



WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD

136TH SESSION

GENEVA, 26 JANUARY–3 FEBRUARY 2015

**SUMMARY RECORDS
LIST OF PARTICIPANTS**

GENEVA
2015

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

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

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

PREFACE

The 136th session of the Executive Board was held at WHO headquarters, Geneva, from 26 January to 3 February 2015. The proceedings are issued in two volumes. The present volume contains the summary records of the Board's discussions, the list of participants and officers, and details regarding membership of committees. The resolutions and decisions, and relevant annexes are issued in document EB136/2015/REC/1.

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 - 6.3 Update on the Commission on Ending Childhood Obesity
 - 6.4 Follow-up to the 2014 high-level meeting of the United Nations General Assembly to undertake a comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases

¹ As adopted by the Board at its first meeting (26 January 2015).

² **EB133(1) Deletion of agenda item**

The Executive Board decided:

- (1) to delete item 6.3 from its provisional agenda;
- (2) to request the Director-General to hold informal consultations with Member States from all regions with a view to reaching consensus on the title and content of that item;
- (3) to include an item in the draft provisional agenda of the Executive Board at its 134th session, with no title and a footnote referring to the present decision, on the understanding that the final title and content of the item will reflect the outcome of the informal consultations by the Director-General.

(Second meeting, 29 May 2013)

The informal consultations have not been concluded. The Director-General will provide an update to Executive Board members.

- 6.5 Global status report on violence and health
- 6.6 Global burden of epilepsy and the need for coordinated action at the country level to address its health, social and public knowledge implications
- 7. Promoting health through the life course
 - 7.1 Monitoring of the achievement of the health-related Millennium Development Goals
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- 8. Preparedness, surveillance and response
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 - 8.3 Implementation of the International Health Regulations (2005)
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LIST OF DOCUMENTS

EB136/1 Rev.1	Agenda ¹
EB136/1 (annotated)	Provisional agenda (annotated)
EB136/1 Add.1	Proposal for a supplementary agenda item
EB136/2	Report by the Director-General to the Executive Board at its 136th session
EB136/3	Report of the Programme, Budget and Administration Committee of the Executive Board
EB136/4	Report of the regional committees to the Executive Board
EB136/5	Framework of engagement with non-State actors ²
EB136/6	Method of work of the governing bodies
EB136/7	WHO reform: overview of reform implementation
EB136/8	Outcome of the Second International Conference on Nutrition
EB136/9	Maternal, infant and young child nutrition: development of the core set of indicators
EB136/10	Update on the WHO Commission on Ending Childhood Obesity
EB136/11	Follow-up to the 2014 high-level meeting of the United Nations General Assembly to undertake a comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases ³
EB136/11 Add.1	Follow-up to the 2014 high-level meeting of the United Nations General Assembly to undertake a comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases Proposed work plan for the global coordination mechanism on the prevention and control of noncommunicable diseases covering the period 2016–2017

¹ See page ix.

² See document EB136/2015/REC/1, Annex 7.

³ See document EB136/2015/REC/1, Annex 6.

EB136/12 and EB136/12 Corr.1	Global status report on violence and health
EB136/13	Global burden of epilepsy and the need for coordinated action at the country level to address its health, social and public knowledge implications ¹
EB136/14	Monitoring of the achievement of the health-related Millennium Development Goals
EB136/15	Health and the environment: addressing the health impact of air pollution
EB136/16	Health and the environment Climate and health: outcome of the WHO Conference on Health and Climate
EB136/17	Adolescent health
EB136/18	Women and health: 20 years of the Beijing Declaration and Platform for Action
EB136/19	Antimicrobial resistance Summary report on progress made in implementing resolution WHA67.25 on antimicrobial resistance
EB136/20	Antimicrobial resistance Draft global action plan on antimicrobial resistance
EB136/21	Poliomyelitis
EB136/21 Add.1	Report on financial and administrative implications for the Secretariat of decisions proposed for adoption by the Executive Board or Health Assembly
EB136/22	Implementation of the International Health Regulations (2005) Responding to public health emergencies ¹
EB136/22 Add.1	Implementation of the International Health Regulations (2005) Report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation ²
EB136/23	Malaria: draft global technical strategy: post 2015 ¹
EB136/24	Dengue: prevention and control

¹ See document EB136/2015/REC/1, Annex 7.

² See document EB136/2015/REC/1, Annexes 1 and 7.

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EB136/25	Global vaccine action plan
EB136/26	Current context and challenges; stopping the epidemic; and preparedness in non-affected countries and regions
EB136/27	Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage ¹
EB136/28	WHO Global Code of Practice on the International Recruitment of Health Personnel
EB136/29	Substandard/spurious/falsely-labelled/falsified/ counterfeit medical products
EB136/30	Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination
EB136/30 Add.1	Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination Health research and development demonstration projects
EB136/31	Evaluation of the global strategy and plan of action on public health, innovation and intellectual property
EB136/32	Blood and other medical products of human origin ¹
EB136/33 Rev.1	Implementation and financing of Programme budget 2014–2015: update
EB136/34 and EB136/34 Corr.1	Draft Proposed programme budget 2016–2017
EB136/35	Strategic budget space allocation ²
EB136/36	Draft financial strategy for WHO
EB136/37	Scale of assessments for 2016–2017
EB136/38	Evaluation
EB136/39	Real estate: update on the Geneva buildings renovation strategy
EB136/40	Reports of committees of the Executive Board Standing Committee on Nongovernmental Organizations ³

¹ See document EB136/2015/REC/1, Annex 7.

² See document EB136/2015/REC/1, Annexes 4 and 7.

³ See document EB136/2015/REC/1, Annex 2.

EB136/41	Awards ¹
EB136/42	Provisional agenda of the Sixty-eighth World Health Assembly and date, place and draft provisional agenda of the 137th session of the Executive Board
EB136/43	Appointment of the Regional Director for Africa
EB136/44	Appointment of the Regional Director for Europe
EB136/45	Human resources: update
EB136/46	Report of the International Civil Service Commission
EB136/47	Amendments to the Staff Regulations and Staff Rules ²
EB136/47 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly ³
EB136/48 Rev.1	Reports of advisory bodies: Expert committees and study groups
EB136/48 Add.1	Reports of advisory bodies: Expert committees and study groups – expert advisory panels and committees and their membership
EB136/49	Ensuring WHO's capacity to prepare for and respond to future large-scale and sustained outbreaks and emergencies

Information document

EB136/INF./1	Statement by the representative of the WHO staff associations
EB136/INF./2	Framework of engagement with non-State actors Information on regional committee debates
EB136/INF./3	Process for developing the Proposed programme budget 2016–2017
EB136/INF./4	Fast-tracking the development and prospective roll-out of vaccines, therapies and diagnostics in response to Ebola virus disease Special Session of the Executive Board on the Ebola Emergency

¹ See document EB136/2015/REC/1, Annex 5.

