



WORLD HEALTH ORGANIZATION

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# **EXECUTIVE BOARD**

**135<sup>TH</sup> SESSION**

**GENEVA, 26 MAY 2014**

**RESOLUTION AND DECISIONS  
ANNEXES**

**SUMMARY RECORDS  
LIST OF PARTICIPANTS**

**GENEVA  
2014**

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## 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

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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 135th session of the Executive Board was held at WHO headquarters, Geneva, on 26 May 2014.<sup>1</sup>

The Sixty-seventh World Health Assembly elected 10 Member States to be entitled to designate a person to serve on the Executive Board<sup>2</sup> in place of those whose term of office had expired,<sup>3</sup> giving the following new composition of the Board:

Designating country	Unexpired term of office <sup>4</sup>	Designating country	Unexpired term of office <sup>4</sup>
Albania .....	2 years	Japan .....	2 years
Andorra .....	2 years	Kuwait .....	3 years
Argentina .....	2 years	Lebanon .....	1 year
Australia .....	1 year	Liberia .....	3 years
Azerbaijan .....	1 year	Lithuania .....	1 year
Belgium .....	1 year	Malaysia .....	1 year
Brazil .....	2 years	Maldives .....	1 year
China .....	3 years	Namibia .....	2 years
Chad .....	1 year	Nepal .....	3 years
Croatia .....	1 year	Panama .....	1 year
Cuba .....	1 year	Republic of Korea .....	2 years
Democratic People's Republic of Korea .....	2 years	Russian Federation .....	3 years
Democratic Republic of the Congo .....	3 years	Saudi Arabia .....	2 years
Egypt .....	2 years	South Africa .....	2 years
Eritrea .....	3 years	Suriname .....	2 years
Gambia .....	3 years	United Kingdom of Great Britain and Northern Ireland .....	3 years
Iran (Islamic Republic of) ...	1 year	United States of America ....	3 years

Details regarding members designated by the above Member States can be found in the list of members and other participants.<sup>5</sup>

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<sup>1</sup> Decision EB134(15).

<sup>2</sup> Decision WHA67(7).

<sup>3</sup> The retiring members had been designated by Cameroon, Mexico, Myanmar, Nigeria, Papua New Guinea, Qatar, Senegal, Sierra Leone, Switzerland and Uzbekistan (see decision WHA64(7)).

<sup>4</sup> At the time of the closure of the Sixty-seventh World Health Assembly.

<sup>5</sup> See page 39.



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2. Opening of the session and adoption of the agenda
3. Outcome of the Sixty-seventh World Health Assembly
4. Report of the Programme, Budget and Administration Committee of the Executive Board
5. Technical and health matters
  - 5.1 Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage
  - 5.2 Health and the environment – addressing the health impact of air pollution
6. Management and financial matters
  - 6.1 Evaluation: annual report
  - 6.2 Committees of the Executive Board: filling of vacancies
7. Staffing matters
  - 7.1 Statement by the representative of the WHO staff associations
  - 7.2 Amendments to the Staff Regulations and Staff Rules
8. Matters for information: report on meetings of expert committees and study groups
9. Future sessions of the Executive Board and the Health Assembly
10. Closure of the session

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<sup>1</sup> As adopted by the Board at its first meeting.





## LIST OF DOCUMENTS

EB135/1 Rev.1	Agenda <sup>1</sup>
EB135/1 (annotated)	Provisional agenda
EB135/2	Report of the Programme, Budget and Administration Committee of the Executive Board
EB135/3	Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage
EB135/4	Health and the environment – addressing the health impact of air pollution
EB135/5	Evaluation: annual report
EB135/6 and EB135/6 Add.1	Committees of the Executive Board: filling of vacancies
EB135/7	Amendments to the Staff Regulations and Staff Rules <sup>2</sup>
EB135/7 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly <sup>3</sup>
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<sup>1</sup> See page vii.

<sup>2</sup> See Annex 1.

<sup>3</sup> See Annex 2.



# COMMITTEES<sup>1</sup>

## 1. Programme, Budget and Administration Committee<sup>2</sup>

Mr Tomás Augusto Pippo Briant (Argentina), Dr Ren Minghui (China), Mr Kim Chang Min (Democratic People's Republic of Korea), Dr Blanchard Mukengeshayi Kupa (Democratic Republic of the Congo), Professor Adel Al-Adawy (Egypt), Mr Omar Sey (Gambia), Dr Shigeru Omi (Japan), Dr Vilius Jonas Grabauskas (Lithuania), Dr Praveen Mishra (Nepal), Dr Zelibeth Valverde (Panama), Dr Ziad Ahmed Memish (Saudi Arabia), Dame Sally Davies (United Kingdom of Great Britain and Northern Ireland), Dr Mariyam Shakeela, Chairman of the Board, member ex officio, and Dr Jarbas Barbosa da Silva Júnior, Vice-Chairman of the Board, member ex officio.

**Twentieth meeting**, 14–16 May 2014:<sup>3</sup> Dr Dirk Cuypers (Belgium, Chairman), Dr Martina Baye Lukong (Cameroon, Vice-Chairman), Mr J.C. Mercado (Argentina, alternate to Mr Tomás Augusto Pippo Briant), Mr Kim Chang Min (Democratic People's Republic of Korea), Dr W.M. Abdelnasser (Egypt, alternate to Professor Adel Al-Adawy), Dr M. Ushio (Japan, alternate to Dr Shigeru Omi), Mr M. Stelemekas (Lithuania, alternate to Dr Vilius Jonas Grabauskas), Dr Feisul Idzwan Mustapha (Malaysia, alternate to Dr Sathasivam Subramaniam), Mr M.H. Shareef (Maldives, alternate to Dr Mariyam Shakeela), Mr R. Reina Liceaga (Mexico), Dr M.H. Al-Thani (Qatar, alternate to Mr Abdulla Al-Qahtani), Dr M. Loume (Senegal, alternate to Professor Awa Marie Coll Seck), Ms Precious Matsoso (Vice-Chairman of the Executive Board).

## 2. Standing Committee on Nongovernmental Organizations<sup>4</sup>

Dr Gazmend Bejtja (Albania), Dr Walid Ammar (Lebanon), Dr Sathasivam Subramaniam (Malaysia), Dr Richard Nchabi Kamwi (Namibia), Dr Zelibeth Valverde (Panama).

## 3. Léon Bernard Foundation Prize<sup>5</sup>

Chairman and Vice-Chairmen of the Board, members ex officio, and Professor Rajko Ostojić (Croatia).

## 4. Jacques Parisot Foundation Fellowship

*Jacques Parisot Foundation Committee:*

Chairman and Vice-Chairmen of the Board, members ex officio.

*Jacques Parisot Selection Panel:*

Chairman of the Board and a member of the Foundation Committee, members ex officio.

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<sup>1</sup> Showing current membership as of 26 May 2014, and listing the names of those committee members who attended meetings since the previous session of the Executive Board, see document EB135/6 Add.1.

<sup>2</sup> Decision EB135(2).

<sup>3</sup> See document EBPBAC20/DIV./1.

<sup>4</sup> Decision EB135(3).

<sup>5</sup> Decision EB131(7).

**5. Ihsan Doğramacı Family Health Foundation Fellowship and Prize**

Chairman of the Board, member ex officio, a representative of the International Children's Centre, Ankara, and the President of Bilkent University, Turkey, or his or her appointee.

**6. Sasakawa Health Prize<sup>1</sup>**

Chairman of the Board and a representative of the Founder, members ex officio, and Mr Jeon Man-bok (Republic of Korea).

**7. United Arab Emirates Health Foundation Prize<sup>2</sup>**

Chairman of the Board and a representative of the Founder, members ex officio, and Dr Ziad Ahmed Memish (Saudi Arabia).

**8. State of Kuwait Prize for Research in Health Promotion Foundation Selection Panel<sup>3</sup>**

Chairman of the Board and a representative of the Founder, members ex officio, and Professor Adel Al-Adawy (Egypt).

**9. Membership of the Dr LEE Jong-wook Memorial Prize Selection Panel<sup>4</sup>**

Chairman of the Board and a representative of the Founder, members ex officio and Professor Jane Halton (Australia).

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<sup>1</sup> Decision EB133(5).

<sup>2</sup> Decision EB133(6).

<sup>3</sup> Decision EB135(4).

<sup>4</sup> Decision EB135(5).

**PART I**

**RESOLUTION AND DECISIONS**

**ANNEXES**



## **RESOLUTION**

### **EB135.R1      Confirmation of amendments to the Staff Rules<sup>1</sup>**

The Executive Board,

Having considered the report on amendments to the Staff Regulations and Staff Rules,<sup>2</sup>

CONFIRMS, in accordance with Staff Regulation 12.2, the amendments to the Staff Rules that have been made by the Director-General with effect from 1 July 2014 concerning: the effective date of amendments to the Staff Rules; assignment grant; appointment policies; determination of recognized place of residence; leave without pay; sick leave under insurance cover; and travel of spouse and children.<sup>3</sup>

(Second meeting, 26 May 2014)

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<sup>1</sup> See Annex 2 for the financial and administrative implications for the Secretariat of the adoption of the resolution.

<sup>2</sup> Document EB135/7.

<sup>3</sup> See Annex 1.

## DECISIONS

### **EB135(1) Working Group on Strategic Budget Space Allocation**

The Executive Board, having considered the recommendation of the Programme, Budget and Administration Committee that the membership of the Working Group on Strategic Budget Space Allocation remain unchanged in order to facilitate the continuation of its work,<sup>1</sup>

- (1) decided on an exceptional basis to maintain the current membership of the Working Group on Strategic Budget Space Allocation, namely, Belgium, Cameroon, Egypt, Malaysia, Maldives and Mexico;
- (2) requested that the Programme, Budget and Administration Committee report to the Executive Board at its 136th session, including on the outcome of the deliberations of the Working Group on Strategic Budget Space Allocation.

