risks associated with the human resources of the polio eradication programme should be conducted rapidly.

He endorsed the two draft resolutions under consideration, as amended by the Programme, Budget and Administration Committee.

Ms WISEMAN (Canada)² supported the proposed amendments to the Staff Regulations and Staff Rules as they would enable the Director-General to align her workforce with the changing needs of the Organization more effectively within the framework of the WHO reform process.

The CHAIRMAN said that, if she heard no objections, she would take it that the Board wished to adopt the two amended draft resolutions contained in document EB132/43.

¹ See document EB132/5 Add.6, Annex, p.6.

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

The resolutions, as amended, were adopted.¹

2. MATTERS FOR INFORMATION: Item 15 of the Agenda (continued)

Reports of advisory bodies: Item 15.1 of the Agenda (continued)

• **Expert committees and study groups** (Documents EB132/41 and EB132/41 Add.1)

Mr McIFF (United States of America) welcomed the Secretariat's commitment to ensuring the funding for the Expert Committee on Drug Dependence. He commended the Expert Committee's critical review of 4-hydroxybutanoic acid (GHB) and ketamine, noting that the controls proposed by the Committee regarding the former were similar to those already implemented in his country. Given that 48 countries, including his own, controlled ketamine domestically, the rationale for the Expert Committee's decision not to recommend bringing ketamine under international control was not clear. He asked whether up-to-date information on ketamine abuse and trafficking, which had apparently been on the rise, had been available to the Expert Committee when it had made its decision. As he understood it, the availability of ketamine for medical purposes, which would be restricted if it were to come under international control, was the key factor in the Committee's decision and more detailed information on access and availability would be welcome, together with a summary of Article 4 of the United Nations Convention on Psychotropic Substances in order to provide a context. In addition, the Secretariat might wish to give consideration to updating the information on ketamine abuse before the next meeting of the Commission on Narcotic Drugs in March 2013.

Dr MYINT HTWE (Myanmar) asked the Secretariat to explain how the valuable findings and recommendations of the expert committees were used at headquarters and at regional and country levels.

Experts from the South-East Asia Region were underrepresented on expert advisory panels: could the Secretariat explain how it planned to ensure a more balanced regional representation on those panels?

Dr DE JONCHEERE (Essential Medicines and Pharmaceutical Policies) explained that the decision of the Expert Committee on Drug Dependence not to recommend bringing ketamine under international control had been taken in the light of the available evidence, including information provided by the United Nations Office on Drugs and Crime and the International Narcotics Control Board. As was often the case with illegal use of substances, it was difficult to obtain accurate information on the scope and magnitude of the problem. The Expert Committee would nevertheless continue to monitor emerging evidence of abuse, in cooperation with Member States and the two aforementioned bodies in order to obtain the most recent and reliable data on which to base its decisions.

Members of expert committees were selected from the expert advisory panels, in relation to which the Secretariat strove to maintain a good regional balance. He would nevertheless review the membership of the advisory panels with a view to ensuring an appropriate regional balance on the expert committees.

Dr KIENY (Assistant Director-General) said that representation on the expert advisory panels was uneven not only in terms of regions but also with regard to women. To redress those imbalances, it would be helpful to add more experts to the Secretariat's roster and she urged governments, in particular those in the South-East Asia Region, to submit names of experts from their country.

¹ Resolutions EB132.R10 and EB132.R11.

The Board noted the report.

Progress reports: Item 15.2 of the Agenda (Documents EB132/42, EB132/42 Add.1 and EB132/42 Add.1 Corr.1)

Noncommunicable diseases

- A. Strengthening noncommunicable disease policies to promote active ageing** (resolution WHA65.3)
- B. Global strategy to reduce the harmful use of alcohol** (resolution WHA63.13)
- C. Sustaining the elimination of iodine deficiency disorders** (resolution WHA60.21)

Ms STIRØ (Norway), speaking on behalf of the Nordic countries (Denmark, Finland, Iceland, Norway and Sweden), said that progress reports merited greater attention than they currently received from Member States because monitoring progress was central to oversight and evaluation. Progress reports should be an integral part of the results chain and contribute to WHO's learning process. As her delegation had mentioned at the Sixty-fifth World Health Assembly, in order to serve as effective oversight tools progress reports should specify how the resolutions in question had contributed to the achievement of outcomes set out in the programme budget; provide an overview of the evolution of the themes concerned since the adoption of the resolution; and include information on the financial status of the programme. How useful did the Secretariat find the progress reports, in their present form, as an evaluation and learning tool?

The global strategy to reduce the harmful use of alcohol should be an integral part of preventing and reducing the incidence of noncommunicable diseases, a view shared by a growing number of Member States. Armed with the global strategy, WHO had a solid mandate to strengthen action at all levels, and the proposed increase in the budget allocation for combating noncommunicable diseases would help to ensure that sufficient financial and human resources were assigned to the global strategy and its support mechanisms, such as the global network of WHO national counterparts.

Dr GRABAUSKAS (Lithuania), speaking on behalf of his own country, Latvia and Estonia, said that the global strategy to reduce the harmful use of alcohol had been effective in helping to strengthen national alcohol policies. He asked the Secretariat to add to paragraph 10 of document EB132/42 some detail on the work of the task forces that had been established and to include information on the working plans for implementation of the global strategy on the WHO web site.

Evidence-based policy-making depended on up-to-date, reliable data that could be compared across countries. Yet, the information contained in the Global Information System on Alcohol and Health dated back several years. The Secretariat should accordingly make greater efforts to provide alcohol consumption data that were comparable, and update the relevant information annually or biannually.

Dr CHESTNOV (Assistant Director-General), in response to the member for Norway, affirmed that preparing reports on progress of activities implemented by the Secretariat was useful. They formed part of a dynamic process to track results, and provided an opportunity to inform Member States about which activities had not been implemented because of a lack of funds.

In order to accelerate the implementation of the global strategy to reduce the harmful use of alcohol, recommended actions for Member States, international partners and the Secretariat had been included in the draft action plan for the prevention and control of noncommunicable diseases, 2013–2020, which was being finalized for submission to the Sixty-sixth World Health Assembly. The Secretariat would undertake significant efforts to mobilize resources to put the action plan into practice, in full collaboration with Member States. The progress report on the global strategy to reduce the harmful use of alcohol would be revised to reflect members' comments.

Dr SAXENA (Mental Health and Substance Abuse) said that the global alcohol strategy task forces had made reasonable progress since their establishment in 2011. They would be engaged in the development of several products in 2013, including a toolkit for implementing the global strategy to reduce the harmful use of alcohol, which was due to be ready by the end of 2013. The information in the Global Information System on Alcohol and Health was due to be fully revised in 2013 and the next global status report on alcohol and health would contain the most recent data and should be issued by the end of the year.

The DIRECTOR-GENERAL said that the comment by the member for Norway about progress reports introduced a new dimension. She admitted that the Secretariat was also struggling with the question of progress reports: was a progress report supposed to focus on the work of the Secretariat in response to a resolution's request to do certain things, or was it supposed to respond to the resolution as a whole, encompassing the activities of both the Member States and the Secretariat? The answer was a bit of both, with no set structure. It should certainly be feasible to introduce a description of how matters had evolved since the adoption of the relevant resolution. Furthermore, the format of the progress reports should be revisited with a view to greater concision, and provision of the most up-to-date information. It was often difficult to obtain information from Member States with regard to progress in implementing the resolution in question, but the new web-based reporting platform should make it easier for them to provide updated information. Member States invested a great deal of time negotiating resolutions that often ended up not being implemented, for various reasons. That situation gave rise to two questions: how often should the Secretariat issue progress reports on such resolutions, and how long should those reports be? If the progress reports were not useful in their present format, then they should be modified, and Member States' proposals were welcome in that regard.

The CHAIRMAN said that, as WHO was entering a new budget period, suggestions made by the member for Norway could guide the Secretariat in making the progress reports more valuable.

Preparedness, surveillance and response

- D. Strengthening national health emergency and disaster management capacities and the resilience of health systems** (resolution WHA64.10)
- E. Climate change and health** (resolution EB124.R5)

Mr JIN Song (China) appreciated the Secretariat's efforts to implement resolution WHA64.10. Disaster-management capacities and resilience of the health systems were the basic public health functions of a State. Many countries had made significant progress in the area of national health emergency and disaster management capacities and the resilience of health systems – and in the previous few years, China had been extremely engaged in health emergency management – but they still faced daunting challenges. He looked forward to the global report on national capacities scheduled to be released later in the year. When the Secretariat provided necessary planning and support, it should concentrate not only on specific techniques but overall coordination and integration with the health system.

He welcomed the Secretariat's efforts to help Member States to mitigate the effects of climate change. The Secretariat should: develop a work plan for 2014–2019 to identify priorities and objectives; promote the application of the resulting outcome document; encourage information exchange; extend additional support to Member States for development, implementation and technical training during projects; and support the general development of Member States.

Communicable diseases

- F. Malaria** (resolution WHA64.17)
- G. Eradication of dracunculiasis** (resolution WHA64.16)
- H. Smallpox eradication: destruction of variola virus stocks** (resolution WHA60.1)

The CHAIRMAN informed the Board that section G on dracunculiasis (document EB128/42 Add.1) contained information for the period January to August 2012 only. More recent data would be included in the report to the Health Assembly, reflecting the number of cases for the entire calendar year.

Ms BURRIS (United States of America) welcomed the update on the efforts of Member States and the Secretariat to achieve the targets for malaria, noting that much work still remained to be done. Antimalarial drug resistance was particularly problematic as it threatened to undermine the successes already achieved in malaria prevention and control. For the provisional agenda of the Sixty-sixth World Health Assembly, the Board should elevate discussion of the subject to a technical item. The update in the report on efforts to contain artemisinin resistance and prevent stock-outs of artemisinin-based combination therapy was also useful. To prevent drug resistance, she advocated the promotion of appropriate treatment and prescription guidelines and control of substandard/spurious/false-labelled/falsified/counterfeit antimalarial medicines.