² See document EB136/2015/REC/1, Annex 3.

³ See document EB136/2015/REC/1, Annex 7.

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EB136/INF./5	Building resilient health systems in Ebola-affected countries Special Session of the Executive Board on the Ebola Emergency
EB136/INF./6	Highlight of efforts made to date towards preparing non-affected countries and regions to respond to potential importation of EVD Special Session of the Executive Board on the Ebola Emergency
EB136/INF./7	IHR and Ebola
EB136/INF./8	Ebola at end-2014: “Getting to Zero” Special Session of the Executive Board on the Ebola Emergency
EB136/INF./9	Human resources: update Note on the status of PAHO

Diverse documents

EB136/DIV./1 Rev.1	List of members and other participants
EB136/DIV./2	Preliminary daily timetable
EB136/DIV./3	Decisions and list of resolutions
EB136/DIV./4	List of documents

COMMITTEES¹

1. Programme, Budget and Administration Committee²

Dr Ren Minghui (China), Dr Andrea Carbone (Argentina), 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 (Maldives) Chairman of the Board and member ex officio, and Dr Jarbas Barbosa da Silva Júnior (Brazil) Vice-Chairman of the Board and member ex officio.

Twenty-first meeting, 21–23 January 2015:³ Dr Ren Minghui (China, Chairman), Dr P.A. Kremer (Argentina, alternate to Dr A. Carbone), Mr Kim Myong Hyok (Democratic People's Republic of Korea, alternate to Mr Kim Chang Min), Mrs B. Mukundi (Democratic Republic of the Congo, alternate to Dr B. Mukengeshayi Kupa), Dr Alaa Roushdy (Egypt, alternate to Professor A. Al-Adawy), Dr M. Ushio (Japan, alternate to Dr S. Omi), Mr M. Stelemekas (Lithuania, alternate to Dr V.J. Grabauskas), Dr P.B. Chand (Nepal, alternate to Mr Khaga Raj Adhikari), Dr Reina Gisela Roa Rodriguez (Panama), Dr Abdullah bin Mifreh Assiri (Saudi Arabia), and Mrs Kathryn Tyson (United Kingdom of Great Britain and Northern Ireland, alternate to Dame Sally Davies).

2. Standing Committee on Nongovernmental Organizations⁴

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

Meeting of 27 January 2015: Dr R. Nchabi Kamwi (Namibia, Chairman), Dr G. Bejtja (Albania), Dr W. Ammar (Lebanon), Dr Noor Hisham Abdullah (alternate to Dr S. Subramaniam) (Malaysia), and Dr Reina Gisela Roa Rodriguez (Panama).

3. Jacques Parisot Foundation Committee Meeting⁵

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

Meeting of 28 January 2015: Mr Mohamed Hussain Shareef (Maldives, Chairman), Dr Dirk Cuypers (Belgium), Dr Yankalbe Paboung Matchock Mahouri (Chad) and Dr Walid Ammar (Lebanon).

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

² Decision EB135(2).

³ See document EBPBAC21/DIV./1.

⁴ Decision EB135(3).

⁵ Decision EB123(3).

4. Sasakawa Health Prize Selection Panel¹

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

Meeting of 27 January 2015: Mr Mohamed Hussain Shareef (Maldives, Chairman), Dr Jeon Man-bok (Republic of Korea) and Professor Hiroyoshi Endo (representative of the Founder).

5. United Arab Emirates Health Foundation Selection Panel²

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

Meeting of 27 January 2015: Mr Mohamed Hussain Shareef (Maldives, Chairman), Dr Abdullah bin Mifreh (Saudi Arabia) and Dr Mohammad Salim Al Olama (representative of the Founder).

6. State of Kuwait Prize for Research in Health Promotion Foundation Selection Panel³

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

Meeting of 28 January 2015: Mr Mohamed Hussain Shareef (Maldives, Chairman), Dr Alaa Roushdy (Egypt) and Dr Majda Al Qattan (representative of the Founder).

7. Dr LEE Jong-wook Memorial Prize Selection Panel⁴

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

Meeting of 27 January 2015: Mr Mohamed Hussain Shareef (Maldives, Chairman), Mr Martin Bowles (Australia) and Dr Won-seok Sir (representative of the Founder).

¹ Decision EB133(5).

² Decision EB133(6).

³ Decision EB135(4).

⁴ Decision EB135(5).

SUMMARY RECORDS

FIRST MEETING

Monday, 26 January 2015, at 09:40

Chairman: Mr M.H. SHAREEF (Maldives)

1. OPENING OF THE SESSION AND ADOPTION OF THE AGENDA: Item 1 of the Provisional agenda (Documents EB136/1 and EB136/1 (annotated))

The CHAIRMAN declared open the 136th session of the Executive Board.

Proposal for a supplementary agenda item entitled “WHO guidelines development and governance” (Document EB136/1 Add.1)

Mr RUOCCO (Italy),¹ supported by Dr BEJTJA (Albania) and Mr VARGA (Croatia), proposed that the Executive Board discuss the development and governance of WHO guidelines, with the aim of increasing the involvement of Member States and other stakeholders in the development process. In addition to the information presented in the background document EB136/1 Add.1, an article published in June 2014 on the strength of recommendations and confidence in effect estimates had concluded that strong recommendations based on low or very low confidence estimates were frequently made in WHO guidelines.² Furthermore, in view of the recent discussion on the conditional recommendation on intake of free sugars included in the draft guidelines on the consumption of free sugars by adults and children issued by WHO for consultation in March 2014, the way in which conditional recommendations were included in WHO documents could be revised. He therefore proposed that the publication by WHO of new or revised guidelines should be suspended while discussions were held on updating the procedures for and governance of the development of WHO guidelines and policy papers. Member States should engage in exploratory discussions during the current session, and the issue should be evaluated more deeply at the following session of the Executive Board in May 2015.

Mr CASALS ALÍ (Andorra) supported the proposal but envisaged fuller discussion of the matter by the Board at either its 137th session in May or its 138th session in January 2016.

Ms MATSOSO (South Africa) expressed concern that the proposal appeared to challenge the overall approach adopted to developing WHO guidelines and could therefore be viewed as questioning the essence of the normative work performed by WHO.