(First meeting, 26 May 2014)

### **EB135(2) Membership of the Programme, Budget and Administration Committee**

The Executive Board appointed as members of the Programme, Budget and Administration Committee Dr Blanchard Mukengeshayi Kupa (Democratic Republic of the Congo), Mr Omar Sey (Gambia), Dr Zelibeth Valverde (Panama), Dr Praveen Mishra (Nepal), Dame Sally Davies (United Kingdom of Great Britain and Northern Ireland), Dr Ziad Ahmed Memish (Saudi Arabia) and Dr Ren Minghui (China) for a two-year period or until expiry of their membership on the Board, whichever is first, in addition to Mr Tomás Augusto Pippo Briant (Argentina), Mr Kim Chang Min (Democratic People's Republic of Korea), Dr Vilius Jonas Grabauskas (Lithuania), Professor Adel Al-Adawy (Egypt), and Dr Shigeru Omi (Japan), who were already members of the Committee. Dr Mariyam Shakeela (Maldives), Chairman of the Board, and Dr Jarbas Barbosa da Silva Júnior (Brazil), Vice-Chairman of the Board, were appointed members ex officio. It was understood that, if any Committee member was unable to attend, except the two ex officio members, his or her successor, or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure of the Executive Board of the World Health Organization, would participate in the work of the Committee.

(Second meeting, 26 May 2014)

### **EB135(3) Membership of the Executive Board's Standing Committee on Nongovernmental Organizations**

The Executive Board appointed Dr Gazmend Bejtja (Albania) as a member of its Standing Committee on Nongovernmental Organizations for the duration of his term of office on the Executive Board. It was understood that if any Committee member was unable to attend, his or her successor or

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<sup>1</sup> See document A67/9, paragraph 11.



the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure of the Executive Board of the World Health Organization, would participate in the work of the Committee.

(Second meeting, 26 May 2014)

**EB135(4)      Membership of the State of Kuwait Prize for Research in Health Promotion Foundation Selection Panel**

The Executive Board, in accordance with the Statutes of the State of Kuwait Prize for Research in Health Promotion, appointed Professor Adel Al-Adawy (Egypt) as a member of the State of Kuwait Prize for Research in Health Promotion Foundation Selection Panel for the duration of his term of office on the Executive Board, in addition to the Chairman of the Board, member ex officio, and a representative of the Founder. It was understood that if Professor Al-Adawy was unable to attend, his successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure of the Executive Board of the World Health Organization, would participate in the work of the Foundation Selection Panel.

(Second meeting, 26 May 2014)

**EB135(5)      Membership of the Dr LEE Jong-wook Memorial Prize Selection Panel**

The Executive Board, in accordance with the Statutes of the Dr LEE Jong-wook Memorial Prize for Public Health, appointed Professor Jane Halton (Australia) as a member of the Dr LEE Jong-wook Memorial Prize Selection Panel for the duration of her term of office on the Executive Board, in addition to the Chairman of the Board, member ex officio, and a representative of the Founder. It was understood that if Professor Halton was unable to attend, her successor or the alternate member of the Board designated by the government concerned would participate in the work of the Prize Selection Panel, in accordance with Rule 2 of the Rules of Procedure of the Executive Board of the World Health Organization.

(Second meeting, 26 May 2014)

**EB135(6)      Appointment of representatives of the Executive Board at the Sixty-eighth World Health Assembly**

The Executive Board, in accordance with paragraph 1 of resolution EB59.R7, appointed its Chairman, Dr Mariyam Shakeela (Maldives), and its first three Vice-Chairmen, Dr Dirk Cuypers (Belgium), Dr Walid Ammar (Lebanon) and Dr Yankalbe Paboung Matchock Mahouri (Chad), to represent the Executive Board at the Sixty-eighth World Health Assembly. It was understood that if any of those members were not available for the Health Assembly, the other Vice-Chairman, Dr Jarbas Barbosa da Silva Júnior (Brazil), and the Rapporteur, Mr Jeon Man-bok (Republic of Korea), could be asked to represent the Board.

(Second meeting, 26 May 2014)

**EB135(7)      Date, place and duration of the 136th session of the Executive Board and the twenty-first meeting of the Programme, Budget and Administration Committee of the Executive Board**

The Executive Board decided that its 136th session should be convened on Monday, 26 January 2015, at WHO headquarters, Geneva, and should close no later than Tuesday, 3 February 2015. The Board further decided that the Programme, Budget and Administration Committee of the Executive Board should hold its twenty-first meeting from Wednesday to Friday, 21–23 January 2015, at WHO headquarters.

(Second meeting, 26 May 2014)

**EB135(8)      Place, date and duration of the Sixty-eighth World Health Assembly and the twenty-second meeting of the Programme, Budget and Administration Committee of the Executive Board**

The Executive Board decided that the Sixty-eighth World Health Assembly should be held at the Palais des Nations, Geneva, opening on Monday, 18 May 2015, and close no later than Tuesday, 26 May 2015. The Board further decided that the Programme, Budget and Administration Committee of the Executive Board should hold its twenty-second meeting from Wednesday to Friday, 13–15 May 2015, at WHO headquarters, Geneva.

(Second meeting, 26 May 2014)

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## **ANNEXES**

### **ANNEX 1**

#### **Confirmation of amendments to the Staff Rules<sup>1</sup>**

[EB135/7 – 7 May 2014]

1. Amendments to the Staff Rules made by the Director-General are submitted for confirmation by the Executive Board in accordance with Staff Regulation 12.2.<sup>2</sup>
2. The amendments described in section I of this document are made in the light of experience and in the interest of good human resources management.
3. The amendments described in section II of this document stem from resolution 68/247 adopted by the United Nations General Assembly on 27 December 2013 at its sixty-eighth session on the basis of the recommendations of the United Nations Joint Staff Pension Fund.
4. The amendments to the Staff Rules do not involve any additional costs under the regular budget.
5. The two sets of amended Staff Rules are set out in [Appendices 1 and 2, respectively<sup>3</sup>].

#### **I. AMENDMENTS CONSIDERED NECESSARY IN THE LIGHT OF EXPERIENCE AND IN THE INTEREST OF GOOD HUMAN RESOURCES MANAGEMENT**

##### **Effective date**

6. Staff Rule 040 has been amended to indicate that the effective date of these Staff Rules is 1 July 2014.

##### **Assignment grant**

7. Staff Rule 365.5 has been amended so that the lump sum portion of the assignment grant can be recovered on a proportional basis if a staff member resigns from the service of the Organization within one year of the effective date of the appointment or reassignment to an official duty station. The Staff Rule has also been amended to remove reference to the per diem portion of the grant, which is not recoverable.

##### **Appointment policies**

8. The footnote to Staff Rule 420 has been removed because the Organization no longer has any staff member who holds a career-service or a service appointment.

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<sup>1</sup> See resolution EB135.R1.

<sup>2</sup> Basic documents, 48th ed. Geneva: World Health Organization; 2014.

<sup>3</sup> Available in English and French only.

**Determination of recognized place of residence**

9. Staff Rule 460 has been amended to clarify the basis on which the country of recognized place of residence is determined for the purpose of establishing staff members' entitlements.

**Leave without pay**

10. Staff Rules 655.1, 655.2, 655.2.1 and 655.2.2 have been amended for editorial reasons only.

11. Staff Rule 655.2.3 has been amended and Staff Rule 655.2.4 introduced in order to clarify the conditions for the accrual of service credit during periods of leave without pay of 30 days or less, and periods of leave without pay of more than 30 days.

12. Staff Rule 655.2.4 has been renumbered to Staff Rule 655.3.

**Sick leave under insurance cover**

13. Staff Rule 750.1 has been amended to clarify that reference is made to receipt of salary benefits under the Organization's Accident and Illness Insurance specified in Staff Rule 720, and also for editorial reasons.

14. Staff Rule 750.2 has been amended in order to introduce Staff Rules 750.2.1, 750.2.2, and 750.2.3.

15. Staff Rules 750.2.1 and 750.2.3 have been introduced to clarify that staff members will continue to accrue service credit for all purposes during periods of sick leave under insurance cover of 30 days or less; and that service credit will cease to accrue for all purposes when periods of sick leave under insurance cover exceed 30 days. The Staff Rule has also been amended to clarify that when sick leave under insurance cover exceeds 30 days the service credit will cease to accrue as from the start date of the sick leave under insurance cover.

16. Staff Rule 750.2.2 has been introduced to clarify that sick leave under insurance cover may be granted at 50% of the ordinary rates of accrual, and also to specify that for periods of sick leave under insurance cover at 50% of more than 30 days, service credit will continue to accrue at half the ordinary rate of accrual.

**Travel of spouse and children**

17. Staff Rule 820.2.5 has been amended in order to renumber the cross-reference "Rule 655.2.4" to Staff Rule 655.3 and to make minor editorial changes.

**II. AMENDMENTS CONSIDERED NECESSARY IN THE LIGHT OF  
RESOLUTION 68/247 ADOPTED BY THE UNITED NATIONS GENERAL  
ASSEMBLY****Leave without pay**

18. Staff Rule 655.3 has been amended in light of the adoption of resolution 68/247 by the United Nations General Assembly, whereby staff members who became participants in the United Nations Joint Staff Pension Fund on or after 1 January 2014, will be eligible for the receipt of an early retirement benefit upon separation at age 58.

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19. Staff Rule 655.3 has also been renumbered to Staff Rule 655.4 in order to reflect the proposed amendments to Staff Rule 655.2.4 as indicated in section 1 of this document.

**ACTION BY THE EXECUTIVE BOARD**

20. [This paragraph contained one draft resolution, which was adopted at the second meeting as resolution EB135.R1.]

## Appendix 1

**TEXT OF AMENDED STAFF RULES**

## 040. EFFECTIVE DATE

040. These Staff Rules are effective as from 1 July 2014 and supersede all Staff Rules in force before that date. All subsequent modifications shall become effective as from the date shown thereon.
- .....

## 365. ASSIGNMENT GRANT

- ...  
365.5 If a staff member resigns from the Organization within one year of the date of his or her appointment or reassignment to an official duty station, the lump sum portion of the assignment grant paid under Staff Rule 365.3 is recoverable proportionately under conditions established by the Director-General.
- .....

## 420. APPOINTMENT POLICIES

## 460. DETERMINATION OF RECOGNIZED PLACE OF RESIDENCE

At the time of appointment of a staff member, the Organization shall determine, in consultation with him or her, that place which is to be recognized throughout his or her service as his or her residence prior to appointment, for purposes of establishing entitlements under these Staff Rules. Unless there are reasons to the contrary, and except as provided by Staff Rule 1310.2, the residence shall be determined to be a place in the country of the staff member's nationality. Consideration may be given in individual cases to designating a place in another country on the basis of reasonable justification and the staff member's right to permanent residence in that country.