Mr AGHAZADEH KHOEI (Islamic Republic of Iran), commenting on the progress report on smallpox eradication, said that the scientific review of variola virus research, 1999–2010 and the assessment by the Advisory Group of Independent Experts of the smallpox research programme had concluded that there were no compelling scientific reasons for retaining virus stocks after the end of the authorized programme of variola virus research. Yet, the WHO Advisory Committee on Variola Virus Research had approved a range of projects that used live variola virus, a decision that was inconsistent with the global consensus on the destruction of the remaining stocks of live virus and the Committee's own conclusions. The scope of approved projects using live variola virus should be decreased and their number brought to zero by 2014 at the latest. With regard to transparency of the oversight exercised by the Advisory Committee and WHO over variola virus research, he observed that the reports of the Advisory Committee's meeting and the biosafety inspections of authorized variola virus repositories in 2012 had not been made public before the current session of the Board. Member States had agreed at the Sixty-fourth World Health Assembly to extend the mandate of the Advisory Group, but he asked why no information had been provided regarding the Advisory Group's continued mandate or activities.

Turning to the report on malaria, he acknowledged the substantial progress made but noted with concern the substantial funding shortfall for prevention, control and elimination, and the challenges of controlling malaria in border areas, which needed the cooperation of neighbouring countries. Subregional strategic plans could be used to bring together neighbouring countries, regional offices, development partners and pharmaceutical companies. The plans could serve as platforms for technology transfer to countries with manufacturing capacities in each subregion and include programmes with a special focus, such as a joint entomological programme. National plans would need to be aligned with the subregional plans.

In view of the effect that the use of non-standard preventive equipment had on control programmes, the Organization should prequalify the companies that produced insecticide-treated bed nets and other vector-control equipment. The global plans for managing insecticide resistance in malaria vectors and containing artemisinin resistance should be incorporated into both subregional strategic plans and national plans.

Professor HALTON (Australia) agreed with the member for the United States of America that the item on malaria should be included on the provisional agenda of the Health Assembly. Her Government was very supportive of the Organization's work on malaria and had recently hosted a ministerial-level

summit on the subject. Referring to her delegation's earlier remarks on substandard/spurious/falsely-labelled/falsified/counterfeit medical products, she underscored their linkage with resistance in malaria.

Dr NAKATANI (Assistant Director-General), in response, commented that government bodies set the provisional agenda of the Health Assembly. The funding shortfall was indeed very large: an expected US\$ 3000 million a year was additionally needed to combat malaria, and resources needed to be mobilized at the international and national levels. Subregional collaboration on vector control was an important part of combating insecticide resistance and work was underway in the Mekong Delta region with the cooperation of two regional offices and the support of donors. With respect to concerns with the quality of vector-control equipment, the Secretariat had a programme in place to monitor the quality and durability of bed nets and diagnostic tests.

Dr FUKUDA (Assistant Director-General), responding to the member for the Islamic Republic of Iran, recalled that the major issues related to variola virus would be discussed at the Sixty-seventh World Health Assembly in 2014. The reports of the biosafety inspections in 2012 of the two variola virus repositories were going through the clearance process and would be published soon. The report of the recent meeting of the Advisory Committee on Variola Virus Research was also being cleared by the experts in order to ensure that it had no factual errors; it would become available in the coming weeks. The Advisory Group of Independent Experts to review the smallpox research programme comprised public health experts and had been convened to conduct an independent assessment of the work of the WHO Advisory Committee on Variola Virus Research in time for the 10-year review of the Committee's work; it did not meet on a regular basis. The mechanism of an independent review had proved to be successful and could be used again if the Member States so wished.

Mr AGHAZADEH KHOEI (Islamic Republic of Iran) said that his understanding was that the Sixty-fourth World Health Assembly had decided to extend the mandate of the Advisory Group of Independent Experts in order to review the smallpox research programme.

The DIRECTOR-GENERAL said that, although Member States had agreed to the continuation of the Advisory Group of Independent Experts, the body did not meet at regular intervals but only as needed to conduct an independent review of the Advisory Committee on Variola Virus Research. The Advisory Group provided a system of checks and balances, as it comprised public health experts and policy-makers who were not necessarily smallpox experts. The decision to convene the Advisory Group to conduct another independent review would be made ahead of the 2014 meeting of the Executive Board.

Mr AGHAZADEH KHOEI (Islamic Republic of Iran) said that the Advisory Group should conduct its independent evaluation before the 134th session of the Board when the topic would next be considered.

Health systems

- I. Patient safety**
- J. Drinking-water, sanitation and health**
- K. Workers' health: global plan of action**
- L. Strategy for integrating gender analysis and actions into the work of WHO**
- M. Progress in the rational use of medicines**
- N. Health policy and systems research strategy**

Ms STIRØ (Norway), speaking on behalf of the Nordic countries, Denmark, Finland, Iceland, Norway and Sweden as well as Estonia, Latvia, Lithuania and the Netherlands with regard to the strategy for integrating gender analysis and actions into the work of WHO, said that an analysis of the impact of the important initiatives to integrate gender equality into the work of the Organization would be helpful. What had been the follow up to the request in resolution WHA60.25 to the

Director-General to define indicators and to monitor the implementation of the strategy for integrating gender analysis and actions into the work of the Organization? Future reports should identify progress on the indicators developed for the strategy. In addition to mainstreaming issues related to gender, equity and human rights, the Organization should play an active role in the implementation of the United Nations System-Wide Action Plan on gender equality and women's empowerment. She looked forward to a report on those efforts.

Regarding the rational use of medicines, antimicrobial resistance jeopardized the effective treatment of many common diseases and was therefore an increasingly urgent issue. The establishment of an antimicrobial resistance task force and the choice of the subject as the theme for World Health Day 2011 had been important steps toward raising awareness and tackling the problem. It was a matter of concern that national efforts to implement resolution WHA60.16 on progress in the rational use of medicines remained limited. Even though the lack of data constituted a challenge for monitoring, it would be useful to see an analysis of the global situation and the impact of the activities undertaken. Efforts to promote the rational use of medicines and to combat antimicrobial and antibiotic resistance needed to take place at all levels. Sufficient resources, strong leadership from the Secretariat and action in every Member State were needed in order to avoid the unimaginable scenario where no efficient antibiotics were available.

Dr MYINT HTWE (Myanmar), speaking on the progress report on health policy and systems research strategy, said that Member States must develop country-specific strategies for ensuring that the national health policy and budgetary allocations were appropriate for the country's health status. Rapidly changing epidemiological conditions meant that many health policies needed to be reviewed. Noting that no unit on research policy and cooperation apparently existed at headquarters to provide support to Member States, he asked the Secretariat to support developing countries specifically with capacity-building to enable health policy analysis at the country level.

The CHAIRMAN, speaking as the member for Barbados, said that analysing the effectiveness of policy frameworks was a challenge facing her Government as well. If no department existed at WHO headquarters, a regional or country office could be asked to support the Member State's government.

Dr AMMAR (Lebanon), referring to the progress report on health policy and systems research strategy, said that the Secretariat needed to assume a larger role in operationalizing the six options proposed under the strategy. He proposed a two-step process for the implementation of the strategy whereby the Secretariat would establish a subcommittee of the advisory group that had steered the development of the strategy in order to support the Secretariat and the Alliance for Health Policy and Systems Research in developing a plan for the implementation of the proposed options for action. The Secretariat could then consider submitting a draft resolution to the Health Assembly in order to secure commitments by Member States to increase the use of the strategy to improve the performance of national health systems and achieve universal health coverage.

Ms LIU Yue (China) said that her Government was ready to play its part in the implementation of its five-year strategy on patient safety and the injection safety initiative. In relation to the rational use of medicines, ongoing medical reforms in her country included measures to ensure fair access, sufficient supply and rational use of essential medicines. Together with the Secretariat and Sweden, her Government was working to counter antibiotic resistance.

Health policy and systems research played an important role in evidence-based decision-making and improving health system performance. She supported the implementation of the health policy and systems research strategy and the proposal made by the member for Lebanon. Almost all cases discussed at the Second Global Symposium on Health Systems Research: Inclusion and innovation towards universal health coverage (Beijing, 31 October–3 November 2012) had come from the experiences of developing countries, giving the strategy a more global and practical nature.

Mr HAZIM (Morocco) strongly supported the proposal by the member for Lebanon, as it capitalized on what had been accomplished at the global symposiums on health systems research in 2010 and 2011.

Mr BERTONI (Italy),¹ commenting on workers' health, said that the Italian Ministry of Health monitored closely public health issues related to asbestos. Having banned its use in 1992 and undertaken an abatement programme, the Government was focused on eliminating all possible risks linked to asbestos fibres and eradicating asbestos-related diseases through global campaigns. The Organization should play a fundamental role in that strategy by adopting the precautionary principle in uncertain cases. His Government recognized IARC's technical and scientific stance on the link between exposure to asbestos and cancer and supported the initiative on asbestos that had been recently launched by the Regional Office for Europe. The public needed to be made aware of the situation and pertinent scientific knowledge in order to ensure that it could evaluate and manage asbestos-related risks. No support for scientifically unsound stances or approaches that were influenced by commercial or political interests should be given in WHO publications or when representatives issued statements on the topic.

Ms PALMIER (Canada) said that her Government strongly supported the strategy for integrating gender analysis and actions into the work of the Organization and urged further gender mainstreaming. She sought more information about the work of the newly established Gender, Equity and Human Rights unit. Clear benchmarks, indicators and specific areas of work should be identified for gender equality.

Mr LE GOFF (France),¹ speaking on the topic of drinking-water, sanitation and health, expressed satisfaction with the progress made in implementing resolution WHA64.24, in particular with respect to the unitary strategy that encompassed drinking-water quality, safe use of wastewater, and safe management of recreational waters. Meeting Target 7.C of Millennium Development Goal 7 must not overshadow the need to overcome the major obstacles to achieving the other targets of Goal 7 and other health-related Goals. Those difficulties should be taken into consideration when setting the post-2015 development agenda. He welcomed the development of targets and indicators for post-2015 monitoring as part of the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation.