Mr GHILAGABER (Eritrea), speaking on behalf of Member States of the African Region and supported by Dr OMI (Japan), said that involvement of Member States in WHO's process for developing guidelines was not obligatory, and the Regulations for Expert Advisory Panels and

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

² Alexander PE, Bero L, Monton VM, Brito JP, Stoltzfus R, Djulbegovic B et al. World Health Organization recommendations are often based on low confidence in effect estimates. *Journal of Clinical Epidemiology*, 2014, 67(6): 629-634 (<http://www.sciencedirect.com/science/article/pii/S0895435613004344>, accessed 9 February 2015).

Committees had not been updated for many years in order to reflect Member States' concerns. Member States needed the Secretariat to do preparatory work as it would be unacceptable to discuss the item without information and evidence, and to consult Member States. He suggested postponing discussion of the proposed supplementary item until the Board's 137th session.

Dr CUYPERS (Belgium), supported by Ms MATSOSO (South Africa), pointed out that the proposal involved three separate issues: first, questions about the scientific evidence; secondly, WHO's process for guideline development; and, thirdly, the draft recommendations on free sugars intake. The Board should discuss the questioning of scientific evidence. The issue of guideline development was separate from the issues around nutrition, which the member for Italy had raised as urgent. He agreed with the member for Eritrea that those items should be included on the provisional agenda for the Executive Board's consideration in May 2015.

Dr KREMER (Argentina), speaking on behalf of Member States of the Region of the Americas, said that the information in the annex to document EB136/1 Add.1 was not new and the issue was not sufficiently urgent to be placed on the agenda of the Executive Board under the urgent procedure provided for in Rule 10 of its Rules of Procedure. Items should not be added to the Board's agenda without time for prior consideration.

Dr ASADI-LARI (Islamic Republic of Iran) said that sufficient time should be allowed for thorough discussion of the issue by a designated scientific group of experts from the six WHO regions. Moreover, the approach to generating evidence needed examination, as proposed by the member for Italy, but without haste.

Dr BEJTJA (Albania) agreed with the division of the issue into one concerning governance and the second dealing with responses to international agreements. He supported the proposal to defer discussion until the 137th session.

The CHAIRMAN said that there appeared to be a consensus that the Board should not discuss the proposed supplementary item at the current session. He suggested that, after consultation with scientific experts and Member States, the Secretariat should prepare a report covering the issues raised, and that the item should be placed on the provisional agenda of the 137th session of the Board in May 2015, as proposed by several Executive Board Members.

It was so decided.

The DIRECTOR-GENERAL recalled that, at its 133rd session, the Board had adopted a decision¹ requesting her to hold informal consultations with Member States from all WHO regions with a view to reaching consensus on the title and content of a proposed agenda item. At its 134th session, owing to a persistent lack of consensus, the Board had requested that she continue the consultation process. Despite further cross-regional discussions, which had deepened understanding of the range of views on the complex and sensitive issue, consensus had still not been reached on either the title or the content of the agenda item.

The CHAIRMAN suggested that the Director-General should continue informal consultations and report back to the Executive Board at a later date.

¹ Decision EB133(1).

Mr SEY (Gambia), speaking on behalf of Member States of the African Region and supported by Professor AL-ADAWY (Egypt), speaking on behalf of Member States of the Eastern Mediterranean Region, Dr REN Minghui (China) and Mr KIM Myong Hok (Democratic People's Republic of Korea), thanked the Director-General for her consultations with all regional groups. Member States in the African Region were concerned about attempts to politicize the work of WHO, which detracted from its technical and scientific focus. WHO had made tremendous progress in addressing diseases that affected all people, and implementation of its existing action plans and programmes had strengthened the provision of health care for all. A statement of sexual orientation should not be required to access health care services. Sexual orientation was a lifestyle choice, not a disease, and any distinctions made on those grounds would not be in line with WHO's mandate. The Director-General had fulfilled the Board's request to hold consultations, but no consensus had been achieved. The proposed agenda item should therefore be deleted altogether and no further consultations held.

Dr CUYPERS (Belgium), speaking on behalf of the European Union and its Member States and supported by Dr BEJTJA (Albania), Mr CASALS ALÍS (Andorra), Dr KREMER (Argentina), Mr BOWLES (Australia), Dr BARBOSA DA SILVA (Brazil), Ms ROA RODRIGUEZ (Panama), Dr EERSEL (Suriname) and Dr FRIEDEN (United States of America), welcomed the Director-General's efforts and said it was unfortunate that consensus had not been reached. The agenda should be adopted without amendment, including the footnote referring to decision EB133(1), and consultations should continue. The European Union recognized the mandate of WHO to address the topic from a health perspective, as well as the duty to provide equal health care for all, without discrimination.

Dr NCHABI KAMWI (Namibia) said that further consultations should be encouraged.

The CHAIRMAN said that, although there was clearly no consensus among Member States on how to proceed, the proposal to maintain the footnote in the agenda and request the Director-General to continue consultations seemed to enjoy broad support.

It was so agreed.

The agenda was adopted.¹

2. ORGANIZATION OF WORK

Dr CUYPERS (Belgium), speaking on behalf of the European Union and its Member States, requested that, as at previous sessions, representatives of the European Union be invited to participate without vote in the meetings of the 136th session of the Executive Board and its committees, subcommittees or other subdivisions that addressed matters falling within the European Union's competence.

It was so agreed.

The Executive Board also agreed to the proposed organization of work as contained in document EB136/DIV./2.

¹ Document EB136/1 Rev.1.

3. REPORT BY THE DIRECTOR-GENERAL: Item 2 of the Agenda (Document EB136/2)

The DIRECTOR-GENERAL, introducing her report, said that, in a world facing conflicts, terrorism and epidemics, universal health coverage was a vital social equalizer. The Executive Board had before it an agenda that covered pressing health problems, including the effects of climate change, antimicrobial resistance and the failure of market-led systems and incentives to stimulate the development of new medical products for diseases that disproportionately affected the poor. Considerable progress had been made towards attaining the health-related Millennium Development Goals, thus paving the way to an exodus from poverty. However, substantial health challenges would occur in the post-2015 era, particularly with regard to the increasing burden of chronic noncommunicable diseases, promulgated by non-health factors, which could only be overcome by a multisectoral response and behavioural change. In light of the outbreak of Ebola virus disease in West Africa and other diseases, such as plague in Madagascar, she urged the Board, in its consideration of WHO reform and the Proposed programme budget, to keep in mind the need for a strong and flexible WHO, well-equipped to respond to such situations.