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## 655. LEAVE WITHOUT PAY

- 655.1 Leave without pay may be granted, for a period normally not in excess of one year, except as indicated in Staff Rule 655.4, for purposes normally covered by sick or annual leave when that leave has been exhausted.

- 655.2 During any leave without pay under Staff Rule 655.1 the following conditions shall apply:

655.2.1 cover under any insurance provided by these Staff Rules shall cease unless the staff member pays both his or her and the Organization's contributions under the appropriate insurance plans; and

655.2.2 no credit shall accrue for purposes of pensionable service time unless the staff member pays both his or her own and the Organization's contributions to the United Nations Joint Staff Pension Fund;

655.2.3 subject to Staff Rule 655.2.4, service credit shall accrue for all purposes during periods of leave without pay of 30 calendar days or less;

655.2.4 service credit shall cease to accrue for all purposes from the start date of periods of leave without pay of more than 30 calendar days.

655.3 If the duration of the leave without pay is more than one third of the scholastic year of a child for whom the staff member is eligible to receive an education grant, the amount of the grant shall be reduced proportionally and the child's travel shall not be paid.

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## 750. SICK LEAVE UNDER INSURANCE COVER

750.1 Sick leave under insurance cover shall be granted to a staff member who is unable to perform his or her duties because of illness or injury and who is entitled to salary benefits under the Organization's Accident and Illness Insurance policy (see Staff Rule 720). While a staff member is on sick leave under insurance cover, the staff member and the Organization shall continue to make contributions to the United Nations Joint Staff Pension Fund, Accident and Illness Insurance, and the Staff Health Insurance.

750.2 During any sick leave under insurance cover under Staff Rule 750.1, the following conditions shall apply:

750.2.1 service credit shall continue to accrue for all purposes during sick leave under insurance cover of 30 days or less;

750.2.2 service credit shall accrue for all purposes at half the ordinary rates of accrual from the start date of sick leave under insurance cover at 50 percent for more than 30 days;

750.2.3 service credit for all purposes shall cease to accrue from the start date of sick leave under insurance cover of more than 30 days, except as provided in Staff Rule 750.2.2.

.....

## 820. TRAVEL OF SPOUSE AND CHILDREN

...

820.2.5 for a child for whom there is an entitlement to an education grant under Staff Rule 350 for study outside the commuting distance of the official duty station, provided Staff Rule 655.3 does not apply:

[No further changes]

## Appendix 2

**TEXT OF THE AMENDED STAFF RULES CONSIDERED NECESSARY  
IN THE LIGHT OF RESOLUTION 68/247 ADOPTED BY THE  
UNITED NATIONS GENERAL ASSEMBLY<sup>1</sup>**

## 655. LEAVE WITHOUT PAY

...

655.4 The Director-General may authorize leave without pay for pension purposes for a staff member who is:

655.4.1 within two years of reaching the age that would qualify him or her for receipt of an early retirement benefit upon separation pursuant to Staff Rule 1020.2 and 25 years of contributory service; or

655.4.2 over the age that would qualify him or her for receipt of an early retirement benefit upon separation pursuant to Staff Rule 1020.2 and within two years of reaching 25 years of contributory service.

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<sup>1</sup> See resolution EB135.R1 and see Annex 2 for the financial and administrative implications for the Secretariat of the adoption of the resolution.



## ANNEX 2

### Financial and administrative implications for the Secretariat of resolutions adopted by the Executive Board

[EB135/7 Add.1 – 7 May 2014]

<b>1. Resolution EB135.R1:</b> Confirmation of amendments to the Staff Rules
<b>2. Linkage to the Programme budget 2014–2015</b> (see document A66/7 <a href="http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf">http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf</a> )  Category: 6. Corporate services/enabling functions Programme area(s): Management and administration Outcome 6.4 Output 6.4.2  <b>How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?</b>  The amendments outlined in document EB135/7 are made in the light of experience and in the interest of improved human resources management and as a follow-up to the adoption of resolution 68/247 by the United Nations General Assembly.  <b>Does the programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)</b> Yes.
<b>3. Estimated cost and staffing implications in relation to the Programme budget</b>  (a) <b>Total cost</b> <b>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).</b> No cost implication.  (b) <b>Cost for the biennium 2014–2015</b> <b>Indicate how much of the cost indicated in 3 (a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).</b> No cost implication.  <b>Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.</b> Not applicable.  <b>Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)</b> Yes.  <b>If “no”, indicate how much is not included.</b>

**(c) Staffing implications****Could the resolution be implemented by existing staff? (Yes/no)**

Yes.

**If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.****4. Funding****Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)**

Yes.

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

US\$ n/a; source(s) of funds: n/a.

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## **PART II**

### **SUMMARY RECORDS**

### **LIST OF PARTICIPANTS**



## **SUMMARY RECORDS**

### **FIRST MEETING**

**Monday, 26 May 2014, at 09:40**

**Chairman:** Professor J. HALTON (Australia)

**later:** Dr M. SHAKEELA (Maldives)

#### **1. OPENING OF THE SESSION:** Item 2 of the Provisional agenda

The CHAIRMAN declared open the 135th session of the Executive Board and said that the Board would proceed to elect its Chairman, Vice-Chairmen and Rapporteur before adopting its agenda.

#### **2. ELECTION OF CHAIRMAN, VICE-CHAIRMEN AND RAPPORTEUR:** Item 1 of the Provisional agenda

The CHAIRMAN drew attention to Rule 12 of the Rules of Procedure of the Executive Board, which set out the procedures for electing the Officers of the Board. Following the principle of rotation among geographical WHO regions, Dr Mariyam Shakeela (Maldives) had been nominated for the office of Chairman of the Executive Board. In the absence of other nominees, and pursuant to Rule 48 of the Rules of Procedure of the Executive Board, the Board could decide to proceed without taking a ballot on the agreed candidate.

**Dr Mariyam Shakeela (Maldives) was elected Chairman.**

Professor HALTON (Australia) congratulated Dr Shakeela on her election and said that it had been an honour to serve as Chairman of the Executive Board. In taking forward the process of WHO reform, she had come to realize the value of good humour, patience and courtesy, and she called on the Board to continue its work on behalf of the global population.

The DIRECTOR-GENERAL paid tribute to Professor Halton, who had served WHO in many capacities, including as Chairman of the Executive Board and of its Programme, Budget and Administration Committee, as President of the World Health Assembly, and as Chair of the Intergovernmental Meeting on Pandemic Influenza Preparedness: Sharing of Influenza Viruses and Access to Vaccines and other Benefits.

**Dr Shakeela took the Chair.**

The CHAIRMAN, having expressed appreciation to the outgoing Chairman, said that she was honoured to be elected Chairman of the Executive Board. She welcomed the new Board members and said that the outcome of the Board's future work would constitute a further important step in the history of the Organization.

She drew attention to Rule 12 of the Rules of Procedure of the Executive Board, which set out the procedures for electing the Officers of the Board. Following the principle of geographical rotation, and on the basis of consultations in the respective regions, the following nominations had been made for the four Vice-Chairmen: Dr Yankalbe Paboung Matchock Mahouri (Chad) (African Region), Dr Jarbas Barbosa da Silva Júnior (Brazil) (Region of the Americas), Dr Walid Ammar (Lebanon) (Eastern Mediterranean Region) and Dr Dirk Cuypers (Belgium) (European Region).

**Dr Yankalbe Paboung Matchock Mahouri (Chad), Dr Jarbas Barbosa da Silva Júnior (Brazil), Dr Walid Ammar (Lebanon) and Dr Dirk Cuypers (Belgium) were elected Vice-Chairmen.**

The CHAIRMAN said that, under Rule 15 of the Rules of Procedure of the Executive Board, if the Chairman was unable to act in between sessions, one of the Vice-Chairmen should act in his or her place; the order in which the Vice-Chairmen would be requested to serve should be determined by lot at the session at which the election had taken place.

**It was determined by lot that the Vice-Chairmen would serve in the following order: Dr Cuypers (Belgium), Dr Ammar (Lebanon), Dr Matchock Mahouri (Chad) and Dr Barbosa da Silva Júnior (Brazil).**

The CHAIRMAN said that, pursuant to Rule 12 of the Rules of Procedure of the Executive Board and in accordance with the principle of rotation among geographical regions, Mr Jeon Man-bok (Republic of Korea) had been nominated Rapporteur.

**Mr Jeon Man-bok was elected Rapporteur.**

Dr VALVERDE (Panama) congratulated the Chairman on her election, expressed appreciation to the outgoing Chairman and welcomed the new Board members.

### **3. ORGANIZATION OF WORK**

Mrs VUKOVIC (Croatia) 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. She requested that, at the 135th 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, drafting groups 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.**

### **4. ADOPTION OF THE AGENDA:** Item 2 of the Provisional agenda (Documents EB135/1 and EB135/1 (annotated))

**The agenda was adopted.<sup>1</sup>**

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<sup>1</sup> See page vii.

## **5. OUTCOME OF THE SIXTY-SEVENTH WORLD HEALTH ASSEMBLY:** Item 3 of the Agenda

Dame Sally DAVIES (United Kingdom of Great Britain and Northern Ireland) said that it had become clear at the Sixty-seventh World Health Assembly that the reform process had some way to go. Although it was the Member States that drove the Organization, they needed guidance in order for their participation to have the greatest impact. She therefore urged the Secretariat to increase its efforts in that regard, particularly in advising the chairmen of the main committees as they dealt with their lengthy agendas.

Dr GWENIGALE (Liberia) said that, in the context of the reform process, the Board should send a clear message to Member States discouraging delegates from reading out lengthy prepared statements that described their own national situation and urging them to confine their interventions to the agenda item under discussion. In that way, it should be possible to ensure that meetings finished on time.

Dr OMI (Japan), referring to an issue discussed at the Sixty-seventh World Health Assembly, said that, although reports on poliomyelitis that were submitted two years before to the Health Assembly and the Board had presented a relatively optimistic perspective, the situation was now described as a public health emergency. The factors responsible for poliomyelitis were beyond the control of the health sector alone, and he therefore urged the Secretariat to redouble its efforts to reach out to non-health sectors and other United Nations agencies. Given that the declaration of a public health emergency covered only a three-month period, he proposed that the Secretariat organize a second meeting of the International Health Regulations (2005) Emergency Committee to ensure that the international community remained vigilant.