He supported the Director-General's proposal to adapt the format of the progress reports to allow for a more strategic examination.

Mr KOVALEVSKIY (Russian Federation),¹ commenting on the report on workers' health, said that his Government's health ministry had developed a national policy for the elimination of asbestos-related diseases. Together with the Regional Office for Europe, it had held a regional consultation to assess the risks associated with the use of asbestos and had helped to organize an international conference on the topic. Together with IARC, an epidemiological study had been initiated to assess the risk of cancer from chrysotile asbestos using the largest cohort of occupationally exposed workers ever used in research on this topic.

WHO's policy on asbestos was governed by resolution WHA60.26, which provided for a differentiated approach to regulating different types of asbestos: prohibition and strict regulation of amphibole asbestos, and the controlled use of chrysotile asbestos, which was widely used without significant adverse health effects. That resolution was not always reflected in WHO publications and the actions of individual representatives of the Organization. The scientifically unfounded view prevailed that prohibition was necessary for all types of asbestos, and that view was supported by publications forecasting hundreds of thousands of deaths from asbestos but failing to specify which type. Some working papers and statements issued by the Secretariat ran counter to the decision of the Sixtieth World Health Assembly. Although entities that thrived on unfounded fears of asbestos exerted

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

a great deal of pressure, it was hoped that a more balanced policy would be adopted founded not on liberal interpretations of Health Assembly resolutions and documents published by UNEP or IARC, but on objective research findings.

Mrs KARAGULOVA (Kazakhstan),¹ commenting on the report on workers' health, said that the global plan of action on workers' health 2008–2017 called for a differentiated approach to regulating the different types of asbestos (paragraph 10), thus giving the Secretariat a mandate to eradicate asbestos-related diseases but not to prohibit the use of all types of asbestos. Nonetheless, ILO and WHO jointly published in 2007 a working paper entitled "Outline for the Development of National Programmes for Elimination of Asbestos-Related Diseases", which promoted stopping the use of all types of asbestos. A working paper could not take precedence over a decision of the Health Assembly. Her Government adhered to a policy of controlled use of asbestos in accordance with the ILO Convention on Safety in the Use of Asbestos, 1986 (No. 162) and objected to proposals that prohibited the use of all types of asbestos.

She called for a strict definition of the concept of a differentiated approach to regulating the use of various types of asbestos, which would allow for an unequivocal interpretation of resolution WHA60.26. She would submit four proposals to the Secretariat in writing. She asked the Board to recognize the concerns of several countries and reverse the current situation in favour of a unified international position on the use of chrysotile asbestos.

Professor HALTON (Australia) forcefully reiterated the dangers of asbestos and the agonizing fatal illness it caused. Australia had once had a sizeable asbestos industry and many workers had suffered awful consequences of exposure to the material, and continued to do so. Asbestos had been widely used also in building materials, and, even today, many people who carried out renovations often inadvertently exposed themselves to risk. She respected the sovereignty of the Health Assembly and the appropriate interpretation of its resolutions, but considered that it was inappropriate to conclude the discussion without proper account being taken of the health consequences of exposure to asbestos. She would continue to support the Secretariat in its work and provide information for use in public health campaigns.

Mr KOVALEVSKIJ (Russian Federation) acknowledged the serious consequences of the uncontrolled use of asbestos. His country had endorsed the global plan of action in resolution WHA60.26 and drawn up a programme on the elimination of asbestos-related diseases, which was currently awaiting the Prime Minister's approval. He emphasized that asbestos existed in two forms: amphiboles and serpentines. Historically, Australia had been the largest producer and supplier in the world of amphibole asbestos. The Russian Federation was the largest producer and user of chrysotile (serpentine) asbestos globally and had recorded no adverse effects from its controlled use; serious illness was only seen with the uncontrolled use of asbestos. Since the consequences of exposure to amphibole and chrysotile asbestos differed, he had emphasized a differentiated approach to the various kinds of asbestos.

Mr RUSH (United Kingdom of Great Britain and Northern Ireland)¹ asked whether the global strategy for containment of antimicrobial resistance was covered under progress in the rational use of medicines in document EB132/42 or in a separate progress report?

Dr KIENY (Assistant Director-General) thanked the member for China for endorsing the new five-year strategy on patient safety and recalled the initiative to promote and increase the safety of medicines, the first part of which would be a project on safety of injection, in particular of therapeutic medicines, which would be launched during 2013. She welcomed China's offer of collaboration.

She confirmed that the strategy for integrating gender analysis and actions into the work of WHO was being implemented. With regard to analysing the impact of the Secretariat's initiatives, she

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

assured the Board that undertaking an impact analysis would be a priority for the Gender, Equity and Human Rights programme, which had been created in 2012. On the subject of indicators, WHO was participating in the United Nations System-wide Action Plan and would be attending the next day a meeting to define baseline reporting for work in that area. Indicators prepared by the United Nations System-wide Action Plan were already being translated into the Organization-wide action plan in order to measure the impact of actions related to gender, human rights and equity within WHO. Since its inception, the Secretariat's programme had re-established the regional network of focal points on gender, equity and human rights. A strategy and plan of work for the programme had been outlined, and a capacity building component had been outlined. A mechanism for monitoring equity would be launched soon under the auspices of the Global Health Observatory, in order to monitor and disseminate disaggregated data on equity in populations.

Turning to the health policy and systems research strategy, she reassured the Board that the closing of the Research, Policy and Cooperation Department had not resulted in a down-sizing of the work of the Secretariat under the Evidence-Informed Policy Network (EVIPNet) system; all technical components of that Department had been relocated into other departments in her cluster. An independent evaluation had been commissioned of the way the Secretariat helped Member States to translate evidence into policy; its results should be ready for publication later in the year. Replying to the members for Lebanon and Morocco, she welcomed the idea of setting up a working group tasked with studying the translation of an overall health systems research strategy into concrete action by the Secretariat.

Dr FUKUDA (Assistant Director-General) said that improving water quality, as mentioned by the representative of France, whose continued support he acknowledged, would continue to be a priority in the thematic discussions on preparing a post-2015 development agenda.

Replying to comments made by the member for Norway and the representative of the United Kingdom, he reaffirmed the significance of antimicrobial drug resistance as a major emerging issue. No global strategy on antimicrobial resistance existed yet. WHO's work covered numerous different aspects of the problem, but was scattered; the time had come to prepare comprehensive and coherent organizational and global strategies.

On the subject of asbestos, WHO's technical assessment was accurately reflected in an IARC monograph which stated that all forms of asbestos were related to a group of serious diseases. WHO relied on scientific opinion in deciding on the most effective and efficient ways of eliminating the risks posed by asbestos.

The Board noted the reports.

The meeting rose at 20:40.

SIXTEENTH MEETING

Tuesday, 29 January 2013, at 09:10

Chairman: Dr J. ST. JOHN (Barbados)

WHO REFORM: Item 5 of the Agenda (Documents EB132/5, EB132/5 Add.1, EB132/5 Add.2, EB132/5 Add.3, EB132/5 Add.4, EB132/5 Add.5, EB132/5 Add.6, EB132/5 Add.7, EB132/5 Add.8, EB132/5 Add.9, EB132/INF./2 and EB132/INF./3) (continued from the thirteenth meeting, section 2)

The CHAIRMAN asked Professor Halton (Australia), in her capacity as chairman of the informal consultation group, to provide an update on the outcome of the informal meeting of the Executive Board on WHO reform.

Professor HALTON (Australia) said that the Secretariat had produced a set of draft decision points on WHO reform, which reflected the consensus reached by Member States on the items discussed thus far. The informal consultation group would conclude its discussions on additional reform-related issues during the current session. The draft decision points read as follows:

The Executive Board,

1. Having considered document EB132/5 Add.1 on hosted health partnerships,
 - (1) requested the Programme, Budget and Administration Committee of the Executive Board to ensure that the arrangements for hosted health partnerships are regularly reviewed on a case-by-case and timely basis in respect of their contributions to improved health outcomes, WHO's interaction with individual hosted partnerships, and the harmonization of their work with the work of WHO; and to make recommendations for the consideration of the Board, as appropriate, through a standing item on the subject on the Board's agenda;
 - (2) decided that, when the hosted partnership has an exclusively regional jurisdiction, the review will be conducted by the appropriate regional governing body, in adherence with the global partnership policy and subject to oversight and review by the Programme, Budget and Administration Committee as needed;
 - (3) requested the Director-General to prepare an operational framework for the Programme, Budget and Administration Committee on hosted health partnerships;
 - (4) further requested the Director-General to ensure that WHO fully recovers all costs associated with hosted partnerships;
 - (5) further requested the Director-General to pursue and apply as appropriate the approach proposed in paragraphs 16(b)–16(d) and 16(f)–16(i) of document EB132/5 Add.1 on consulting hosted partnerships, in particular with regard to matters that depend on a partnership's board's decision for managing WHO's relationships with hosted partnerships;
 - (6) encouraged Member States to promote coherence in their positions across the governing bodies of WHO and those of hosted partnerships;