Professor AL-ADAWY (Egypt) emphasized the global importance of viral hepatitis and recalled his country's role in drafting resolution WHA67.6 on that topic. Through a national treatment programme, more than 350 000 patients had been treated since 2006, and a national plan of action for prevention, care and treatment had been launched in 2014 with the aim of eradicating viral hepatitis. A highly-effective direct-acting antiviral agent was being used; the target was to treat more than 150 000 patients by the end of 2015. Collaboration between national and international stakeholders in Egypt to curb viral hepatitis could provide a model for countries with limited resources.

Dr CUYPERS (Belgium), speaking on behalf of the European Union and its Member States, said that the challenges facing global health were increasingly complex and required collaboration across regions, sectors and society. Non-State actors were crucial partners, and he urged the Board to agree on the proposed framework for engagement. He underlined the continued need for reform, which should be enacted throughout the Organization. Continued budget reform efforts should be reflected in a sound and realistic programme and budget for 2016–2017.

He reaffirmed the need for essential population-level public health services, strengthened health systems and a rights-based approach as a basis for introducing universal health coverage.

The fact that some countries were more vulnerable to emergencies and had limited capacity to respond without additional support should be taken into consideration in the discussions of implementation of the International Health Regulations (2005). WHO's role in emergencies, as the lead agency of the Global Health Cluster of the United Nations, should be enhanced.

He welcomed the emphasis on antimicrobial resistance and the draft global action plan, women and health, and health and air pollution.

Dame Sally DAVIES (United Kingdom of Great Britain and Northern Ireland) said that the Ebola crisis had highlighted the need to promote research and investment in new treatments, vaccines and diagnostics, particularly those with the potential to combat pandemic diseases and, most critically, where there was market failure. WHO could play a key role in that regard. The crisis had also shown the need to meet both immediate and longer-term threats and, in that context, she urged support for the draft global action plan on antimicrobial resistance.

Reform would enable the Organization to prioritize its work, with fit-for-purpose budgeting and human-resource systems, an effective and transparent system for monitoring capacity to implement the International Health Regulations (2005), and a renewed focus on combating infectious disease. The events in West Africa were a reminder of the consequences of weak health systems and that universal health coverage should be incorporated into future development goals.

Member States should be encouraged to take action to tackle risk factors for noncommunicable diseases. In one such instance, smoking, the United Kingdom Government had committed itself to the introduction of standardized tobacco packaging. She announced that OECD, WHO and the United Kingdom would jointly host the First Ministerial Conference on Global Action against Dementia in Geneva in March 2015.

Dr REN Minghui (China) commended WHO's work to prevent and control various infectious disease outbreaks during the course of the previous year, including avian influenza A (H7N9), Ebola virus disease and poliomyelitis. However, future challenges would only be met if health systems were strengthened at the country level and continuous reform conducted within WHO. Efforts should not focus solely on outbreaks of communicable diseases but also on global health development and assessment of progress towards achieving the health-related Millennium Development Goals. Health should feature prominently in the post-2015 development agenda, with a drive towards universal health coverage and the creation of a more resilient global health security system.

Dr OMI (Japan) said that his country would be pleased to share its experiences of universal health coverage. With regard to the fruits of innovation, a Japanese company had developed an antimicrobial agent to treat drug-resistant tuberculosis and another had developed a user-friendly test kit for rapid diagnosis of tuberculosis at a price that should be affordable for developing countries. Concerning the health impact of climate change, Japan had seen cases of dengue fever in 2014, resulting in local transmission for the first time in 70 years.

Ms MATSOSO (South Africa), speaking on behalf of Member States of the African Region, congratulated Member States for their adoption of a resolution on Ebola virus disease at the special session the previous day. The acknowledgement of outbreak of plague in Madagascar was welcome. Many African countries were still grappling with HIV/AIDS and HIV/tuberculosis coinfection – the welcome advances made in Japan would assist in reducing the burden of drug-resistant tuberculosis. The key to strengthening health systems was implementation of universal health coverage, and Member States should make every effort to implement the International Health Regulations (2005) without delay. Achievement of the health-related Millennium Development Goals was still necessary; she acknowledged the reduction in infant mortality and noted that mobile technology had been introduced in order to overcome the continuing problem of maternal deaths. While lauding WHO's initiative and the progress made in providing access to antiretroviral treatment, she emphasized the threat posed by antimicrobial resistance and the need for a global response.

Ms SKVORTSOVA (Russian Federation) said that efforts to improve the effectiveness and accountability of WHO were particularly important at a time when the world faced new threats such as the outbreak of Ebola virus disease. The Russian Federation had provided health professionals and a mobile laboratory in response to the outbreak and had sent a fully-equipped 200-bed mobile hospital to Guinea. A rapid diagnostic test had been developed and work was continuing on the development of a vaccine and antiviral agents. Her Government had made a donation of US\$ 8 million to international organizations combating the disease.

National experts had contributed to the drafting of the global action plan on antimicrobial resistance. The control of noncommunicable diseases was a priority for her country, where deaths from cardiovascular disease had been reduced and a strong anti-tobacco policy was in place. The Russian Federation had hosted the sixth session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control in October 2014. The Russian Federation supported WHO's initiatives to combat noncommunicable diseases through the geographically dispersed office opened in Moscow in 2014. It was gratifying that her country's experience in reducing maternal and child mortality was being used by the international community; during the past three years, more than 800 doctors from 18 countries had received training in the Russian Federation.

Mr BOWLES (Australia) welcomed the Director-General's honest assessment and the focus on strategies and action plans to stop communicable diseases and on antimicrobial resistance. The implementation of the International Health Regulations (2005) was vital in order to ensure that WHO was able to respond quickly and effectively to communicable diseases and emerging global health issues and threats. WHO should continue to focus on health systems strengthening initiatives as they were the best means of controlling outbreaks and preparing for emerging global health risks.

Dr NCHABI KAMWI (Namibia) identified the value in malaria control of a combination of strategies, including, for vector control, the use of long-lasting insecticide treated nets and insecticidal residual spraying of households. The outbreak of plague in Madagascar was a particular cause for concern as there appeared to have been cases of human-to-human transmission. Disease response and health programmes were held together by the health systems agenda, which was supported by the universal access initiative. WHO reform would support that process and it should continue rapidly and smoothly.

Dr NOOR HISHAM ABDULLAH (Malaysia) said that the outbreak of Ebola virus disease had derailed progress towards the unmet Millennium Development Goals and exposed weaknesses in health systems. Work towards the health-related Goals had led to significant improvements in health and well-being and it was hoped that the sustainable development goals under discussion would unite countries on the path to universal health coverage. That would need, however, a greater focus on the global health workforce and strengthening of health systems. Noncommunicable diseases should feature prominently in the post-2015 development agenda, given that cancer killed more people in low- and middle-income countries than HIV/AIDS, malaria and tuberculosis combined.