Turning to the subject of the governing bodies' workload, he said that WHO faced a dilemma: the need to respect the right of Member States to propose new agenda items and the need to limit the total number of items. It was difficult to oppose requests made by Member States in an open forum, such as the Board. He therefore proposed that, as suggested at the previous session of the Board, the Director-General and the Chairman of the Board should review all requests to include additional items and submit counter-proposals, with the Board taking the final decision. Some items might be better discussed in other forums, such as the regional committees. Member States should use meeting time at the Health Assembly for genuine discussion, while the information on a country's health situation that currently formed the major part of most statements could, for example, be posted on the WHO website.

Mrs VUKOVIC (Croatia) expressed her appreciation to the Regional Office for Europe and the WHO Croatia country office for their prompt and valuable support during the current severe flooding in her own and neighbouring countries. The Board could be satisfied with the outcome of the Sixty-seventh World Health Assembly. Despite a very lengthy agenda and a session lasting only one week, many important resolutions and decisions had been adopted following exhaustive negotiations. Progress had also been made on WHO reform.

Dr REN Minghui (China) concurred with previous speakers. One solution might be to delegate responsibility to the General Committee for decisions on the resolutions to be discussed. As long as Member States continued to make lengthy statements about their national situations, they could not then reasonably put pressure on the Secretariat to improve the efficiency of the Health Assembly. Country reports should be uploaded to the WHO website instead. Although the progress reports were important, they did not receive as much attention as other agenda items. For this reason, he proposed that they should be discussed on the first day of the Health Assembly, when more time could be allocated to them.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the documents submitted to Member States for discussion at the Health Assembly should be more analytical and should indicate the aspects that were to be discussed and approved by the Health Assembly, so that countries would not merely present a catalogue of their own national actions.

Dr KAMWI (Namibia) said that the key to the efficient management of meetings was a chairman who could exercise control and ensure that participants spoke only for the allotted time.

Ms ADAM (Maldives) said that the progress reports could be considered initially by the regional committees. A consolidated response from each regional committee could then be presented to the Health Assembly for further discussion.

Ms AXELROD (Russian Federation) said that the strict enforcement of the three-minute rule for speakers in recent sessions should be maintained. It would be appreciated if Secretariat documents were sent out more promptly so that Board members and Member States could prepare their positions.

Mr KLEIMAN (Brazil) recognized the difficulty of reconciling the perceived need to limit the number of agenda items with the right of Member States to report on their national situations. The setting of the agenda should be discussed as part of the WHO reform process.

Dr VALVERDE (Panama) said that both proposed agenda items and draft resolutions should be discussed in an inclusive and transparent manner well before the Health Assembly. The creation of numerous drafting groups made it hard for countries, particularly those with small delegations, to discuss the agenda properly.

Dr MUKENGESHAYI KUPA (Democratic Republic of the Congo) placed emphasis on the relevance to Member States of all the subjects that had been discussed during the Health Assembly. The work had been well organized and had focused on genuine priority areas. He encouraged the Board to make the most efficient use of its time during the current session in order to produce worthwhile outcomes.

Dame Sally DAVIES (United Kingdom of Great Britain and Northern Ireland) supported several constructive ideas put forward by previous speakers that were worthy of careful consideration: more use of digital technology; limiting the length of both documents and speaking time; more focused documents; reducing the number of agenda items; and above all, discipline, rigorously applied.

Mr CASALS ALÍS (Andorra) suggested that the solutions proposed by Board members should be considered by the Chairman and the Director-General before they were formally discussed by the Board at its next session.

Dr ASADI-LARI (Islamic Republic of Iran) said that, while he appreciated the need to limit the workload of the Health Assembly, it was nevertheless the main platform for all Member States to discuss global health issues and raise national and local concerns that might have implications for health. Compromise and more work by the Secretariat were needed to balance those two concerns.

Professor HATEM (Egypt) welcomed the adoption by the Health Assembly of the draft resolution on hepatitis recommended by the Executive Board.

Dr AL-OBAIDI (Kuwait) congratulated the Chairman on her election. As a recently elected member of the Board, he hoped to add value to its deliberations.



Dr GWINJI (Zimbabwe)<sup>1</sup> welcomed the increasing use of communication technologies, including online consultations on matters of importance. However, where a common position or a decision was sought, the timing of such consultations required careful consideration. Taking as an example the discussions in the Health Assembly on the draft action plan for newborn health, he warned that to rely solely on online consultations might not be prudent. He therefore suggested holding physical meetings of Member States just before the Health Assembly, in order to avoid protracted in-session debates.

Ms ANDERSSON (Sweden),<sup>1</sup> while welcoming the important decisions taken by the Sixty-seventh World Health Assembly, said that the plethora of agenda items and resolutions, the creation of parallel drafting groups, insufficient time and a disregard for the established rules governing the conduct of Member States had undermined the overall efficiency of the session. Improvements in working methods were therefore needed in the areas of agenda items and resolutions, the conduct of business in committees, including the adequate preparation of committee chairmen, and parallel drafting groups. She requested the Board to continue the discussion on governance reform at its 136th session in January 2015.

Mr SAMAR (Algeria)<sup>1</sup> said that it was vital not to lose sight of the intergovernmental character of the Organization, the supremacy of the Health Assembly in decision-making and the need to guard against conflicts of interest. Its work for equity among countries, with attention focused on the most vulnerable population groups, would strengthen the right to health. In addition to ensuring a place for health issues in the post-2015 development agenda, it was also vital for WHO to promote international cooperation – North–South, South–South and triangular – aimed at providing support for national, regional and global plans for disease prevention and control.

Ms LANTERI (Monaco)<sup>1</sup> said that Member States had encountered unprecedented difficulties in getting through the agenda of the Sixty-seventh World Health Assembly. Delegations of small countries, including her own, had had to work around the clock, which was exhausting and unproductive. The proposals made by Board members at the current meeting should be compiled and circulated for discussion before the next session of the Board in January 2015, in order to avoid a repetition of the situation.

Mr BOISNEL (France)<sup>1</sup> welcomed the concrete and constructive suggestions relating to governance which had been ably summarized by the member for the United Kingdom of Great Britain and Northern Ireland.

The DIRECTOR-GENERAL thanked members for their advice and comments. The Sixty-seventh World Health Assembly had been successful, but the long and intense meetings had placed a considerable strain on all concerned. Some changes were therefore needed. For example, although a drafting group had devoted eight meetings to discussing violence against women, girls and children, the Health Assembly had still reopened the subject. How could the Board fulfil its role of reducing the workload of the Health Assembly if the items that had already been considered by the Board were reopened at the Health Assembly? In reply to the representative of Zimbabwe, she pointed out that the preliminary work he was advocating was already carried out during intersessional informal consultations. However, that did not prevent items that had been agreed being reopened at the Health Assembly.

With regard to suggestions for improving documents, such as making them more concise, providing better guidance or issuing them earlier, she emphasized that, if the number of documents generated by the agenda exceeded the Secretariat's capacity, it would be impossible to make the

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

necessary changes. Member States would need to assume some responsibility in that regard. In the comparative calm of the Board, it was easy to make rational comments; however, the good intentions professed appeared to vanish in the throes of WHO business. She recognized the right of every country to discuss matters they deemed important, but such discussions must be disciplined. Expressing her sympathy for small delegations, she said that the need to attend several drafting groups simultaneously undermined the principles of inclusiveness and solidarity.

The Chairman and she herself had put forward numerous proposals for reducing the number of agenda items but in the past their suggestions had been consistently rejected, and she doubted that the situation had changed. With regard to improving the guidance provided for the officers of the Health Assembly, she said that the President of the Sixty-seventh World Health Assembly had received enormous support from his own Government, as well as from the Secretariat. Both suggestions would be the subject of future reflection in the context of WHO reform, that is, that regional committees might consider the progress reports, and that more responsibility should be given to the General Committee, as would the alignment of priority agenda items between the global governing bodies and the six regional committees.

Acknowledging that a temporary recommendation under the International Health Regulations (2005) lasted for only three months, she reassured the member for Japan that a meeting of the Emergency Committee would be convened before the deadline to investigate the evolving situation of poliomyelitis, so there should be no gaps in the advice provided. She offered her sympathy to the people of Croatia and its neighbours on the devastation caused by the recent flooding and the associated risk of disease outbreaks. She commended the support provided by the Regional Office for Europe and country offices.

All the proposals put forward by the Board members would be carefully reviewed and lessons would be learnt from the Health Assembly. She urged health ministers to liaise with their counterparts in other ministries, as a whole-of-government approach had already been shown to enhance the quality of governing body discussions.

### **Working Group on Strategic Budget Space Allocation**

The CHAIRMAN drew the Board's attention to the Director-General's proposal in paragraph 11 of document A67/9 that the current membership of the Working Group should be maintained, so that work on the issue could continue.

Dame Sally DAVIES (United Kingdom of Great Britain and Northern Ireland), while acknowledging the benefits of retaining the expertise acquired by the members of the Working Group over several years, noted that some members had now left the Executive Board and thus also the Programme, Budget and Administration Committee. It was unclear whether members of the Working Group had also to be members of the Board.

Mr BURCI (Legal Counsel) explained that the members of the Working Group had become very involved in the process and it had been felt that, exceptionally and in the interests of maintaining continuity, the current membership should be preserved. A clear link would be maintained with the Programme, Budget and Administration Committee to ensure that the overall process continued to be owned by the Committee and the Board.

The CHAIRMAN said that, in the absence of any objection, she took it that the Board agreed to maintain the current membership of the Working Group, namely: Belgium, Cameroon, Egypt, Malaysia, Maldives and Mexico.

**It was so decided.<sup>1</sup>**

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<sup>1</sup> Decision EB135(1).

**6. REPORT OF THE PROGRAMME, BUDGET AND ADMINISTRATION COMMITTEE OF THE EXECUTIVE BOARD:** Item 4 of the Agenda (Document EB135/2)

Dr CUYPERS (Belgium), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, drew attention to the report of the Committee's twentieth meeting (document EB135/2). He summarized the Committee's deliberations on the items covered in the report that were not on the Board's agenda, namely, the annual report of the Independent Expert Oversight Advisory Committee and progress on implementation of external and internal audit recommendations.