2. Having considered in addition document EB132/5 Add.2 on engagement with nongovernmental organizations, requested the Director-General;
 - (1) to propose to the Executive Board at its 133rd session in May 2013, overarching principles for WHO's engagement with non-State actors, defining separate operational procedures for both nongovernmental organizations and private commercial entities;
 - (2) to harmonize the development of the draft policy for engagement with nongovernmental organizations with the draft policy on WHO's relations with private commercial entities, such development being guided by the principles stated by the Sixty-fifth World Health Assembly in decision WHA65(9), subparagraphs (9)(i)–(v);
 - (3) to work further on the draft policy of engagement with nongovernmental organizations, proceeding with the revision of accreditation procedures for nongovernmental organizations for WHO's governing bodies (i.e. authorization to participate therein) and incorporating those procedures in the draft; including updated terms of reference and operational procedures of the standing committee on nongovernmental organizations; and incorporating the inputs provided during the deliberations of the Board at its 132nd session;
 - (4) to conduct public web-based consultations on the draft principles and policies of engagement with non-State actors; and convene two separate consultations, one with Member States and nongovernmental organizations, and one with Member States and the private commercial sector, to support the development of the respective draft policies;
 - (5) to report on the development of the two draft policies to the Board at its 134th session in January 2014;
3. Having considered in addition document EB132/5 Add.4 on streamlining national reporting and communication with Member States;
 - (1) welcomed the proposals on streamlining the reporting of and communication with Member States;
 - (2) requested the Director-General to advance the work proposed in document EB132/5 Add.4, taking into account the division of health responsibilities of national and subnational levels of government, and to report back on progress in implementation to the Executive Board at its 134th session in January 2014, including relevant financial information;
 - (3) further requested the Director-General to propose the definition of a minimal set of health data and indicators as well as a recommended additional set in the context of the results of a detailed analysis on the current practice of reporting;
4. Recognizing the importance of WHO's role in global health governance, noted the report on the subject contained in document EB132/5 Add.5, and decided to continue its examination of WHO's role in global health governance at its 133rd session;
5. Welcoming the report of the Joint Inspection Unit provided in document EB132/5 Add.6, requested the Director-General to incorporate and cross-reference the recommendations of the Joint Inspection Unit within the WHO reform implementation plan, and to report back on progress in line with regular reporting on WHO reform implementation;
6. Having considered document EB132/5 Add.7 on the modalities of the second stage evaluation on WHO reform, endorsed the proposed modalities and requested the Director-General to report to the Board at its 133rd session in May 2013 on progress made;
7. Welcoming the report contained in document EB132/5 Add.8 on the implementation of WHO reform, on progress of implementation and the high-level implementation plan contained in document EB132/INF./3, including with respect to submission of regular reports to the Independent Expert Oversight Advisory Committee, requested the Director-General to report

back to the Board in May 2013 on progress on reform implementation, based on an updated version of the high-level implementation plan, including information on costs and indicators.

The CHAIRMAN asked whether the Board was ready to adopt the draft decision points.

The decisions were adopted.¹

Mr AGHAZADEH KHOEI (Islamic Republic of Iran) asked how the outcomes of the forthcoming informal meeting would be incorporated into the decision points.

The CHAIRMAN said that the outcomes would be reflected in an additional set of draft decision points for consideration and adoption by the Board.

The DIRECTOR-GENERAL added that any additional draft decision points agreed by the Board would be incorporated into the document containing the decision points just adopted. The CHAIRMAN proposed that the meeting be suspended until the afternoon in order to allow the informal meeting of the Board to continue its work on WHO reform.

It was so agreed.

(For continuation of the discussion and adoption of a decision, see the summary record of the seventeenth meeting, section 4.)

The meeting rose at 09:20.

¹ Once adopted, the text was presented as discrete decisions: decisions EB132(10), EB132(11), EB132(12), EB132(13) and EB132(14) .

SEVENTEENTH MEETING

Tuesday, 29 January 2013, at 14:45

Chairman: Dr J. ST. JOHN (Barbados)

1. MANAGEMENT MATTERS: Item 13 of the Agenda (continued)

Follow-up of the report of the Working Group on the Election of the Director-General of the World Health Organization: Item 13.1 of the Agenda (Documents EB132/29, EB132/29 Add.1, EB132/29 Add. 2 and EB132/29 Add.3) (continued from the twelfth meeting, section 2)

The CHAIRMAN drew attention to two documents issued the previous day: document EB132/29 Add.2, which contained a draft resolution and document EB132/29 Add.3, which presented the financial and administrative implications of the resolution for the Secretariat should it be adopted. She added that the following footnote should be inserted after the words “Member States” in paragraph 2 of the draft resolution contained in document EB132/29 Add.2 and in paragraph 6 of Annex 2 to that resolution: “And, where applicable, regional economic integration organizations.” She invited the Board to consider first the draft resolution concerning Rule 52 of the Rules of Procedure of the Executive Board, contained in document EB132/29 Add.1.

Ms STIRØ (Norway), speaking on behalf of the Member States of the European Region, said that the draft resolution represented the practical application of resolution WHA65.15 and the culmination of the collective efforts of Member States. The proposed amendment to Rule 52 of the Rules of Procedure of the Executive Board regarding the timing of the candidates’ forum reflected the preference of the Member States. The amendment proposed by the member for Seychelles in the earlier meeting mirrored the language used in paragraph 1(f) of resolution WHA65.15, but, in order to reflect fully that language, she proposed that the following wording should be inserted in paragraph 6 of the proposed text of Rule 52 after the words “determined by it,”: “underscoring the paramount importance of professional qualifications and integrity”.

Mr McIFF (United States of America) acknowledged the collaborative spirit in the informal discussions. He supported the amendment proposed by the member for Norway. For the timing of the candidates’ forum, the preference of the Member States of the Region of the Americas was to hold the forum not later than two months before the opening of the Board’s session, as set out in revised Rule 52 (paragraph 3). He agreed with the other proposed amendments to Rule 52.

Dr BAYE LUKONG (Cameroon), speaking on behalf of the Member States of the African Region, agreed with the amendment proposed by the member for Norway; professional qualifications and integrity were indeed essential criteria.

Mr CORRALES HIDALGO (Panama) supported the amendment proposed by the member for Norway.

The CHAIRMAN took it that the Board wished to adopt the draft resolution contained in document EB132/29 Add.1, as amended.

The resolution, as amended, was adopted.¹

The CHAIRMAN invited the Board to consider the draft resolution contained in document EB132/29 Add.2. The financial and administrative implications for the Secretariat of the draft resolution, should it be adopted, were set out in document EB132/29 Add.3.

Mr McIFF (United States of America) again acknowledged the spirit of interregional cooperation in the informal consultations. With regard to the timing of the candidates' forum, he proposed that the wording just adopted in resolution EB132.R13 be repeated in Annex 2, paragraph 2, to read: "The candidates' forum shall be held not later than two months before the opening of the session".

He supported the proposed addition of Rule 70*bis* to the Rules of Procedure of the World Health Assembly. Noting that some Member States had expressed concern about the complexity of the procedure for nomination and voting outlined in Rule 108 (document EB132/29 Add.3, Annex 4), he suggested that the deletion of subparagraphs 1(d) and 2(c) would streamline and simplify that procedure.

The CHAIRMAN took it that the Board wished to adopt the draft resolution contained in document EB132/29 Add.2, as amended.

The resolution, as amended, was adopted.²

Mr LEWIS (Canada),³ acknowledging the adoption of the resolution, nevertheless wished to make an observation thereon. Canada had taken part in the process that had culminated in consensus. Referring to the voting procedure defined in the revised Rule 108, he cautioned that, although the wording "clear and strong majority" had been accepted by Member States, it had not been defined and must indicate more than a simple majority.

2. PROGRAMME AND BUDGET MATTERS: Item 11 of the Agenda (continued)

Proposed programme budget 2014–2015: Item 11.3 of the Agenda (Documents EB132/27, EB132/27 Add.1 and EB132/INF./4) (continued from the eighth meeting, section 1)

The CHAIRMAN drew the Board's attention to the draft decision on the proposed programme budget 2014–2015 contained in document EB132/27 Add.1, issued that morning.

Ms STIRØ (Norway) welcomed the draft decision, which would contribute to the financing aspects of the WHO reform process. It captured the views of the Member States, and she particularly welcomed the annexed outline of the financing dialogue. She noted, however, that it had been decided that the first meeting in that dialogue would not be solely virtual but would be a physical meeting in

¹ Resolution EB132.R13.

² Resolution EB132.R14.

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

Geneva with the proceedings distributed through a web-conferencing option for those Member States unable to participate otherwise. For that reason, she proposed that references to “virtual session” in the heading and second row of the first main column be replaced with “informal session” in order to avoid any misunderstanding.

Mr McIFF (United States of America) welcomed the draft decision but supported the amendment proposed by the member for Norway, agreeing that there was potential for confusion in retaining the word “virtual”. It had been decided to hold a low-cost but in-person meeting in order to make good progress in the financing dialogue.

Mr AGHAZADEH KHOEI (Islamic Republic of Iran), supported by Dr BAYE LUKONG (Cameroon), speaking on behalf of the Member States of the African Region, endorsed the amendment proposed by the member for Norway.

Dr CUYPERS (Belgium), speaking as Vice-Chairman of the Programme, Budget and Administration Committee, recalled the Committee’s discussion on the proposal for the financing dialogue. He reiterated the Committee’s request that the Secretariat consider the use of a standardized format when preparing the financial updates, so as to present information on human and financial resources by category, region or country, to the extent possible. That would facilitate efficient assessment and discussion.

Mr HAZIM (Morocco) agreed that the first meeting of the financing dialogue was not correctly identified as “virtual”. In the first column of the row entitled “Expected outcomes” in the Annex to the draft decision, he asked whether “resource requirements” referred to financial resources or all resources?

The DIRECTOR-GENERAL, in response to the member for Morocco, said that the resources referred to were financial.

With regard to the comment by the member for Belgium, she observed that, as the financing dialogue was a new process, the format of the documents had not been finalized. The proposed programme budget 2014–2015 would be the primary financial document submitted to the Health Assembly and used during the financing dialogue for Member States’ consideration. Recognizing that Member States had to go into the financing dialogue with an understanding of what WHO needed, what it already had, and what funding gaps it faced, she drew attention to the last entry in the row for the method and programme of work of the informal session for the financing dialogue, which indicated that the financial update would include resource requirements, secured funding, and information on funding shortfalls. That information would be provided in a supporting document. She would welcome the advice of the Chairman and Vice-Chairman of the Programme, Budget and Administration Committee about what information Member States needed. She was committed to sharing whatever information was available with Member States.

The new nature of the process meant that the whole Organization was learning by doing.