Rumours spread through social media had caused panic during the outbreak of Ebola virus disease; there was no easy solution to the rapid and broad dissemination of false information. That highlighted the need for an effective social media strategy in preparedness planning for emergencies and disasters. Nevertheless, information and communication technologies were good enablers for health systems and m-health and e-health would continue to evolve in the hands of trained, well-connected health workers and empower individuals to change behaviour related to noncommunicable disease risk factors.

Dr ASADI-LARI (Islamic Republic of Iran) acknowledged that the International Health Regulations (2005) provided a reliable mechanism to counter the challenge of communicable diseases. Nevertheless, more practical governance was required, with the leadership of WHO, in order to maintain progress towards poliomyelitis eradication and elimination of malaria, particularly in the Eastern Mediterranean Region.

Technical assistance and further cross-border, subregional and international collaboration were required in order to support strengthening of health systems. More training, research and investment in human resources were needed as part of the WHO reform process. National prevention and control policies on noncommunicable diseases should be brought into line with the global agenda in order to support sustainable development.

Dr ROA RODRIGUEZ (Panama) said that a focus on the social determinants of health was increasingly relevant, taking into account infectious diseases and their prevention through access to health services and universal health coverage. Implementation of the International Health Regulations (2005) would undoubtedly lead to health gains and to a strengthening of national health systems, assisted by reform of WHO in strategic areas such as governance. Enhanced tobacco control measures formed part of her country's prioritization of noncommunicable diseases.

Dr ASSIRI (Saudi Arabia) reported that more than 700 cases of Middle East respiratory syndrome had been recorded in his country, with a mortality rate of about 40%. The total reported was greater than for other countries simply because the country tested more people (including all patients with pneumonia and patients with atypical, dengue-like respiratory infections); in neighbouring

countries and other regions the same risk factors for the disease existed, and serological surveys of animals had revealed that the coronavirus was equally present in other areas. He urged more proactive testing for the infection in other countries. Despite much collaboration, there had been no significant progress in understanding the animal-human interface. He strongly supported the action on antimicrobial resistance.

Dr KUPA (Democratic Republic of the Congo) commended WHO's strong support in fighting Ebola virus disease in Africa. However, attention must be paid to other neglected tropical diseases. Despite the extremely limited resources in the affected countries, the mobilization of the international community and coordination of efforts to fight Ebola had rapidly created a more manageable situation; the same would apply to other diseases. In order to achieve results, it was necessary to build stronger health systems, but that was not easy with such limited resources. The solution was better policy coordination, with all stakeholders agreeing on priorities. Individual countries or development partners could not make a difference in isolation, but pooling skills, expertise and resources would make it possible to respond effectively.

Dr AHMED BASHEIR (Sudan)¹ highlighted the growing burden of neglected tropical diseases. Specifically, mycetoma, a disabling disease that was expensive to treat, was not receiving adequate attention; strong action was needed to control it globally. She called on affected countries to support Sudan in drafting a resolution for consideration by the Board at its next session.

Professor VALLET (France)¹ said that implementation of the International Health Regulations (2005) was an essential element of health systems strengthening and must remain a WHO priority. The Ebola crisis had flagged up the need for an innovative, sustainable approach to research and development and for demonstration projects to be funded by Member States; the resolution adopted the previous day at the special session was a good indication of WHO's reform. Universal health coverage and strong, sustainable health systems were essential if health organizations were to respond adequately to present and future health crises. France would host the twenty-first session of the Conference of the Parties to the United Nations Framework Convention on Climate Change (Paris, December 2015), which would provide an opportunity to highlight the many ancillary benefits to health of mitigating climate change. He called upon Member States to adopt the draft framework of engagement with non-State actors; such engagement was essential, but it must not affect WHO's independence or reputation.

The DIRECTOR-GENERAL, responding to speakers' comments, said that, as Member States had acknowledged, WHO could not be responsible for everything health-related: it had limited resources, and must prioritize. The Secretariat would continue the management reform and recruit and retain competent staff to make WHO fit for purpose. Comments on strengthening health systems were very welcome; people tended to expect vertical programmes, but those must be based on horizontal systems, as the Ebola outbreak had demonstrated. Health systems had to be good enough to enable Member States to achieve the health-related Millennium Development Goals, and have in place the core competencies required by the International Health Regulations (2005) to prevent, detect and respond to outbreaks of communicable diseases. Member States also had to fulfil their side of the bargain: the financing dialogue had shown the misalignment between the priorities they set and the financing they were willing to provide WHO.

Health ministers' jobs were more difficult than those of other ministers – they were always on the receiving end of other ministries' policy failures. They needed to persuade other ministers that all policies took health into consideration. Stand-alone vertical systems were fragile, as demonstrated by the damage wrought by the Ebola virus disease outbreak in Liberia, which, until that point, had made

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

enormous progress and achieved Millennium Development Goal 4 three years ahead of schedule. Development partners had to recognize that supplying commodities alone was not enough; they should also invest in strengthening health systems. Strong health systems were essential for universal health coverage which, underpinned by the core capacity requirements of the International Health Regulations (2005), was essential for reducing inequity and inequality and should form the basis of the health goals of the post-2015 sustainable development agenda. Investment in health not only benefited the economy, but served to lift people out of poverty.

Although Member States were understandably cautious about WHO's work with non-State actors, the pharmaceutical industry had provided free medicines for 1000 million people, and the fact that WHO received from it a small amount of money for personnel to deliver the medicines should not be viewed as a conflict of interest. Major health issues such as Ebola virus disease and antimicrobial resistance could not be resolved without input from the private sector. It was possible to work with industry without compromising WHO's policy-making and standard-setting role.

Members had heavy responsibilities for the Board's current session, including consideration of the draft global action plan on antimicrobial resistance and the role of non-State actors. She thanked members for the trust in WHO they had demonstrated by adopting the resolution on the Ebola emergency the previous day and their commitment to WHO as the pre-eminent organization for health in the United Nations system. If Member States wanted a stronger WHO, they should give it the necessary financial support.