Ms ADAM (Maldives) asked for the Working Group on Strategic Budget Space Allocation to be informed at its next meeting of the reasons for limiting country-level technical support to 23% for all Member States, which amounted to less than US\$ 1 billion out of a global budget of US\$ 4 billion and compared with country-level allocations of between 55% and 60% in 2006. In order to throw more light on budget allocation for the next biennium, she requested that the Secretariat indicate the proportion of funds to be allocated to Member States in the current biennium. She proposed that, in future, the weighting given to criteria, as well as that between the four operational segments, should be transparent, in particular with regard to segment 1.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) commended the work of the Programme, Budget and Administration Committee and welcomed the valuable and rich report of the Independent Expert Oversight Advisory Committee. She hoped to see a prompt and serious response to it through action by WHO.

The DIRECTOR-GENERAL, responding to the point raised by the member for Maldives, said that when analysing the four operational segments it was important to understand that considerably more than the 23% specified for one segment was used for supporting countries. A significant proportion of segment 2, which related to the regional offices and headquarters, also went to countries, for example, through visits by experts from those offices when countries experienced particular disease outbreaks. Overall, she estimated that a sum closer to 50% of WHO's resources was used for supporting countries but agreed with the need for further horizontal and vertical analyses of the segments in order to show explicitly the proportion of each that went to countries.

**The Board noted the report.**

**7. TECHNICAL AND HEALTH MATTERS:** Item 5 of the Agenda

**Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage:** Item 5.1 of the Agenda (Document EB135/3)

Mr KOLKER (United States of America) said that task-shifting and more rational use of resources would help to improve access to surgical procedures within primary health care, which could save lives, particularly in low- and middle-income countries where the need for surgical care was greatest. He asked for an item on emergency and essential surgical care and anaesthesia to be included on the agenda of the 136th session of the Board, pending the preparation of a draft resolution on the subject.

Dr AL-OBAIDI (Kuwait) said that more needed to be done to reduce the disparities in access to emergency and essential surgical care, both among and within countries. WHO should provide technical guidance on establishing and strengthening such services within primary and secondary health care.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the report should place more emphasis on the need for close links among the various levels of care so that, for example, a patient with major head trauma presenting at a primary health care facility could be quickly transferred to a higher-level facility for treatment. It should also pay more attention to anaesthetic services since, worldwide, a patient was more likely to have a surgeon available than an anaesthetist.

Dr REN Minghui (China) agreed that the issue of emergency and essential surgical care and anaesthesia should be included on the agenda of the Board at its next session. However, other related services, such as medical imaging and medical technology, must also be considered, and appropriate components of the service and indicators to measure their performance must be identified.

Dr PILLAY (South Africa) said that the issue should be discussed by the Health Assembly at its next session.

Dr GWENIGALE (Liberia) said that many of the patients requiring emergency surgical care were young adults, with families who would be left destitute if the patient died. Anaesthetists were often involved in the resuscitation of newborn infants; that issue should also be reflected in any further discussions.

Dr KAMEYAMA (Japan) said that emergency surgical care and anaesthesia should be integrated into existing medical systems. Pre-hospital medical care should be provided at the community level to reduce the number of preventable deaths.

Dame Sally DAVIES (United Kingdom of Great Britain and Northern Ireland) said that any report submitted to the Board at its next session should also consider the need for access to and rational use of antibiotics in the context of emergency surgical care.

Ms ALGOE (Suriname) said that access to emergency and essential surgical care and anaesthesia should be assessed by region in all Member States so that gaps in those services could be properly mapped.

Dr MUKENGESHAYI KUPA (Democratic Republic of the Congo) said that a detailed baseline survey of technical and other needs at primary, secondary and tertiary care level would be required in order to avoid unwelcome surprises later.

Ms AXELROD (Russian Federation) said that the work already done on emergency surgery should be supplemented by a clearer definition of the content of emergency surgery programmes and by advocacy work to raise awareness about the issue. It was also important to address the provision of surgical care in rural and remote areas.

Dr KAMWI (Namibia) emphasized the need for well trained surgical health professionals and for adequate infrastructure and equipment, particularly at the district level, in order to guarantee equity and accessibility of care.

Dr NOOR HISHAM ABDULLAH (Malaysia) said that some countries were obliged to make a clear distinction between the services they could provide at primary level and at secondary level. Detailed definitions of emergency and essential surgical care and anaesthesia would be needed before they could comment on the appropriateness of integrating such services into primary health care. In his own country, the staff of specialist hospitals shared their expertise and resources; in addition, they trained staff from non-specialist hospitals.

Professor HALTON (Australia) said that any future debate on emergency and essential surgery and anaesthesia should cover both antimicrobial resistance and the safety and quality of surgical care. It was important to determine the basic services and care that people should be able to access and receive through universal health coverage. However, in large countries, the reality was that the provision of even basic surgery was not feasible in every location; it was important not to create unrealistic expectations among the public. Her country would sponsor any future draft resolution.

Mr JEON Man-bok (Republic of Korea) said that the State should pay for emergency and essential surgical care, even in countries with social or private health insurance systems. WHO should provide further opportunities for Member States to share knowledge and experiences of strengthening such care.

Dr MISHRA (Nepal) said that the provision of anaesthesia services at the first-referral level was constrained both by a shortage of trained human resources and by problems of staff retention. Medical school curricula should include at least a basic level – to be defined with technical support from WHO – of training in anaesthesia.

Ms ADAM (Maldives) echoed the concerns expressed by the member for Cuba and called on Member States to coordinate their efforts to strengthen emergency and essential surgical care.

Dr AMMAR (Lebanon) said that a specific resolution was needed on the integration of surgical care into the health care delivery system, in the framework of the future WHO global strategy on people-centred and integrated health services. Task-shifting and the delivery of surgical care in primary care settings could provide an acceptable solution, if hospital care was not available. However, interventions must be limited to simple surgical procedures carried out by trained personnel in properly equipped health centres.

Mr KLEIMAN (Brazil), noting that his country was to host the 31st International Conference of The International Society for Quality in Health Care Incorporated in October 2014, said that it was important to define priority actions on quality and patient safety, as well as indicators for monitoring national programmes.

Dr BEJTJA (Albania) said that the necessary skills for emergency surgical care must be built up and maintained, especially within smaller health care institutions. A balance must be struck between access to surgical services and the quality of those services, and the possibility of referral to a higher level or another part of the health care system must be preserved.

Mr GHEBRETINSAE GHILAGABER (Eritrea) said that WHO should provide technical support and guidance to countries in their efforts to develop strategies for the management of emergency and essential surgical care and anaesthesia at all levels of health care.

Mr SEY (Gambia) said that the issue should be discussed by the Board at its next session and included on the agenda of the next Health Assembly.

Mr CORRALES HIDALGO (Panama) said that national health planning should pay attention to inefficiencies within surgical services and emergency care, including the cost–effectiveness of surgery.

Mr CASALS ALÍS (Andorra) said that there should be more cross-border health cooperation. Andorra, a small country, had established agreements with its neighbours, France and Spain, to ensure the necessary access to health services.

Mr PIPPO BRIANT (Argentina) said that emergency surgical care and anaesthesia services should be strengthened, inter alia, by enhancing coordination between primary health care services and hospitals. Human resource capacity should also be increased through ongoing training, and the issue of migration of health professionals should be addressed.

Dr MATCHOCK MAHOURI (Chad) said that his country had already achieved the political commitment to surgical services advocated in the report, with monthly meetings chaired by the Head of State. He stressed the importance of conducting a baseline assessment of the health situation before introducing new services.

Dr ASADI-LARI (Islamic Republic of Iran) called on the Secretariat to prepare a technical report on all aspects of essential surgical care and anaesthesia, to be considered by the Board at its 136th session.

Mrs SINJELA (Zambia)<sup>1</sup> hoped that any resolution that was adopted would help countries to assess their health systems and identify gaps in surgical and anaesthetic service delivery; incorporate an essential package of surgical and anaesthetic services into national health strategies and budgets; improve surgical training for existing and new front-line health workers; improve surgical and anaesthesia infrastructure; and monitor and evaluate the provision of services.

Dr SUTHAT DUANGDEEDEN (Thailand)<sup>1</sup> said that there were gaps in countries' capacity to provide timely and effective surgical care, in particular at primary health care level in disaster-prone areas. The term “essential surgical care” must be precisely defined.

Mr ALI YAHIA ELABASSI (Sudan)<sup>1</sup> said that efforts to strengthen emergency and essential surgical services and anaesthesia should focus on low-income countries and include training for health professionals and an efficient mechanism for monitoring the outcome of activities.

Dr ELOAKLEY (Libya)<sup>1</sup> expressed support for the proposal to include the subject as an item on the agenda of the Sixty-eighth World Health Assembly and to prepare a draft resolution for submission to the Executive Board at its 136th session. The discussion should cover the issue of antimicrobial resistance and explore a wider range of methods for funding health care services. It was important to emphasize that health care expenditure should be the responsibility of both governments and individuals.

Dr WILKINSON (World Federation of Societies of Anaesthesiologists), speaking at the invitation of the CHAIRMAN, called on Board members to give their full support to efforts to strengthen emergency and essential surgical care and anaesthesia. An indicator, such as perioperative mortality, would be required to measure progress.

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Professor GUNN (International Federation of Surgical Colleges), speaking at the invitation of the CHAIRMAN, said that extending essential surgical care to developing countries was an urgent priority and one that was not only financially bearable and cost-effective but also a moral obligation.

Professor SPIEGEL (International Society of Orthopaedic Surgery and Traumatology), speaking at the invitation of the CHAIRMAN, said that the incidence of musculoskeletal conditions and the global burden of trauma and injuries were enormous and increasing. That burden could be significantly reduced, however, by closing the gaps in access to safe and timely surgical services. He further called on Member States to take the action required to protect health care personnel from threats, aggression and physical violence, which compromised the health care system.

Ms WANJAU (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, said that surgical care had previously been neglected in global health discourse, largely because of misconceptions over its cost. She called on the Secretariat and Member States to expand the scope of surgery in public health discussions beyond emergency interventions so that it included comprehensive, quality surgical care; to consider surgery as a key component of health system strengthening; to address the current global disparity in and inequity of access to surgical care; and to ensure that appropriate numbers of surgeons were trained.