Mr MIŠKINIS (Lithuania), speaking on behalf of the European Union and its Member States, supported the outcomes of the second extraordinary meeting of the Programme, Budget and Administration Committee, including approval by the Health Assembly of the proposed programme budget in its entirety. He proposed amending paragraph (1) of the draft decision to reflect the relevant decision in that Committee’s report (document EB132/3), so as to read “the Executive Board proposed to the Health Assembly that the entire programme budget be approved by the Health Assembly;”. As a result of that proposal, he suggested inclusion of a footnote in the draft decision, specifying that the Board at its current session had not approved or recommended approval of the proposed programme budget 2014–2015. He expected that a fully-costed revised draft of that programme budget, which should include the provisional allocation and distribution of funding from assessed and voluntary contributions by major office and between categories, would be submitted for consideration to the

Programme, Budget and Administration Committee in advance of the Sixty-sixth World Health Assembly.

He welcomed the first part of document EB132/27 Add.1, Annex, which outlined the proposed process of the financing dialogue. The information given in that Annex reflected most of the views put forward by Member States, and, as such, he supported the proposed process. The combined virtual and physical meeting to be held in June 2013 fitted well into the wider reform agenda.

He welcomed the role of the governing bodies following the financing dialogue, as set out at the end of the Annex to document EB132/27 Add.1. However, that information needed further elaboration; for example, provision of an explanation of “review” and definition of the role of the governing bodies in the strategic allocation of assessed contributions and the targeted mobilization of resources to fill remaining funding gaps. He asked the Director-General to facilitate further discussion on that aspect of the Annex before the Health Assembly in May 2013. In addition, he proposed amending the text to reflect the provisional status of the proposals, by amending the heading of the second part to read “Indicative role of governing bodies following financial dialogue”.

Finally, he suggested that the word “Chairman” be replaced with the word “Chair” or “Chairperson” throughout the draft decision and the Annex thereto.

The CHAIRMAN requested that the member for Lithuania submit his proposals in writing.

The DIRECTOR-GENERAL said that the statement just made by the member for Lithuania was complex, and appeared to be a reversal of a previous position of the European Union. It was true that the Executive Board had not approved the proposed programme budget 2014–2015. The Annex to the draft decision, on page 3 of document EB132/27 Add.1, clearly indicated regular reporting by the Director-General to the Organization’s governing bodies. She also expressed concern at the contradictory action being requested. On the one hand, the Director-General was requested to indicate the allocation of voluntary and assessed contributions in the proposed programme budget to be submitted to the Health Assembly; but on the other hand, other Member States of the European Union such as Germany had requested that the assessed contributions be used in a strategic manner. The intervention had confused her, and she sought clarification on how to proceed.

Dr REN Minghui (China) said that he understood the reason behind the proposed replacement of “virtual” by “informal” in the Annex to the draft decision. If the first stage was informal, so too, according to the method and programme of work, was the second stage: “working method: informal consultation”. How was the degree of informality to be made clear, particularly to those Member States that had not been a part of the discussion?

Professor HALTON (Australia) agreed that the use of “virtual” could be misleading. She thought that it had been agreed that the purpose of the first meeting of the financing dialogue was to inform participants of all the facts, as a preamble to the second meeting, which was to promote active dialogue. She asked for confirmation of that understanding and for removal of any ambiguity created by using “informal” in two different contexts.

Dr THABET NASHER (Yemen) proposed, with regard to the suggested amendment to the Annex, replacing “virtual” with “launch” in the title of the first column, as that would encompass both the informal and virtual characteristics of the meeting. He further proposed that the launch of the financing dialogue be included in the purpose or expected outcomes of the first session.

Dr REYNDERS (Belgium), speaking as a delegate of a Member State of the European Union, said that he wished to explain the content of the statement made by the member for Lithuania regarding the role of governing bodies. In the past, the Health Assembly adopted an appropriation resolution, which meant that the governing bodies, be it the Health Assembly, the Board or the Programme, Budget and Administration Committee, had a role to play in the allocation of funds. The

Programme, Budget and Administration Committee had decided that the entirety of the budget should be approved by the Health Assembly, yet at the time of its approval, the budget would be unfunded.

His concern lay in the fact that the table in the Annex to the draft decision did not clarify the role of the governing bodies in terms of their authority to allocate funds. For that reason, the member for Lithuania had requested further consultations to clarify the future of that role. The table indicated that the governing bodies would receive a report, but the receipt of such a report did not mean that the governing bodies had a role to play.

Ms PENEVEYRE (Switzerland) asked to see the proposed amendments made by the member for Lithuania in writing. She concurred with the Director-General that, as it was the first time such a financing dialogue had been undertaken, it was important to learn from the process as it progressed. She acknowledged a need to discuss the role of the governing bodies, but said that the Board should not agree to the need to finalize allocations by May 2013.

Mr McIFF (United States of America) said that he did not see the confusion between the roles of the governing bodies and the financing dialogue. He expected the governing bodies to contribute to the decision on allocations at the start of each biennium. He was concerned that the amendment proposed by the member for Lithuania would add uncertainty rather than clarification.

Regarding the titles of the sessions for the financing dialogue, it was true that both meetings were informal, and so he supported the proposal made by the member for Yemen, which would clarify the different purposes of those two meetings.

The CHAIRMAN clarified that the proposal being made requested no change to organizational rules and regulations regarding the role and primacy of the governing bodies in making budget decisions.

The DIRECTOR-GENERAL stated that the Member States seemed not to have confidence in the Secretariat. They had previously told her to use assessed contributions in a strategic manner, but were now requesting that she spell out in advance how every dollar and cent of the assessed contributions and voluntary contributions were being used. She reminded the Board that when the programme budget was approved in May, it would not be “real money”; Member States would not yet have paid their contributions. As Director-General, she was already severely limited in what she was able to do, and any decision was approved by the Member States. That did not bode well for the reform process. She reiterated the statement by the Chairman that no Member State had requested a change to organizational rules and regulations. She appealed to Member States to have confidence in her and her staff, in their commitment to the Organization, and to reconsider the proposal.

Professor HALTON (Australia) encouraged Board members to show flexibility. They had already widely accepted the proposal to replace the word “virtual” in the Annex to the draft decision by “launch”.

It had been clearly stated that the primacy of the governing bodies would not be altered by the outcome of the financing dialogue or adoption of the draft decision. The proposal made by the member for Lithuania was unclear and confusing, and had been made at the last minute. She reminded the Board of the need to discharge the obligation given to it by the Health Assembly, and encouraged the members of the Board to accept the draft decision and its Annex, as amended by the member for Yemen. She reiterated that the financing dialogue was a tool that the Board had created for its own purpose, and as such it could be changed at any time if it did not work as expected.

The meeting was suspended at 15:30 and resumed at 16:05.

Mr ABDULLA (Qatar), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that he fully endorsed the steps being taken by the Director-General to reform the Organization and the proposals currently before the Executive Board, including the proposal for a

financing dialogue in every detail. Such a dialogue was extremely important for all Member States in that it would help to attract financial resources for the proposed programme budget 2014–2015. He thus supported submission of the draft decision to the Sixty-sixth World Health Assembly with a view to its adoption by consensus.

He took the opportunity to reiterate his confidence in the Director-General and the Secretariat with respect to taking appropriate budget allocation measures on the basis of available resources and existing needs, in accordance with the proposed budget.

Mr MIŠKINIS (Lithuania), speaking on behalf of the European Union and its Member States, said that he wanted to clarify his earlier statement. The European Union remained fully committed to WHO reform, and supported the outcomes of the extraordinary meeting of the Programme, Budget and Administration Committee, including the recommendation that the Health Assembly adopt the proposed programme budget in its entirety. He therefore proposed amending paragraph (1) of the draft decision to read that the Executive Board proposed to the Health Assembly that “the entire programme budget be approved by the Health Assembly”, so as to reflect the wording in the Committee’s decision (document EB132/3, paragraph 13).

The table in the Annex (document EB132/27 Add.1, p.3) did set out the role of the governing bodies following the financing dialogue, but he would welcome further discussions before the Health Assembly in May 2013 in order to clarify the different elements.

He assured the Director-General of his commitment to working with WHO towards global health. The purpose of his proposal had been to ensure the creation of as robust an instrument as possible to allow Member States to work together, including the financing dialogue.

Dr VALVERDE (Panama) said that, despite a complex regional consultation on how to proceed, all Member States of the Region of the Americas had agreed to support WHO and the Director-General. The Organization was in a period of transition and deserved its Member States’ vote of confidence. She proposed that the Board adopt the draft decision as amended by the member for Norway.

Dr REN Minghui (China) said that the draft decision captured the points made during the current discussions on the financing of WHO, and the lateness of the proposed amendments made by the member for Lithuania meant it was unrealistic to expect them to be given due attention. He therefore suggested that the draft decision be adopted without amendment, with the Annex to the document being amended as proposed by the member for Yemen to include the word “launch” in the title of the first column.

As it was his last meeting as a member of the Board, he had prepared a gift to each other member. The three-faceted picture frame represented his impressions of WHO: the first facet represented the many resolutions and decisions that had been adopted; the second, the experience and memory of the Board’s evening sessions; and the third, the Director-General’s devotion to the Organization. Throughout his term of office, Board members had not agreed on everything but had always reached consensus in the end.

Ms DÁVILA CHÁVEZ (Mexico) welcomed the flexibility shown by the Member States of the European Union. Dialogue was the only way to resolve differences and build consensus. The outcome of the extraordinary meeting of the Programme, Budget and Administration Committee regarding the programme budget was clear, and the draft decision provided a way of implementing that outcome. At such an unprecedented moment, she was pleased to support the draft decision, as amended by the member for Yemen. Future changes or improvements could be made if Member States remained open to communication.

Mr McIFF (United States of America) agreed with the comments made by the members for Mexico and Panama. The Board had reached a strategic moment in the reform process. Members of the Board must think strategically and demonstrate their confidence in the Director-General and her

staff. He supported the draft decision with the small amendment to the Annex proposed by the member for Yemen; it was a strategic document.

He thanked the Member States of the European Union for their flexibility, and encouraged the Board to accept the rewording of paragraph (1) of the draft decision, which reflected the decision of the Programme, Budget and Administration Committee.