4. REPORT OF THE PROGRAMME, BUDGET AND ADMINISTRATION COMMITTEE OF THE EXECUTIVE BOARD: Item 3 of the Agenda (Document EB136/3)

Dr REN Minghui (China), speaking in his capacity as Chairman, of the Programme, Budget and Administration Committee, introduced the five items discussed by the Committee that were not included on the agenda of the Board. The Committee had noted the report of the Independent Expert Oversight Advisory Committee, echoing its concerns about recurrent control weaknesses and concurring that compliance units needed to work in a coordinated way. It had requested a more detailed costing of the various elements of the Organization's strategy for information technology and telecommunications. It had welcomed the progress made in implementing the internal control framework and the introduction of the "accountability compact" for delegation of authority from the Director-General to Assistant Directors-General; it had asked whether the compact could be extended to apply to the regional directors. Having considered the first report of the Office of Compliance, Risk Management and Ethics, it had requested the Secretariat to ensure adequate analysis, escalation and mitigation of risk and to share updates on the corporate risk register with the governing bodies. It had requested that the Office's role in ethics training across the Organization be enhanced and that the scope of declarations of interest be broadened for staff members. It had also taken note of the reports of the Joint Inspection Unit.

Ms MATSOSO (South Africa) welcomed the suggestions regarding the internal control framework made by the Independent Expert Oversight Advisory Committee (document EB136/3, paragraph 56). According to previous audit findings, around US\$ 400 million in direct financial cooperation had been transferred during the period 2012–2013. It was particularly important that Member States' reports in respect of direct financial cooperation were submitted in a timely manner and that the regional offices had the capacity to implement assurance measures and compliance checks. With regard to implementation and financing of the Programme budget 2014–2015, she commended the Committee on its foresight in ensuring the availability of funding to address the outbreak of Ebola virus disease without a resolution and costing document. The Director-General must be given the flexibility to fulfil the mandate conferred upon her by the Executive Board through its resolutions, to ensure an adequate level of preparedness and outbreak response.

5. REPORT OF THE REGIONAL COMMITTEES TO THE EXECUTIVE BOARD: Item 4 of the Agenda (Document EB136/4)

Dr CHAND (Nepal), speaking on behalf of Member States in the South-East Asia Region, emphasized that, in respect of the follow-up to the financing dialogue, the Regional Committee for South-East Asia had recommended that budgetary support should be linked to regional health concerns and challenges, rather than donor priorities and mandates, and that core budget funding should be increased and made more flexible. With respect to strategic budget space allocation, the new methodology must include new and evidence-based strategic allocation of resources to support those Member States in greatest need, based on epidemiological data and with a view to ensuring fairness and equity. The Regional Committee had adopted resolution SEA/RC67/R1 on the Proposed programme budget 2016–2017, calling for flexibility in budget allocations to allow for the controlled transfer or reallocation of funds to areas of work requiring additional funding. Concern had been expressed on the uneven mobilization and distribution of resources.

Dr REYNDERS (Belgium), speaking on behalf of Member States of the European Region, observed that the report strengthened the link between regional and global work and between the regional committees and the Board. The process should be further encouraged. Given that all the regional committees had reviewed the global documents, the Board should review the feedback on WHO reform in order to learn lessons for future action. The Regional Committee for Europe had focused in particular on governance reform besides the global malaria technical strategy, viral hepatitis, antimicrobial resistance and polio eradication. It had updated regional action plans in line with Health 2020, the European policy framework for health and well-being, and had paid particular attention to social determinants of health and intersectoral activities.

Dr AMMAR (Lebanon), speaking on behalf of Member States in the Eastern Mediterranean Region, said that the Regional Committee had urged Member States to prioritize implementation of the International Health Regulations (2005) and to undertake a comprehensive assessment of their capacities to cope with the importation of Ebola virus disease. It had also urged Member States to allocate a minimum of 1% of the WHO country budget to the regional Emergency Solidarity Fund, and to contribute to a regional logistics hub and a regional surge roster of experts for rapid deployment in emergencies. It had asked the current Board to invite the Director-General to prepare a set of process indicators for implementation of the Political Declaration on noncommunicable diseases. It had also asked Member States to consider a regional framework for action on advancing universal health coverage and to develop and implement a national road map to achieve that goal. It had decided that 79 resolutions would be “retired” and that an accountability mechanism would be introduced to monitor active resolutions and regularly report on their implementation.

Dr ALWAN (Regional Director for the Eastern Mediterranean) highlighted the unprecedented increase in crises and emergencies faced by the Member States in the Region, which hosted more than half the world’s refugee population, and noted that the outcome of the Regional Committee had been useful in establishing the regional Emergency Solidarity Fund. The Committee had endorsed a regional framework for national health information systems, which was already in use by Member States to strengthen the set of core indicators and civil registration and vital statistics systems.

An effective compliance and risk reduction system had been established under his direct supervision. With regard to internal control, compliance by all units in the Regional Office and country offices was monitored through a specially developed monthly dashboard, shared with all WHO Representatives and directors, which focused on several priority areas, including direct financial cooperation. Progress included major reductions in the number of overdue direct financial cooperation reports and the travel budget of the Regional Office and country offices.

The DIRECTOR-GENERAL applauded the practice of retiring resolutions; that was a good approach that headquarters might usefully follow. She planned to review all the resolutions adopted by the Health Assembly and to suggest that, in some cases, reporting on their implementation be discontinued. She also commended the progress of the Regional Office for the Eastern Mediterranean in harmonizing health information systems; other regions and headquarters could usefully draw on that experience. Annual indicators were collected from all Member States and compiled in a global report; alignment and harmonization were clearly necessary.

Responding to the question whether the accountability compact between herself and the Assistant Directors-General could be extended to the regional directors, she noted that the former were appointed officials who were accountable to herself. Regional directors, on the other hand, were nominated by regional committees and appointed by the Executive Board. She delegated authority to the regional directors, but they were accountable to her for managing the budget allocated to the regions. The accountability picture was thus complex, and she would welcome further guidance from the Programme, Budget and Administration Committee on how the regional directors should be held to account and at what level.

The Board noted the report.

6. COMMUNICABLE DISEASES: Item 9 of the Agenda

Malaria: draft global technical strategy: post 2015: Item 9.1 of the Agenda (Document EB136/23)

Ms ROSE-ODUYEMI (Governing Bodies and External Relations) announced that a drafting group had been established to consider a draft resolution.

The meeting rose at 12:40.