Ms THOMAS (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, said that several surgical procedures could be performed by staff with more limited training than those employed in large hospitals, although training programmes must be carefully designed. Some types of surgery could be referred to a higher-level facility or performed by a visiting surgical team. Ensuring that surgical services were effective required systems for gathering evidence and data, generating guidelines and encouraging compliance. She called upon WHO to include surgeons with experience of performing surgery in low-resource settings in any expert committees that it set up.

Dr KIENY (Assistant Director-General) welcomed the wide-ranging support for the inclusion of the topic on the agenda of the Sixty-eighth World Health Assembly, following consideration by the Executive Board. The Secretariat had taken note of the various points made during the discussion, including the conviction that surgical care and anaesthesia should be considered a core aspect of universal health coverage; the need for safe, effective and affordable antibiotics to avoid infection resulting from surgery and the related issue of addressing antimicrobial resistance; the need to strengthen human resource capacities; and the need to carry out a thorough baseline assessment of the current situation so as to better understand what the required measures were. Those points would be reflected in a new version of the report by the Secretariat, which would be sent to Member States in preparation for discussions by the Executive Board at its 136th session.

The DIRECTOR-GENERAL said that the number of Member States that had spoken on the subject testified to the importance that they ascribed to it. In the context of overall health system strengthening, Member States had underscored the importance of access, safety and quality. Relevant professional associations and organizations could help to demystify some of the measures that might be necessary: she agreed, for example, that there was not always a need for fully trained specialists in anaesthesia or surgery to work in primary health care. Task-shifting was an important concept to consider. The most important thing was that health care workers needed to have adequate training, to be properly supervised and to provide safe and high-quality care to patients.

WHO would facilitate discussions among Member States as they sought to transfer and share experience and knowledge, and defined the types of solutions that they wanted. She was disappointed, however, that nobody had mentioned the importance of prevention, which could alleviate some of the pressure on Member States in terms of the growing need and cost of surgical interventions.

The CHAIRMAN took it that, in the absence of any objections, the Executive Board wished to include strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage on the provisional agenda of its 136th session.

**It was so agreed.**

**The meeting rose at 12:35.**



## SECOND MEETING

Monday, 26 May 2014, at 14:35

Chairman: Dr M. SHAKEELA (Maldives)

### 1. TECHNICAL AND HEALTH MATTERS: Item 5 of the Agenda (continued)

**Health and the environment – addressing the health impact of air pollution:** Item 5.2 of the Agenda (Document EB135/4)

Dr VALVERDE (Panama), speaking also on behalf of the representatives of Bangladesh, France and Norway, appreciated the inclusion of the agenda item, the main aim of which was to strengthen WHO's capacity to confront the global health threat stemming from air pollution, raise awareness and increase Member States' commitment to prevention. Air pollution had not been provided for in the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020, yet it was one of the main causes of preventable diseases, resulting in about seven million premature deaths a year. It deserved a strong and rapid response from the Secretariat and Member States alike. It was a concern for both developed and developing countries and was central to the discussions about the post-2015 sustainable development agenda. Transboundary air pollution in particular required a concerted effort involving countries, economic sectors and other interested parties. Air pollution should be considered separately within WHO programmes, with linkages to climate change, health and other overlapping areas. It was crucial for WHO to support preventive action against illnesses caused by air pollution through intersectoral cooperation and coordination initiatives involving United Nations actors, such as WMO and UNEP, governments and civil society.

Ms SAMIYA (Maldives) said that air pollution was a major concern in Maldives, where the rise in noncommunicable diseases related to poor-quality air was stretching the health budget to an unsustainable level. Air pollution was a global issue requiring coherent, coordinated and cross-sectoral efforts at national and global levels. She called on all countries to harness the political and social will to reduce air pollution.

Dr CUYPERS (Belgium), speaking on behalf of the European Union and its Member States, said that indoor and outdoor air pollution had been one of the European Union's main political concerns since the late 1970s. The European Union had developed an extensive body of legislation, based on health standards, to improve air quality and was currently working on a new clean air package for Europe up to 2030. With a view to further discussion by the Executive Board in January 2015, specific opportunities for further action would need to be identified and analysed at national, regional and global levels, building on existing evidence and initiatives. A multisectoral approach should be promoted at all levels, with health systems assuming a leading role and with due consideration given to populations most at risk.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) argued that the health sector should not only attend to the health problems generated by air pollution but also undertake preventive actions through efforts by government and society. WHO should play a leadership role and alert other organizations of the United Nations system to the need to curb air pollution. Indoor air pollution was a separate issue, as it was connected to the social environment: for example, poor populations would not be able stop using wood as a fuel for cooking if they had no other source of energy.

Professor HATEM (Egypt) said that strategies to tackle air pollution should be drafted by a variety of ministries and authorities and not just by health ministries. Since the current energy crisis was prompting his Government to reconsider using coal in factories, the Secretariat should draft a strategy incorporating strict guidelines on air pollution.

Dr REN Minghui (China) said that the number of areas impacted by air pollution was expanding owing to the rapid development of the world economy, urbanization and vehicle emissions. Research suggested that air pollution could accelerate the onset of chronic cardiovascular and respiratory diseases and exacerbate disease in ageing populations. The previous year, China had issued a national action plan on air pollution prevention and control for 2013–2017, based on the concept of society as a whole fighting air pollution, and setting strict targets and measures. He hoped that the Secretariat would work more closely with related United Nations agencies and provide Member States with empirical technical support for formulating countermeasures.

Mr KLEIMAN (Brazil) said that, although difficult, reducing air pollution was feasible. His country was directly committed to preventing the release of atmospheric pollutants, and promoting and protecting human health. It fully supported the initiative to establish a global platform for air quality and health, and considered highly desirable the inclusion of the topic on the agenda of the next sessions of the Executive Board and World Health Assembly.

Dame Sally DAVIES (United Kingdom of Great Britain and Northern Ireland), noting the synergies between measures against air pollution and those against greenhouse gas emissions, requested that any action on the agenda item should be taken before the twenty-first session of the Conference of the Parties to the United Nations Framework Convention on Climate Change in 2015. Although a continued multisectoral approach should be pursued, the health sector was in the best position to influence policy in areas of the post-2015 development agenda. She agreed that the item should be added to the agenda of the next session of the Executive Board, but requested that in future Board members and representatives be provided with a draft agenda for the next session of the Board in advance, so that they could see which other items had already been mandated by the Health Assembly.

Dr NOOR HISHAM ABDULLAH (Malaysia) said that air pollution was a complex issue and therefore required a comprehensive multisectoral approach. He would welcome a further update of the 2005 air quality guidelines, as well as ongoing support to Member States in building capacity for assessment of the risk posed by air pollutants. He commended the establishment of a health task force to discuss transboundary air pollution, since his country and the surrounding region often suffered from haze.

Mr PIPPO BRIANT (Argentina) said that the Board should consider effective measures to improve air quality in both indoor and outdoor settings. The report did not give adequate coverage to tobacco, which contained some 60 carcinogens and other toxins. Effective and integrated measures to tackle air pollution needed to be devised in the areas of transport, energy, urban development and industrial production, with the health sector playing a coordinating role. WHO must keep constant track of developments, provide leadership in the debates and recommendations, and make sure to update and disseminate the related guidelines, at the same time providing information on air quality and its health impact.

Mr KIM Young-hak (Republic of Korea) praised WHO's air quality guidelines. At regional level, networks should be established to share experiences of similar problems by Member States, while at global level information and experience should be shared to produce data on the health impact of air pollution and to provide support with efficient resource allocation. It was particularly important to develop science-based guidelines for vulnerable groups, broken down by type of disease. Finally,

the Secretariat's programme of activities related to air pollution should be expanded, perhaps using WHO's conference on health and climate in August 2014 to define the programme.

Ms ALGOE (Suriname) said that, although many people in rapidly industrializing and developing countries were exposed to both indoor and outdoor air pollution, her Government was particularly concerned about domestic indoor air pollution in places where wood was still the principal fuel for cooking and heating. Other air pollution issues worthy of note were smoking and pesticides, the latter being toxic to humans and animals when suspended in the air. The drive to increase industrial and agricultural production, alongside rapid economic growth, had also contributed to increased air pollution. Strong multisectoral efforts were now required to improve air quality and mitigate the consequences of air pollution.

Mr KOLKER (United States of America), supporting the statement by the member for Panama, favoured WHO taking a more active and cross-sectoral role to counter the health impacts of air pollution. The links between air pollution, climate change and health were interrelated but distinct, so in preparation for the air pollution discussion at the Sixty-eighth World Health Assembly, it would be important to see how air pollution fit into existing WHO instruments, such as the work plan on climate change and health and the Twelfth General Programme of Work, 2014–2019. WHO should look for synergies with its efforts to combat noncommunicable diseases, and he commended the Organization's work in the Health Task Force of the Climate and Clean Air Coalition.

Dr TAKASAKI (Japan) welcomed the inclusion of the item on the agenda. To address air pollution, which had been particularly severe since his country's post-war reconstruction in 1945, Japan had enacted laws, introduced regulations and paid reparations for the health damage it had caused. Japan's experience and current practices could support other countries facing problems related to air pollution. Outdoor air pollution was a problem that transcended national boundaries and required a global solution, while adequate measures needed to be taken to tackle indoor air pollution, which actually caused more deaths. He looked forward to continuing to receive evidence-based guidelines from WHO and encouraged the Secretariat to provide support to Member States to take action across multiple sectors.

Dr AMMAR (Lebanon) said that air pollution was an environmental health determinant that could not simply be addressed through health programmes along the lines of those on noncommunicable diseases, but required concerted action across countries, based on a multisectoral national approach covering the areas of environment, energy, industry, transport and others. WHO should use its leadership and convening power to call for concerted efforts and advocate taking the issue of health as an entry point to tackle air pollution and climate change. In addition, the Secretariat should endeavour to support countries wishing to build their air pollution monitoring capacities and develop relevant norms and policies. He would welcome the inclusion of the agenda item and a draft resolution at the next session of the Executive Board.

Dr MISHRA (Nepal) said that air pollution was particularly a threat to health in developing nations, causing: respiratory problems and related noncommunicable diseases; raised temperatures, which adversely affect agriculture; characteristics of vectors to change, contributing to vector-borne diseases; glaciers to melt, resulting in floods; and spread of dust during the summer months. Efforts to combat air pollution needed to be concentrated and coordinated immediately through a multisectoral approach at local, national, regional and global levels.