Dr BAYE LUKONG (Cameroon), speaking on behalf of the Member States of the African Region, reiterated their full support for the WHO reform process and expressed their full confidence in the Director-General and her staff. She welcomed the flexibility demonstrated by the Member States of the European Union. She supported the draft decision, with the amendment to the Annex proposed by the member for Yemen.

Mr ASALOU (Nigeria) thanked the Member States of the European Union for reconsidering their proposed amendments. Supporting the financial dialogue, he recommended adoption of the draft decision and its Annex for submission to the Health Assembly. He assured the Director-General of his support.

Ms ESCOREL DE MORAES (Brazil)¹ supported the proposed amendment to the Annex to the draft decision to replace “virtual” with “informal”. If the meeting were not to be virtual, then the first bullet point referring to the “Date/location” of the first meeting should be amended to read “Informal session in the Executive Board Room, WHO headquarters, with the option to follow on a restricted webcast”.

She reaffirmed her country’s full support for the Director-General and her staff.

The CHAIRMAN, welcoming the flexibility shown by the member for Lithuania, took it that the Board agreed with the proposal made by the member for the United States to accept the proposed amendment to paragraph (1) of the draft decision, to bring it in line with the outcome of the extraordinary meeting of the Programme, Budget and Administration Committee.

She asked the Board whether it was ready to adopt the draft decision with its Annex as amended by the members for Yemen, Norway and Lithuania.

Dr REN Minghui (China) said that he preferred not to amend the draft decision, but asked the member for Lithuania to re-read his proposal so that he could consider it further.

Mr MIŠKINIS (Lithuania) said the proposed amendment to paragraph (1) of the draft decision was as follows, “The Executive Board recommends that the programme budget be approved in its entirety in the World Health Assembly”, and agreed to that amendment being edited by the Secretariat.

The CHAIRMAN asked the Board whether it was ready to adopt the draft decision and the Annex thereto, as amended by the members for Yemen, Norway and Lithuania.

Mr AGHAZADEH KHOEI (Islamic Republic of Iran) agreed to the adoption of the draft decision in principle, but said that the amendments referred to by the Chairman were contradictory. In replacing the word “virtual”, the member for Norway had proposed using “informal” and the member for Yemen had proposed “launch”. The amendment proposed by the latter seemed to have consensus.

He expressed his confidence in the Secretariat.

The CHAIRMAN took it that the Board wished to adopt the draft decision on the proposed programme budget 2014–2015 and the financing dialogue contained in document EB132/27 Add.1

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

and the Annex thereto, as amended by the members for Yemen and Lithuania, following editing by the Secretariat.

The decision was adopted, as amended.¹

3. MANAGEMENT MATTERS: Item 13 of the Agenda (continued)

Provisional agenda of the Sixty-sixth World Health Assembly and date and place of the 133rd session of the Executive Board: Item 13.6 of the Agenda (Document EB132/36)

The CHAIRMAN invited comments from the Board on the draft decision contained in document EB132/36.

Dr DAULAIRE (United States of America) proposed that provisional agenda item 18 F, which dealt with the progress report on malaria, be elevated to the status of a technical item for consideration by Committee A of the World Health Assembly in May 2013 in order to highlight the serious and growing threat to global malaria control and treatment programmes. To redesignate the item in that manner would be to recognize the importance of malaria as a WHO priority and the tremendous investments being made in those programmes. Given the concern that the recent significant progress was at grave risk of being undermined by the emerging drug resistance, he further proposed that the Secretariat give a presentation on the efforts being made to counter that problem, so as to allow more time for discussion of the issue. The item should preferably be inserted into the agenda before the item on substandard/spurious/falsely-labelled/falsified/counterfeit medical products, given the relevance of antimalarial drug resistance to the discussion of those products in view of the part they played in drug resistance.

Dr LOUME (Senegal), supported by Mr ASAOLU (Nigeria), supported the proposal to discuss malaria as a technical item in the light of many problems encountered in tackling the disease, particularly in areas where it was rife, such as the African Region. High on the list of those problems, besides funding, was the emerging resistance to antimalarial medicines, including artemisinin, and shortages of artemisinin-based combination therapy. If full consideration of malaria were deferred until 2014, those problems would have become even more acute, with a corresponding rise in deaths from the disease.

The CHAIRMAN said that, in the absence of any objection to the proposal to amend the provisional agenda for the Sixty-sixth World Health Assembly, she took it that the Executive Board wished to approve the draft decision.

It was so decided.²

The CHAIRMAN proposed that the 133rd session of the Executive Board should be held on 29 and 30 May 2013, in Geneva.

It was so decided.¹

¹ Decision EB132(16).

² Decision EB132(17).

The CHAIRMAN said that, in compliance with Rule 8 of the Rules of Procedure of the Executive Board, the provisional agenda for the 133rd session of the Board would be drawn up by the Director-General and circulated to Member States and Associate Members within four weeks of the closure of the current session.

4. WHO REFORM: Item 5 of the Agenda (Documents EB132/5, EB132/5 Add.1, EB132/5 Add.2, EB132/5 Add.3, EB132/5 Add.4, EB132/5 Add.5, EB132/5 Add.6, EB132/5 Add.7, EB132/5 Add.8, EB132/5 Add.9, EB132/INF./2 and EB132/INF./3) (continued from the sixteenth meeting)

Professor HALTON (Australia), speaking in her capacity as chairman of the informal consultation group, reported that the group had resumed its consideration of the proposals to amend the Rules of Procedure of the Executive Board, taking into account the concerns expressed about the potential for confusion with regard to their scope. New text had been agreed for two Rules. The first, a proposed new Rule 28, read as follows:

“Proposals for resolutions or decisions to be considered by the Board relating to items of the agenda may be introduced until the close of the first day of the session. However, if a session is scheduled for two days or less, such proposals may be introduced no later than 48 hours prior to the opening of the session. The Board may, if it deems it appropriate, permit the late introduction of such proposals.”

The word “introduced”, in the context of that Rule, should be taken to mean “presented to the Secretariat for translation and distribution”, and the words “proposals for resolutions or decisions” were intended to make clear the focus of the proposal.

The second new Rule, proposed new Rule 29, would read as follows:

“Proposals and amendments related to items on the agenda shall normally be introduced in writing and handed to the Director-General, who shall circulate copies to the delegations. Except as may be decided otherwise by the Board, no proposal shall be discussed or put to the vote at any meeting of the Board unless copies of it have been circulated to all delegations at least one day previously. The Chairman may, however, permit the discussion and consideration of amendments, even though they have not been circulated or have only been circulated the same day.

She expressed her preference to see the use of the word “Chair” introduced.

Mr AGHAZADEH KHOEI (Islamic Republic of Iran) said that the proposed new Rules 28 and 29 could not be considered in isolation, as they related largely to specific Rules of Procedure of the World Health Assembly: the former to Rules 48 and 49 and the latter to Rule 50, which were also currently subject to review. The relevant Rules must be examined in the context of the Rules of Procedure of both the Executive Board and the World Health Assembly in order to ensure consistency. His delegation looked forward to having an opportunity to consider the matter further at a later stage.

Professor HALTON (Australia) said that the group had also agreed consensus language for a possible draft decision requesting options for criteria for the inclusion, exclusion or deferral of items

¹ Decision EB132(18).

on the provisional agenda of the Executive Board, taking into account resolution EB121.R1 and decision WHA65(9). The text in question would read as follows:

The Executive Board,

Having considered the report on streamlining of the work of the governing bodies and harmonization and alignment of the work of regional committees,

REQUESTS the Director-General:

- (1) to take the necessary steps to improve capacity-building and training for new Board members and Officers;
- (2)
 - (a) to improve electronic access to governing body meetings and documentation on a registered basis;
 - (b) to prepare a study, including options on the feasibility of holding meetings of the Executive Board and the World Health Assembly with minimal use of paper documents. Taking into account the experience of other United Nations specialized agencies, the study would include a cost-benefit analysis. It should be considered by the Executive Board at its 134th session;
 - (c) to prepare options for criteria for inclusion, exclusion or deferral of items on the Executive Board's provisional agenda taking into account EB121.R1 and decision WHA65(9) and criteria underpinning the draft general programme of work to be submitted to the World Health Assembly in May 2013, for consideration by the Executive Board at its 133rd session.

The CHAIRMAN, seeing no objections, said that she took it that the Board wished to accept the draft decision proposed by the informal consultation group, as read out by its Chairman.

Professor HALTON (Australia) said that some other issues were raised during the informal consultation but not discussed by the group owing to a lack of time. One such matter was a draft decision point proposed by the European Union relating to the consequences of the late reception of Board documentation and containing an amendment to paragraph 3 of Rule 5 of the Rules of Procedure of the Executive Board. At the request of the CHAIRMAN, she read aloud the proposed draft decision:

The Executive Board,

DECIDES to amend paragraph 3 of Rule 5 of the Rules of Procedure of the Executive Board, as follows: [new language is underlined and in bold]

Documents for the session shall be dispatched by the Director-General not less than six weeks before the commencement of a regular session of the Board. They shall be made available in electronic form in the working languages of the Board on the Internet site of the Organization. **If documents for the session are not dispatched three weeks before the commencement of a regular session, the agenda item point to which they refer shall be deferred to the next session, subject to the discretion of the Officers of the Board which shall include exceptional circumstances.**

Mr AGHAZADEH KHOEI (Islamic Republic of Iran) said that the proposed amendment would ultimately have a negative impact by depriving Member States of the opportunity to engage in discussions on particular items. Removing items from the agenda in such a way did not seem just. The Secretariat should be requested to identify and recommend other ways to resolve the matter raised.

Mr MIŠKINIS (Lithuania), speaking on behalf of the European Union and its Member States, explained that the proposed amendment to Rule 5 had been put forward so that all delegations could have sufficient time to consider the documentation in order to carry out their work as effectively as possible.

Dr DAULAIRE (United States of America) supported the proposed amendment, which would create better discipline across the whole process if there were consequences to the delayed submission of documents. There was never a perfect solution to such issues, but the language proposed would help to make both the Board and the Secretariat more efficient and more accountable, while the final sentence would allow some leeway when it was required.