SECOND MEETING

Monday, 26 January 2015, at 14:40

Chairman: Mr M.H. SHAREEF (Maldives)

COMMUNICABLE DISEASES: Item 9 of the Agenda (continued)

Malaria: draft global technical strategy: post 2015: Item 9.1 of the Agenda (Document EB136/23) (continued)

The CHAIRMAN drew attention to the report and the associated draft resolution proposed by Australia, Italy, Kenya, Namibia, South Africa, United States of America and Zambia, which read as follows:

The Executive Board,
Having considered the report on malaria: draft global technical strategy: post 2015,¹

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

The Sixty-eighth World Health Assembly,
(PP1) Recalling resolutions WHA58.2 on malaria control, WHA60.18 on malaria, including proposal for establishment of World Malaria Day and WHA64.17 on malaria, and United Nations General Assembly resolutions 65/273, 66/289, 67/299 and 68/308 on consolidating gains and accelerating efforts to control and eliminate malaria in developing countries, particularly in Africa, by 2015;

(PP2) Acknowledging the progress made towards the achievement of Millennium Development Goal 6 (Combat HIV/AIDS, malaria and other diseases), and towards the targets set by the Health Assembly in resolution WHA58.2;

[(PP2 bis) Recognizing the urgent need to accelerate progress towards elimination and the opportunity provided by both the recent progress achieved and the emergence of new cost-effective interventions;]

(PP3) Noting that approximately 200 million cases of malaria are estimated to have occurred in 2013 and that the disease led to more than 580 000 deaths in 2013, mostly in children under five years of age in Africa, and poses a significant burden on households, communities and health services in high-burden countries, and that this number will increase unless efforts to reduce the disease burden are intensified;

(PP4) Recognizing that malaria interventions are highly cost-effective yet there is a need to urgently address and overcome the barriers that hinder universal access to vector-control measures, preventive therapies, quality-assured diagnostic testing and treatment for malaria;

[PP5 Recognizing also that malaria-related morbidity and mortality throughout the world can be substantially reduced with political commitment and commensurate resources

¹ Document EB136/23.

if the public is educated and sensitized about malaria and appropriate health services are made available, particularly in countries where the disease is endemic; – note: UNGA Res 68/308 – PP13 verbatim text]

(PP6) Deeply concerned by the regional and global health threat posed by the emergence and spread of insecticide and drug resistance, including artemisinin resistance, and the systemic challenges impeding further progress, including weak health and disease surveillance systems in many affected countries;

(PP7) Cognizant of the grave economic and social burden that malaria inflicts on the most vulnerable and poorest communities in countries in which malaria is endemic such as in Latin America, and of the disproportionate burden that is borne by countries in sub-Saharan Africa, and high-risk groups, including mobile populations;

[(PP8) Cognizant that efforts to reduce malaria transmission can improve social conditions, lift communities out of poverty, and deliver strong economic returns on investment, while a high disease incidence places a heavy financial burden on health systems, leads to work absenteeism, worsens school attendance and discourages investment, limiting the economic prospects of malaria-endemic areas and countries;]

(PP9) Acknowledging that recent successes in malaria prevention and control are fragile and further progress depends on action within and beyond the health sector, which requires long-term political and financial commitments, strong regional collaboration, the strengthening of health systems, and investments in innovation and research;

(PP10) [Recognizing the current and likely future impact of malaria on non-endemic countries and the risk of re-emergence in countries that have recently become malaria-free];

(OP) 1 ADOPTS the global technical strategy for malaria 2016–2030, with:

- (a) its bold vision of a world free of malaria, and its targets to reduce malaria incidence and mortality rates globally by at least 90% by 2030, to eliminate the disease in at least 35 new countries, and to prevent its re-establishment in countries that were free of malaria in 2015;
- (b) its associated milestones for 2020 and 2025;
- (c) its five principles addressing: acceleration of efforts towards elimination; country ownership and leadership with the involvement and participation of communities; improved surveillance, monitoring and evaluation; equity in access to health services; and innovation in tools and implementation approaches;
- (d) its three pillars of: ensuring universal access to malaria prevention, diagnosis and treatment; acceleration efforts towards elimination and attainment of malaria-free status; and transforming malaria surveillance into a core intervention;
- (e) its two supporting elements of: harnessing innovation and expanding research; and strengthening the enabling environment;

(OP) 2 URGES Member States:¹

- (a) to update national malaria strategies and operational plans consistent with the recommendations of the global technical strategy for malaria 2016–2030;
- (b) to intensify national and regional efforts to reduce malaria morbidity and mortality in high-burden countries and accelerate progress towards elimination, and, where appropriate, maintain malaria-free status;
- (c) to strengthen health systems, including both the public and private sectors, and devise plans for achieving and maintaining universal coverage of WHO-recommended core malaria interventions for at-risk populations;

¹ And, as applicable, regional economic integration organizations.

- (d) to intensify national and regional efforts to address the threat posed by rising insecticide and drug resistance, including artemisinin resistance;
 - (e) to promote multisectoral collaboration, educational programmes, and community involvement to strengthen efforts for malaria control and elimination;
 - (f) to establish and strengthen, as appropriate, national malaria surveillance systems in order to improve the quality of data and the effectiveness and efficiency of national malaria responses;
 - (g) [to promote basic and applied research in malaria and accelerate the rapid development and adoption of quality and cost-effective new tools, [in particular vaccines, medicines and diagnostics to prevent and control malaria] and [to collaborate on new approaches] approaches]; [SECRETARIAT TO PROPOSE LIST OF TOOLS AND APPROACHES]
 - (h) to strengthen human resource capacity and infrastructure to improve the effectiveness, efficiency and sustainability of malaria responses, while ensuring integration and synergies with the wider health system;
 - (i) to consider the financial implications of this resolution in the broader context of health sector development, and increase national, regional and international funding for malaria interventions, and for cross-border and regional initiatives;
- (OP) 3 INVITES international, regional and national partners from within and beyond the health sector, in particular those in the Roll Back Malaria Partnership, to engage in, and support, the implementation of the global technical strategy for malaria 2016–2030;
- (OP) 4 CALLS UPON WHO's international partners, including intergovernmental and international organizations, financing bodies, academic and research institutions, civil society and the private sector to support Member States,¹ as appropriate:
- (a) to mobilize sufficient and predictable funding to enable an accelerated reduction of the malaria burden, particularly in high-burden countries, and progress towards elimination, in line with the milestones and targets proposed in the strategy;
 - (b) to support knowledge generation, research and innovation to speed up the development of new vector-control tools, diagnostics, medicines, vaccines, and surveillance, data management, operational delivery and implementation solutions;
 - (c) to harmonize the provision of support to countries for adopting and implementing WHO-recommended policies and strategies;
- (OP) 5 REQUESTS the Director-General:
- (a) to provide technical support and guidance to Member States¹ for the implementation, national adaptation and operationalization of the global technical strategy for malaria 2016–2030;
 - (b) to update technical guidance on malaria prevention, care and elimination regularly, as new evidence is gathered and new innovative tools and approaches become available;
 - (c) to monitor the implementation of the strategy and evaluate its impact in terms of progress towards set milestones and targets;
 - (d) to strengthen the Secretariat's capacities to enable it to increase its technical support to Member States,¹ in order to meet the global milestones and targets;

¹ And, as applicable, regional economic integration organizations.