Mr SEY (Gambia), recalling the debates on environmental waste and pollution at the Second Inter-ministerial Conference on Health and Environment in Africa, organized by WHO and UNEP in 2010, as well as current concerns about the impacts of air pollution on global health, urged the Board to make the health impact of air pollution an agenda item at the next Health Assembly.

Ms IVANKO (Croatia), observing that air pollution was among the top five causes of the global burden of disease, said that the theme should be high on WHO's agenda and that the health sector should direct other governmental and nongovernmental sectors to address root environmental causes of ill health.

Dr BEJTJA (Albania) suggested that WHO should place its air quality improvement activities within the framework of climate change mitigation measures. Commending the work of the Secretariat in drafting guidelines, indicators and protocols on indoor air pollution, he called for further work to be done along the same lines and for additional evidence to be produced on the benefit of scenarios to curb air pollution.

Ms AXELROD (Russian Federation), drawing attention to the impact of air pollution on the health of people working in industry, said that an essential element of the Russian Federation's policies was to assess and monitor workers' health in relation to the environment. She welcomed the multisectoral approach to air pollution and endorsed the suggestion to include the topic on the agenda of the next session of the Executive Board.

Dr PILLAY (South Africa) supported the inclusion of air pollution on the Health Assembly's agenda provided it did not become too full, as had been the case in the current year. Indoor and outdoor air pollution was especially a problem among the poor, who used low-quality wood and coal and lived in poor housing conditions. His Government had set targets for both household and ambient air quality but monitoring was a continuous challenge. He supported the call by the Director-General urging countries to hold national consultations in preparation for the discussion at the Health Assembly the following year.

Ms RUIZ VARGAS (Mexico)<sup>1</sup> highlighted the need to strengthen multisectoral approaches to reduce the health impact of air pollution. Although WHO had considered the connection between the environment and health, health impacts had not been central issues in other United Nations international forums. It would be useful to link WHO air pollution activities with those referred to in resolution WHA61.19 on climate change and health.

Ms DUSSEY-CAVASSINI (Switzerland)<sup>1</sup> said that the agenda item provided an opportunity to decompartmentalize disciplines and act on all fronts through a multisectoral approach. She supported WHO's drive to intensify its efforts and encouraged it to work with other United Nations actors to cover more areas connected to health, such as economic, environmental and social dimensions. As a first step, WHO could publish an updated report of the number of premature deaths from chronic illnesses due to air quality in each country. Such a report would reveal the urgency of specific national situations.

Ms LANTERI (Monaco)<sup>1</sup> fully agreed with the statement by the representative of Switzerland, and believed that the report proposed could carry weight in negotiations at upcoming high-level conferences. As the correlation between air pollution and health was now beyond doubt, WHO should take a leading role in drawing the attention of other organizations to the issue and convincing Member States to take national initiatives. Although countries were aware of environmental risks, health issues were often neglected rather than being used as a catalyst for consensus on environmental reform.

Mr BOISNEL (France)<sup>1</sup> pointed out that air pollution caused more deaths than tobacco. Feasible solutions did exist, and there was now a window of opportunity to push collective efforts forward and search for new courses of action at global and regional levels. The recent Health Assembly had made

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

climate change a priority issue, for which there had been considerable agreement and engagement. Similarly, health had a crucial role to play in upcoming conferences, such as the WHO global conference on health and climate in August 2014, the United Nations Secretary-General's Climate Summit in September 2014 and the next two sessions of the Conference of the Parties to the United Nations Framework Convention on Climate Change in Lima (December 2014) and Paris (2015). He therefore supported adding air pollution as an item on the agendas of the forthcoming sessions of WHO's governing bodies.

Dr SURIYA WONGKONGKATHEP (Thailand)<sup>1</sup> said that open burning in communities and fields and seasonal forest fires were major causes of transboundary haze pollution in the South-East Asia Region and increased the incidence of acute respiratory diseases. The current system for surveillance of environmental health strategies was inadequate, while the data collection and monitoring system for detecting haze air pollution still had room for improvement. The Secretariat should provide Member States with more support for building capacity, developing multisectoral strategies to reduce the health impacts of air pollution, and making the transition to clean technologies and sustainable energy at national and community levels.

Mr AASLAND (Norway),<sup>1</sup> noting that air pollution ranked as a major global health issue, said that the health sector, through WHO, had a key role to play in ensuring that health concerns were fully taken into account in global and national responses. Although endorsing the view expressed at the Sixty-seventh World Health Assembly that the climate change work plan should be updated, he pointed out that air pollution required a separate response to deal with important aspects not covered by the climate agenda. Member States should work closely with the Secretariat to draft a resolution on the issue, with further steps to be taken being debated in a full discussion based on background information provided by the Secretariat. He strongly supported the inclusion of the item in the agenda of the next session of the Executive Board.

Dr MAKASA (Zambia)<sup>1</sup> said that it was high time that WHO brought the item into focus and considered it with the seriousness that it deserved, as a risk factor for many communicable and noncommunicable diseases. He would appreciate technical input by the Secretariat to produce evidence of the health impacts of air pollution, both by industry and from the domestic use of organic fuels. Member States could then use the information to devise their own multisectoral response.

Mrs DE TROEYER (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, said that any strategies to decrease the health impact of air pollution must deal with the causes of inequity between developed and developing countries. Urbanization must be restrained and the practices of transnational corporations must be addressed. However, the political challenges involved in implementing the necessary infrastructure changes had not been considered in the report. Strategies must be developed in collaboration with civil society organizations, especially those from the most affected communities. Open channels for technology transfer and the provision of support for innovation would be critical. She urged WHO to strengthen the engagement of the health sector regarding clean air policy and practice, and to consider the development of binding international instruments to achieve change.

Dr BUSTREO (Assistant Director-General) thanked Member States for their comments, which clearly demonstrated support for discussion of the health impact of air pollution at the next session of the Executive Board. Strong policy coherence would be needed between national policies and those of WHO. Air pollution was a key determinant of health and would be dealt with as an integral component of work addressing the relationship between health, climate change and social, economic and

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

environmental factors, as defined in the leadership priorities of the Twelfth General Programme of Work, 2014–2019. The next report for consideration by the Board would include additional details of the work currently under way.

The Organization was working closely with other United Nations agencies, and data on the health impact of air pollution by country, to be published in later in the year, would inform the debate on climate change within the framework of the sessions of the Conference of the Parties to the United Nations Framework Convention on Climate Change. The year 2015 would be critical for ensuring political support and taking preventive action to address the health impact of air pollution.

The DIRECTOR-GENERAL said that the large number of views presented on the linkages between health and the environment during the general discussion in the plenary meetings of the Sixty-seventh World Health Assembly clearly indicated the importance accorded by governments to the subject.

The CHAIRMAN said that, in the absence of any objections, she took it that the Board wished to include the issue of the health impact of air pollution on the provisional agenda of the 136th session of the Executive Board, in January 2015.

**It was so decided.**

## **2. MANAGEMENT AND FINANCIAL MATTERS: Item 6 of the Agenda**

### **Evaluation: annual report: Item 6.1 of the Agenda (Document EB135/5)**

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) welcomed the report but expressed disappointment at the slow progress in implementing the WHO evaluation policy. Occasional evaluation of the Organization by external bodies was not sufficient. It was essential to ensure thorough, regular assessment of all WHO's activities in order to review their effectiveness, learn how they could be improved and demonstrate their importance.

Mr KOLKER (United States of America) said that establishment of the evaluation policy and a culture of evaluation had been an essential part of the WHO reform process. However, the results and recommendations of evaluation exercises must be carefully reviewed, contribute to changes in programme design and implementation, and be shared in a useful and timely manner with regional and, especially, country offices. The methodology for evaluating the impact and sustainability of programmes, projects and functions must be improved. He welcomed plans to evaluate WHO's normative functions and many of its flagship programmes, such as those on multidrug-resistant tuberculosis and malaria, in the Organization-wide evaluation work plan for 2014–2015 and looked forward to the ensuing recommendations. Pointing out that the report of the Internal Auditor had classified the work of some country offices as "unsatisfactory", he hoped that WHO had reviewed its managerial procedures and accountability framework at global and regional levels to address such shortcomings.

Ms ZHANG Yang (China) expressed concern that only three regions had conducted consultations with the network of planning officers, owing to a lack of funding. The possible deferment to 2016 of evaluations due to be performed in the current biennium could result in incomplete evaluations for 2014. While appreciating the report's clarification of the staffing situation within the Office of Internal Oversight Services, she noted that information on the source of funding for such posts had not been provided.

Mr WEBB (Office of Internal Oversight Services) said that significant progress had been made in 2013 on creating the Global Network on Evaluation. He concurred with the comment that the

source of funding for evaluation activities was not fully established, explaining that the Organization-wide evaluation work plan for 2014–2015 had not been completed in time to coincide with the Programme budget 2014–2015. Retrospective alignment of the work plan with the Programme budget would be needed, but the evaluation activities for 2016–2017 would be more closely integrated into the proposed programme budget for the next biennium. The Office of Internal Oversight Services was recruiting additional staff to strengthen the capacity to provide technical support for evaluation.

The DIRECTOR-GENERAL recalled that the Programme, Budget and Administration Committee at its twentieth meeting had engaged in a robust discussion, following which she had discussed with the Committee the limited capacity of the Office of Internal Oversight Services in relation to the size of WHO. Efforts had been made to enhance that capacity within existing budgetary constraints, and additional staff were being recruited. Member States had highlighted the need to enhance audit capacity and accelerate evaluation activities: the Global Network on Evaluation and the Organization-wide evaluation work plan for 2014–2015 provided a framework for action, but additional human resources would be required for their implementation. She hoped to be able to make the necessary resources available.

She reassured members that the Global Policy Group was aware of the shortcomings of some country offices and the need for action. To achieve results, an Organization-wide cultural change was needed: non-compliance must not be tolerated and consequences must be enforced. She was working with the Legal Counsel and the Director of Human Resources Management to take action to improve performance, within the boundaries of current United Nations human resources policies and regulations.

The CHAIRMAN took it that the Board wished to note the report and approve the work plan.