Mr CORRALES HIDALGO (Panama) said that a decision on the amendments to the Rules of Procedure of the Executive Board and the World Health Assembly should be deferred to a later date in order to enable further consultations on the issue. Although there was consensus on the need to improve working methods, there was still disagreement among Member States on some points and it was important to ensure coherence in the Rules of Procedure of both bodies. Although he welcomed the proposal being discussed, it would be hasty to make a decision at the current time; if other issues were to be discussed at a later date, the proposal in question should be included in those discussions.

Mr ASAOLU (Nigeria) said that he wondered how many items would have been removed from the agendas of previous meetings if such an amendment to that Rule had been adopted earlier. There would be times where it was not possible to have the documents on certain items as early as Member States wished, but if such items were removed from the agenda and not discussed, he asked when would it be possible to add them again. It was certainly important to have the relevant documents and information available in good time before a meeting, but there must be a careful assessment of all the potentially negative effects of the amendments proposed.

Ms PENEVEYRE (Switzerland) said that her delegation was one that often complained about the late arrival of documents and thus strongly supported the intention to ensure that Member States received documents in good time. The new text proposed at the end of paragraph 3 of Rule 5, however did not link very well with the existing text. The paragraph already referred to documents being dispatched six weeks before a meeting so, in theory, the situation envisaged by the amendment should never arise. Further consideration was therefore needed on how to ensure the timely dispatch of documents.

Ms DÁVILA CHÁVEZ (Mexico) agreed with the member for the Islamic Republic of Iran that Member States should not be prohibited from discussing certain items because the relevant documentation was not ready in time; she therefore proposed an alternative amendment to paragraph 3 of Rule 5, which would read “Where documents are not available four weeks prior to the Board’s session, the Director-General shall prepare a status report on all unpublished documents, which shall include the reasons for its delay and an anticipated publication date”. She indicated that she was prepared to consider alternative time frames.

Mr HAZIM (Morocco) said that the proposal to defer agenda items was problematic; it did not affirm the principle of discipline as it allowed the Executive Board to retain any item on the agenda whenever it was judged necessary.

Governing body meetings always began with a provisional agenda, which also did not help to maintain discipline. He urged the Board either to resolve to set a deadline beyond which items could not be added to the agenda, or to defer further discussion of the proposal to a future time as it seemed unlikely that consensus would be reached during the current session.

Dr DAULAIRE (United States of America) said that the proposed amendment by Mexico was a constructive one. He expressed, however, a preference for retaining the existing text of six weeks instead of four.

Ms DÁVILA CHÁVEZ (Mexico), at the request of the CHAIRMAN and accepting that proposal, repeated her proposed amendment, replacing “four weeks” with “six weeks”.

Mr BURCI (Legal Counsel) said that, from the Secretariat’s perspective, the proposed amendment with a peremptory six weeks’ deadline would pose some practical problems for the May sessions of the Board, given that the draft provisional agenda needed to be sent to members within four weeks of the January session and the members had 10 weeks to propose other items before the Officers of the Board met. It was only at that point that the provisional agenda was set and documentation could be issued. That timespan would likely overlap with the proposed six week deadline, meaning that it would be difficult to issue documents in time for the May session of the Board. The Board could either change that suggestion of six weeks or it could decide to revise the entire timeline that he had just described.

Mr MIŠKINIS (Lithuania) expressed support for the proposal from the member for Mexico, as amended by the member for the United States of America.

Mr AGHAZADEH KHOEI (Islamic Republic of Iran) welcomed the constructive proposal from the member for Mexico but said that the Board should not seek to impose constraints on the Secretariat. Some documents for the current session of the Board had been issued only a very few days in advance. He suggested that, so as to limit the practical issues for the Secretariat, the proposed time frame could be reduced considerably.

Dr DAULAIRE (United States of America), acknowledging that six weeks might not a reasonable time frame, said that in that case that time limit should not appear in the first line of the existing text for paragraph 3 of Rule 5. Member States must have enough time to read, digest and consider the documents before coming to Board sessions for informed discussion on the items.

Mr CORRALES HIDALGO (Panama) endorsed the suggestion put forward by the member for Mexico but could be flexible about timing. If reducing the time limit before the Sixty-sixth World Health Assembly posed a problem for the Secretariat, a shorter time frame could be introduced in the current cycle before the implementation of the new Rule in 2014. He could accept either alternative.

Mr ASAOLU (Nigeria) supported the proposals put forward by the members for Panama and the United States of America. The suggestion made by the member for Mexico could create difficulties for the Secretariat, in which case three weeks would be acceptable.

Mr HAZIM (Morocco) recognized that the provision as formulated and amended by the member for Mexico could interfere with the work of the Board. He supported the proposal to reduce the period from six to three weeks, provided that no loophole allowed the inclusion of documents that had not been submitted on time.

Dr EL OAKLEY (Libya),¹ said that, if the new date of the 134th session of the Board were 1 February 2014, the preceding six weeks would include a holiday period of between two and three weeks, in practice reducing six weeks to three weeks. He therefore supported the proposal to reduce the number of weeks before which documents must be dispatched from six to three weeks. He

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

suggested replacing the word “three” with the word “two” in the amendment to paragraph 3 of the draft decision on Rule 5.

The DIRECTOR-GENERAL pointed out that a decision had been taken not to reschedule the 134th session of the Board to February, but to retain current practice, with the session being held in January.

She distinguished the documentation for the Health Assembly from that for the Board. The Health Assembly was the supreme governing body where WHO’s membership as a whole decided issues. Documents submitted to the Board could be revised in the light of the Board’s guidance or requests for additional information before they were transmitted to the Health Assembly, unless the Board had asked for further consultation on a matter. The Board had requested further consultations on partnerships; if it were not possible to hold those before March, the resulting documents would not be ready for the Health Assembly. When the Board’s agenda was not too heavy and subsidiary agenda items were not submitted late, the Secretariat did its best to make them available on time. She recalled that the Working Group of Member States on Substandard/spurious/falsely-labelled/falsified/counterfeit medical products had met in November 2012 and the Programme, Budget and Administration Committee had held its second extraordinary meeting in December 2012; it had been impossible to provide reports on those meetings within the time limit set by the Rules of Procedure. The Board’s Rules did have a let-out clause, leaving a final decision to its Officers. In the past its invocation meant that all documents had been made available, even if sometimes they were delayed.

The provisional agenda for the 134th session of the Board in January 2014 – a short session in the two-year cycle – already contained 58 agenda items, reflecting existing reporting requirements. The Secretariat must continue to prepare documentation unless and until the Officers of the Board gave it permission to stop. It was therefore crucial for the Officers of the Board and the Member States to find a way of deciding on the strategic issues to be discussed at the Board’s sessions.

Mr SEN (Turkey)¹ said that, in addition to the issues mentioned by the Director-General, the Board should also consider the amount of time available for preparing the report of the Programme, Budget and Administration Committee, as well as those of the regional committees, both of which were discussed on the first day of the January session of the Board. He asked whether some additional wording in the Rules was required to cover their submission.

The DIRECTOR-GENERAL suggested the following formulation for the Board’s consideration: that the Secretariat should also be requested to carry out an in-depth study of the legal implications of the proposed changes to the Rules of Procedure of the governing bodies. If that were acceptable, the Board need not make a decision immediately. The Secretariat could also undertake a historical review of numbers of agenda items and the number of documents that had been provided late, with the underlying reasons. With that additional information the Board could decide on what action should be taken and when. In order to allow the two studies to be conducted, she proposed amending the wording of the reporting requirements in the draft decision to read 134th session rather than the 133rd session of the Board. If that were acceptable, both the legal and operational aspects could be covered within a realistic time frame that would allow Member States to study the document before the governing bodies met.

The CHAIRMAN asked Professor Halton (Australia), in her capacity as chairman of the informal consultation group, to explain in further detail the draft decision point related to the in-depth study of the proposed amendments to the Rules of Procedure of the governing bodies.

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

Professor HALTON (Australia) summarized the informal discussions on the reform issues that were not related to the Rules of Procedure of the governing bodies. Member States had agreed to maintain the current financial year, but had not reached consensus on the proposal to move the sessions of the Executive Board and the Programme, Budget and Administration Committee to February. The financial implications of draft resolutions and the proposal to establish a time limit on reporting requirements for the Director-General in Health Assembly resolutions should be debated within the context of the reform issues related to the Rules of Procedure, given that they were closely linked. All other items for consideration had been discussed by the informal consultation group.

The wording of the draft decision point related to the in-depth study had been proposed by the member for the Islamic Republic of Iran. However, the informal consultation group had not been able to discuss that language in detail owing to time constraints. The proposed draft decision point would read:

“Requests the Director-General to perform an in-depth study to ensure that, from a legal point of view, the proposed amendments to the Rules of Procedure of the governing bodies contained in document EB132/5 Add.3 are in conformity with the existing Rules of Procedure and report back to the Executive Board at its 133rd session in May 2013.”

She recognized that the text could be further amended in order to encompass practical and logistical considerations and in view of the fact that alternative amendments to the Rules of Procedure might be proposed following the comprehensive review.

The CHAIRMAN, taking into account the comments made by the Director-General and the member for Australia regarding the need to consider the proposed amendments to the Rules of Procedure from an operational and logistical point of view as well as from a legal perspective, asked whether it would be feasible to conduct an in-depth study before the 133rd session of the Board.

Mr BURCI (Legal Counsel) said that, given the large and increasing scope of the proposed in-depth study and the number of items already on the provisional agendas of the Board and the Health Assembly in May 2013, he would welcome an amended deadline of January 2014.

Professor HALTON (Australia), speaking in her capacity as chairman of the informal consultation group, said that the language needed changing in order to make clear that it did not refer only to the proposed amendments to the Rules of Procedure, as other matters might emerge at a later stage, and to allow the Secretariat more time to complete the study. She therefore suggested inserting the words “and practical” before “point of view”, and amending the end of the paragraph to read: “... to the Executive Board at its 134th session in January 2014, and to make such other proposals based on this study and discussions so as to improve the work of the governing bodies”. That would give the Director-General the latitude to submit substantive proposals that would assist the Board in its consideration.