**It was so agreed.**

**Committees of the Executive Board: filling of vacancies:** Item 6.2 of the Agenda (Documents EB135/6 and EB135/6 Add.1)

- **Programme, Budget and Administration Committee**

The CHAIRMAN said that the Programme, Budget and Administration Committee was composed of 14 members: two from each region, selected from among Board members, plus the Chairman and a Vice-Chairman of the Executive Board, members ex officio. There were seven vacancies to be filled on the Committee.

In the absence of any objections, she took it that the Board wished to approve the proposals contained in paragraph 2 of document EB135/6 Add.1.

**It was so decided.<sup>1</sup>**

- **Standing Committee on Nongovernmental Organizations**

The CHAIRMAN said that there was one vacancy to be filled on the Standing Committee on Nongovernmental Organizations.

In the absence of any objections, she took it that the Board wished to approve the proposal contained in paragraph 3 of document EB135/6 Add.1.

**It was so decided.<sup>1</sup>**

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<sup>1</sup> Decision EB135(2).

- **Foundation committees and selection panels**

The CHAIRMAN said that there were two vacancies to be filled on the foundation committees.

In the absence of any objections, she took it that the Board wished to approve the proposals contained in document EB135/6 Add.1.

**It was so decided.<sup>2</sup>**

- **Appointment of representatives of the Executive Board at the Sixty-eighth World Health Assembly**

The CHAIRMAN proposed that the Executive Board be represented by the Chairman and the first three Vice-Chairmen at the Sixty-eighth World Health Assembly. If any of them were not able to attend the Health Assembly, the other Vice-Chairman and/or the Rapporteur could be asked to represent the Board.

In the absence of any objections, she took it that the Board wished to approve that proposal.

**It was so decided.<sup>3</sup>**

### **3. STAFFING MATTERS: Item 7 of the Agenda**

**Statement by the representative of the WHO staff associations:** Item 7.1 of the Agenda (Document EB135/INF./1)

Dr ZUBER (representative of the WHO staff associations) said that the WHO staff associations had paid close attention to the discussions at the Sixty-seventh World Health Assembly, particularly those on the human resources annual report, and had been pleased to note that Member States' points of interest were closely aligned with those of the staff associations. Summarizing key issues from the statement contained in document EB135/INF./1, he drew attention to the importance placed by the staff associations on WHO reform, particularly issues related to conditions of service. Staff professional development was important for staff in all categories and duty stations and he hoped that, through the creation of attractive career paths, reform would enable talented staff to be retained and promising young people to be attracted to work for the Organization and the wider United Nations system. An effective performance management system must be implemented. Managed mobility would increase cohesion within the Organization but would need to be given careful consideration in view of the complexity of WHO, which required a high level of technical expertise for many functions. With regard to internal justice systems, the staff associations and the Secretariat were aware of the current deficiencies. The staff associations would be supporting a conference organized by ILO in September 2014 to identify good practices. He expressed appreciation for the addition of enhanced administration of justice to the human resources strategy but noted that it should be included and considered separately from the three areas of programmatic, governance and managerial reforms.

Since the beginning of 2014, the Staff Health Insurance Global Oversight Committee had begun examining the difficulties faced by staff and had decided to engage external experts to conduct a comprehensive review. In the meantime, ad hoc mechanisms should be put in place to ensure round-

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<sup>1</sup> Decision EB135(3).

<sup>2</sup> Decision EB135(4) and decision EB135(5).

<sup>3</sup> Decision EB135(6).



the-clock emergency support, as well as procedures enabling provision of payment guarantees to health care facilities. Conditions of service were also affected by the broader framework of the common United Nations system and, in particular, the current review of the compensation package by the International Civil Service Commission would have a profound impact. Members of the Board could provide a strong voice to advocate the promotion of good practices throughout the United Nations system. He reiterated the staff associations' commitment to continued close collaboration with the Secretariat to modernize and further improve organizational efficiency.

Mr KOLKER (United States of America) commended the Secretariat's tireless efforts during the recent session of the Health Assembly, including its valuable advice and facilitation of work. Welcoming the constructive statement by the representative of the WHO staff associations, he highlighted the importance of a culture of good management and a high-performing workforce, as well as the need to develop a well managed mobility programme.

The DIRECTOR-GENERAL thanked the representative of the WHO staff associations for his constructive statement, which had been compiled following consultation with staff at all levels and duty stations. While the meetings of the governing bodies and working groups provided an opportunity for Member States to witness the commitment and dedication of Secretariat staff, in fact that commitment and dedication continued all the time, whether or not such major events were taking place. Work to improve a culture of good management and high performance would continue. With regard to staff mobility, valuable lessons had been learnt from the experiences of the regions, and the comments of the staff associations would continue to be addressed.

**The Board took note of the statement by the representative of the staff associations.**

**Amendments to the Staff Regulations and Staff Rules:** Item 7.2 of the Agenda (Documents EB135/7 and EB135/7 Add.1)

The CHAIRMAN drew attention to the draft resolution contained in document EB135/7 and its financial and administrative implications for the Secretariat in document EB135/7 Add.1. As indicated in its report to the Board (document EB135/2), the Programme, Budget and Administration Committee had recommended the adoption of the draft resolution.

**The resolution was adopted.<sup>1</sup>**

**4. MATTERS FOR INFORMATION: REPORT ON MEETINGS OF EXPERT COMMITTEES AND STUDY GROUPS:** Item 8 of the Agenda (Document EB135/8)

Mr PIPPO BRIANT (Argentina) said that, with regard to the sixty-fourth report of the Expert Committee on Biological Standardization, technological developments in the field of biological substances used in human medicine had provided a means to treat a wide range of illnesses and could be expected to be able to treat many more in the future. Pharmaceutical regulations and, consequently, the recommendations of the Expert Committee should incorporate the need to ensure access to quality, safe, effective and affordable biotherapeutic products, in line with resolution EB134.R17. The work of the Expert Committee should continue to be transparent and based on solid scientific evidence, free from external influence and biased information.

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<sup>1</sup> Resolution EB135.R1.

Dame Sally DAVIES (United Kingdom of Great Britain and Northern Ireland), welcoming WHO's continued provision of excellent reference materials, supported the development of reference materials for cancer diagnostics, given that cancer was an extremely complex area requiring considerable resources.

Dr KIENY (Assistant Director-General) looked forward to continuing the work to strengthen WHO's standard-setting mandate, including the development of reference materials in the crucial area of cancer diagnostics.

The CHAIRMAN requested the Secretariat to convey the gratitude of the Board to the experts for their contributions.

**The Board noted the report.**

**5. FUTURE SESSIONS OF THE EXECUTIVE BOARD AND THE HEALTH ASSEMBLY:**  
Item 9 of the Agenda (Document EB135/9)

The CHAIRMAN took it that the Board wished to adopt the two draft decisions contained in document EB135/9 concerning the 136th session of the Executive Board and the Sixty-eighth World Health Assembly, as well as the twenty-first and twenty-second meetings of the Programme, Budget and Administration Committee of the Executive Board.

**It was so decided.<sup>1</sup>**

**6. CLOSURE OF THE SESSION:** Item 10 of the Agenda

After the customary exchange of courtesies, the CHAIRMAN declared the 135th session of the Executive Board closed.

**The meeting rose at 16:20.**

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<sup>1</sup> Decision EB135(7) and decision EB135(8).

## **LIST OF MEMBERS AND OTHER PARTICIPANTS**

### **MEMBERS, ALTERNATES AND ADVISERS**

#### **MALDIVES**

Dr M. SHAKEELA, Minister of Health and Gender, Malé (**Chairman**)

*Alternates*

Ms I. ADAM, Ambassador, Permanent Representative, Geneva

Ms A. SAMIYA, Deputy Director-General, Ministry of Health and Gender, Malé

Ms A. IBRAHIM, Director, Ministry of Health and Gender, Malé

Ms R. RASHEED, First Secretary, Permanent Mission, Geneva

#### **ALBANIA**

Dr G. BEJTJA, General Director of Health Policy and Planning, Tirana

*Alternates*

Ms F. KODRA, Ambassador, Permanent Representative, Geneva

Ms D. XHIXHO, Second Secretary, Permanent Mission, Geneva

#### **ANDORRA**

M. J.M. CASALS ALÍS, Directeur général, Département de la Santé et du Bien-être social, Andorra la Vella

#### **ARGENTINA**

Sr. T.A. PIPPO BRIANT, Director de Economía de la Salud, Ministerio de Salud, Buenos Aires

*Alternates*

Sra. A. POLACH, Analista de la Dirección Nacional de Relaciones Internacionales, Ministerio de Salud, Buenos Aires

Sr. J.C. MERCADO, Consejero, Misión Permanente, Ginebra

Sr. M. ALVAREZ WAGNER, Secretario de Embajada, Misión Permanente, Ginebra

*Adviser*

Sra. M. RIOS, Analista de la Dirección Nacional de Relaciones Internacionales, Ministerio de Salud, Buenos Aires

#### **AUSTRALIA**

Professor J. HALTON, Secretary, Department of Health and Ageing, Canberra

*Alternates*

Mr P. WOOLCOTT, Ambassador, Permanent Representative, Geneva

Mr S. COTTERELL, Acting First Assistant Secretary, Portfolio Strategies Division, Department of Health, Canberra

Ms R. STONE, Deputy Permanent Representative, Geneva

Mr C. BEDFORD, Acting Assistant Secretary, International Strategies Branch, Department of Health, Canberra

Ms M. HEYWARD, Adviser (Health), Permanent Mission, Geneva  
Ms J. KAINE, First Secretary, Permanent Mission, Geneva  
Mr T. POLETTI, Adviser (Health), Permanent Mission, Geneva  
Ms M. CARTER, Health Policy Officer, Department of Foreign Affairs and Trade, Canberra

## **AZERBAIJAN**

Dr O. SHIRALIYEV, Minister of Health, Baku

### *Alternates*

Mr S. ABDULLAYEV, Head, International Relations Department, Ministry of Health, Baku  
Ms G. GURBANOVA, Chief Adviser, International Relations Department, Ministry of Health, Baku  
Mr E. ASHRAFZADE, Third Secretary, Permanent Mission, Geneva  
Mrs S. SULEYMANOVA, Attaché, Permanent Mission, Geneva

## **BELGIUM**

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