Dr DAULAIRE (United States of America), pointing out that some amendments were intentionally inconsistent with existing Rules, expressed confusion at the apparent suggestion that an amendment aimed at making changes could no longer do so. He therefore suggested inserting the words “except where explicitly amended” after “the existing Rules of Procedure”.

Secondly, in view of the likelihood of the words “in conformity” generating extensive legal debate, he suggested that they be replaced by “not in conflict”.

Mr HAZIM (Morocco) said that, in his limited understanding of legal matters, questions of conformity should be examined with reference to a stronger text than the Rules of Procedures. Furthermore, it seemed inappropriate to use the latter as the basis upon which to consider amendments to the Rules; the Director-General’s study should seek to ensure that they were in conformity with the WHO Constitution.

Mr AGHAZADEH KHOEI (Islamic Republic of Iran) supported the suggestion that the amendments should also be considered from the practical point of view, and agreed that the Secretariat should be given more time to complete the study. As for the additional language to be added to the end of the paragraph, he said that it needed to make clear that the discussions in question were those taking place at the current session of the Board, and that it should therefore be amended to read: "... based on this study and discussions during the 132nd session of the Executive Board so as to ...".

Regarding the comments made by the member for the United States of America, he said that the words "in conformity" had been agreed after much discussion in the informal group in order to provide flexibility to the Secretariat and the Legal Counsel, and that the intention had not been to prevent anything from being changed but to ensure that new or amended Rules were consistent with the spirit of the Rules of Procedure as a whole.

Mr BURCI (Legal Counsel) said that the language in question defined the scope of what the Secretariat was being asked to do: whether to ensure that proposed amendments were in conformity with existing Rules of Procedure or to propose possible alternatives in order to improve the work of the governing bodies. A compromise solution might be to replace the words "in conformity with" by "consistent with" or, as the previous speaker had suggested, "coherent with the spirit of" the existing Rules.

Mr AGHAZADEH KHOEI (Islamic Republic of Iran) said that the words "except where explicitly amended" were unclear and, given that the suggestion of the Legal Counsel seemed to cover the concerns raised by the member for the United States of America, he requested that they be deleted.

Dr DAULAIRE (United States of America) requested confirmation from the Legal Counsel that the intention of the text would remain intact if that phrase was deleted.

Mr BURCI (Legal Counsel) said that, given the stated requirement of coherence with the existing Rules of Procedure, the phrase "except where explicitly amended" was redundant and could therefore be deleted.

The CHAIRMAN said that, on the understanding that the phrase "except where explicitly amended" was to be deleted and that previously considered points on which there had been no consensus would feed into the in-depth study, she took it that the Executive Board wished to adopt the draft decision, as amended.

The decision was adopted, as amended.¹

Mr RUSH (United Kingdom of Great Britain and Northern Ireland)² commended the advances made on some crucial areas of global health, including noncommunicable diseases and poliomyelitis. However, even with such a packed agenda, progress on WHO reform had been disappointing. The relevant documents had been of high quality and contained clear recommendations and options that Member States should have decided to act upon. Despite the challenges inherent in reform, countries had to take difficult decisions in order to make WHO more efficient. The Director-General had set out a vision, which Member States said that they supported, so they should put it into practice. Without taking such decisions, the matter could be postponed indefinitely. He therefore urged Member States, before the Sixty-sixth World Health Assembly, to identify those areas where organizational reform would have the most impact.

¹ Decision EB132(15).

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

The DIRECTOR-GENERAL said that the current session of the Board had been unprecedented in terms of the number of agenda items, associated documents and participants, all of which indicated a high level of commitment to, and interest in, the work of WHO. Several members had mentioned late publication of documents and the Secretariat would endeavour to do better in future. But it was up to Member States to determine the strategic agenda items that they wished to pursue. Some of the discussions had been on contentious issues and she thanked members for their tolerance, understanding, constructive criticism and hard work. She warmly commended the Chairman's ability and discipline as demonstrated in the timely completion of such a challenging agenda, and thanked Professor Halton for her role in taking the Board through tough issues.

Noting a general desire for a faster pace of WHO reform, she recalled that the process was sensitive and faced many obstacles. However, the engagement of Member States during the past two years had convinced her of their determination to see the Organization fulfil its mandate as the directing and coordinating authority in global health in the interests of improving the health of people globally.

5. CLOSURE OF THE SESSION

After the usual exchange of courtesies, the CHAIRMAN declared the 132nd session closed.

The meeting rose at 18:20.

LIST OF MEMBERS AND OTHER PARTICIPANTS

MEMBERS, ALTERNATES AND ADVISERS

BARBADOS

Dr J. ST. JOHN, Chief Medical Officer, Ministry of Health, Bridgetown

Alternates

Dr M. WILLIAMS, Ambassador, Permanent Representative, Geneva

Mr H. ALLMAN, Deputy Permanent Representative, Geneva

Dr C. BABB-SCHAEFER, Counsellor, Permanent Mission, Geneva

Mrs S. GRIFFITH-JACK, First Secretary, Permanent Mission, Geneva

ARMENIA

Mrs S. ABGARIAN, Deputy Permanent Representative, Geneva (**alternate to
Mr A.S. Babloyan**)

Alternate

Mr G. KOCHARIAN, Counsellor, Permanent Mission, Geneva

AUSTRALIA

Professor J. HALTON, Secretary, Department of Health and Ageing, Canberra

Alternates

Ms C. PATTERSON, Minister Counsellor (Health), Permanent Mission, Geneva

Mr S. COTTERELL, Assistant Secretary, International Strategies Branch, Department of Health
and Ageing, Canberra

Advisers

Mr J. ACACIO, Assistant Director, International Health Policy Section, Department of Health
and Ageing, Canberra

Ms N. COHEN, Director, Health Policy Section, AusAID, Canberra

Ms K. SNOWBALL, Policy and Program Manager, Health Policy Section, AusAID, Canberra

Dr T. POLETTI, Health Adviser (AusAID), Permanent Mission, Geneva

Ms J. KAINE, First Secretary, Permanent Mission, Geneva

AZERBAIJAN

Professor O. SHIRALIYEV, Minister of Health, Baku

Alternates

Dr M. NAJAFBAYLI, Ambassador, Permanent Representative, Geneva

Dr A. VALIBAYOV, Deputy Minister of Health, Baku

Mr I. ASADOV, Counsellor, Permanent Mission, Geneva

Dr S. ABDULLAYEV, Head, Division of International Relations, Ministry of Health, Baku

Mr E. ASHRAFZADE, Attaché, Permanent Mission, Geneva

Adviser

Dr G. GURBANOVA, Senior Advisor, Division of International Relations, Ministry of Health,
Baku

BELGIUM

Dr D. CUYPERS, Président du Comité de Direction, SPF Santé publique, Sécurité de la Chaîne
alimentaire et Environnement, Bruxelles

Alternates

M. B. DE CROMBRUGGHE, Ambassadeur, Représentant permanent, Genève

Advisers

Dr D. REYNDERS, Conseiller général, Chef de Service des Relations internationales, SPF
Santé publique, Sécurité de la Chaîne alimentaire et Environnement, Bruxelles

Dr P. CARTIER, Ministre Conseiller, Mission permanente, Genève

Dr I. RONSE, Expert Santé publique, Représentant du SPF Affaires étrangères, Service
Multilatéral et Programmes européens, Bruxelles

Mme E. DEPOORTERE, Policy Support, Institut de Médecine Tropicale, Anvers

Mme S. LANGEROCK, Attaché, Service des Relations internationales, SPF Santé publique,
Sécurité de la Chaîne alimentaire et Environnement, Bruxelles

Mme J. BYNENS, Conseillère, Délégué du Gouvernement de la Flandre auprès des
Organisations multilatérales, Genève

CAMEROON

Dr M. BAYE LUKONG, Technical Adviser, Ministry of Public Health, Yaoundé

Alternates

Mr A.F.M. NKOU, Ambassador, Permanent Representative, Geneva

Mr F. NGANTCHA, Minister Counsellor, Permanent Mission, Geneva

CHAD

Dr Y.P. MATCHOK-MAHOURI, Conseiller du Ministre de la Santé publique, N'Djamena

CHINA

Dr REN Minghui, Director-General, Department of International Cooperation, Ministry of Health,
Beijing

Alternates

Dr LIU Peilong, Senior Advisor, Department of International Cooperation, Ministry of Health,
Beijing

Dr SHI Guang, Director, Department of Health Policy and Legislation, Ministry of Health,
Beijing

Mr LI Quan Le, Director, Bureau of Disease Prevention and Control, Ministry of Health,
Beijing

Ms LIU Yue, Director, Department of International Cooperation, Ministry of Health, Beijing

Mr CHU Guang, Deputy Director, Department of International Organizations and Conferences,
Ministry of Foreign Affairs, Beijing

Mr JIN Song, Associate Research Staff, Bureau of Investigation and Enforcement, State Food
and Drug Administration, Beijing

Ms RU Lixia, Program Officer, Department of International Cooperation, Ministry of Health,
Beijing
Mr CHEN Hongbing, Counsellor, Permanent Mission, Geneva
Mr SHI Yuefeng, Attaché, Permanent Mission, Geneva

CROATIA

Professor R. OSTOJIĆ, Minister of Health, Zagreb

Alternates

Dr M. CESARIK, Vice Minister of Health, Ministry of Health, Zagreb
Ms V. VUKOVIĆ, Ambassador, Permanent Representative, Geneva
Ms S. ŽABICA, Minister's Adviser on European Affairs and International Relations, Ministry
of Health, Zagreb
Ms Z. PENIĆ IVANKO, First Secretary, Permanent Mission, Geneva
Ms L. REK SOLARO, First Secretary, Directorate for UN, Global Issues and International
Organisations, Ministry of Foreign and European Affairs, Zagreb

CUBA

Dr A. GONZÁLEZ FERNÁNDEZ, Head, Department of International Organizations, Ministry of
Public Health, Havana (**alternate to Dr R. Morales Ojeda**)

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