- (e) to ensure that all relevant parts of the organization, at Headquarters, regional and country level, are actively engaged and coordinated in promoting and implementing the global technical strategy for malaria 2016–2030;
- (f) to report on the progress achieved to the Seventieth and Seventy-second World Health Assemblies, and at regular intervals thereafter, through the Executive Board.

A report was being prepared on the draft resolution's administrative and financial implications for the Secretariat.

Dr ASADI-LARI (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, affirmed that drug resistance and vector resistance to insecticides remained major challenges. Limited pharmaceutical regulation should be dealt with at the international level, while issues of resistance should be tackled through coordination between WHO and FAO at the global level and between agriculture and health ministries at the national level. Enforcement of legislation on vector control was essential. Experience in his country had shown that community participation was a valuable dimension in strengthening surveillance, which should become a core intervention. He endorsed the draft strategy, which highlighted the importance of prevention and control activities and had been developed through an excellent consultative process. Its implementation would hinge on support from the Secretariat and adequate funding.

Dr EERSEL (Suriname) endorsed the draft resolution but proposed that paragraph 2(d) should also refer to cross-border and subregional collaboration.

Mr JEON Man-bok (Republic of Korea) stressed the importance of the draft strategy for eradication of malaria, in particular pillar 3 and supporting element 2, and called on the Secretariat to actively coordinate its implementation. His country would provide active support to and share its experiences on eradicating vivax malaria with other countries.

Dr CHAND (Nepal), speaking on behalf of the Member States of the South-East Asia Region, endorsed the proposal made by the member for Suriname; cross-border and regional cooperation were important. He acknowledged existing support for malaria programmes. Impressive progress had been made but longer-term funding commitments were needed to eliminate malaria. A strategy was needed to cope with outbreaks and recurrences of disease through integrated vector control. Drug resistance needed attention and laboratory services had to be strengthened in severely affected countries. WHO and its partners should cooperate in order to ensure adequate financial support for the strategy's implementation.

Mr RASHEED (Maldives) endorsed the draft strategy but requested that it contain provisions for surveillance in countries where transmission had ceased, such as his own, so as to prevent reintroduction of the disease. His country wished to sponsor the draft resolution.

Dr CHANG Jile (China), expressing support for the draft strategy, stressed the importance of timely and accurate reporting and of addressing the threat of international spread of malaria due to globalization. In addition to adequate and sustainable funding, it was essential to ensure optimal human resources, high-quality coordination and sensitive surveillance networks. WHO should establish regional reference laboratories and build a platform for training, quality control and exchange of information. He proposed two amendments to the draft strategy. In paragraph 48, the third sentence should be modified to read as follows: "In areas such as Africa, where chloroquine-susceptible *P. vivax* is highly prevalent, artemisinin-based combination therapy can be used for treatment. In areas such as China, where *P. vivax* is the only prevalent malaria, chloroquine should be first considered as a first-line drug." In paragraph 57, the phrase "with appropriate supporting authorities" should be inserted between "health ministries" and "need to assume".

Mr BOWLES (Australia), expressing concern at increasing drug resistance, welcomed the draft strategy's focus on increased political commitment and the strengthening of cross-border collaboration. He drew attention to the recent decision by the East Asia Summit and Pacific island countries to set a goal of an Asia-Pacific free of malaria by 2030.

Dr OKABAYASHI (Japan) welcomed the draft strategy, which was in line with his country's approach, and supported the draft resolution. A community-based approach, including extending malaria control to vulnerable and hard-to-reach populations, was needed to achieve universal coverage of malaria-related interventions.

Dr BARBOSA DA SILVA (Brazil), noting that challenges remained in the fight against malaria and highlighting the significant progress made in his country, said that Brazil wished to sponsor the draft resolution. The strategy would facilitate the sharing of experiences, in which Brazil was keen to participate.

Ms SHEVYREVA (Russian Federation), welcoming the comprehensive consultative process used to develop the draft strategy, said that its goals were realistic. If current funding were maintained, the target of a 40% reduction in global malaria morbidity and mortality by 2020 was feasible; however, further progress would require increased financial investment and the development of innovative technologies. Furthermore, widespread training programmes would be needed for malaria experts in areas such as surveillance, on which the Russian Federation was willing to cooperate with WHO to share its expertise.

Dr NCHABI KAMWI (Namibia), speaking on behalf of the Member States of the African Region, also commended the consultative process. Malaria continued to be a particular challenge in the Region; predictable and sustained funding for malaria prevention, control and elimination programmes was crucial. The draft strategy's emphasis on research and innovation was welcome at a time of increasing parasite resistance to medicines and mosquito resistance to insecticides. Technical guidance from WHO and intersectoral collaboration at the national level would also be vital to ensure effective interventions. As the draft strategy provided a long-term approach, he recommended a clear process for review and revision be defined. He asked the Secretariat to explain how the strategy would be revised and what would be the role of the governing bodies in that process. He supported the draft resolution.

Dr FRIEDEN (United States of America), strongly supporting the draft strategy, observed that the use of rapid diagnostic tests and improvements in diagnostic modalities and case management were particularly important in the fight against malaria. He requested more detailed information on how the estimated costs of implementation had been calculated and suggested that a placeholder be created to allow for adjustment of those costs in order to ensure consistency in the calculations between those of the draft strategy and those of the Second Global Malaria Action Plan of the Roll Back Malaria Partnership. He highlighted the importance of transparent and clear presentation of financial data by WHO and stressed that the efforts to eliminate malaria must be sustained.

Dr GONZÁLEZ FERNANDEZ (Cuba), stressing the importance of ensuring that malaria continued to be a priority in the post-2015 sustainable development agenda, said that it was crucial to educate the public about the risks of the disease. More emphasis was needed on scientific research into prevention, control and treatment. He welcomed the draft strategy.

Mr TOMLINSON (United Kingdom of Great Britain and Northern Ireland), expressing support for the draft strategy, said that greater investment in high-quality surveillance and increased technical guidance would be crucial for responses to different local situations. Such support should be provided by the Secretariat at all levels and the Programme budget should include adequate resources.

Dr MAKUBALO (South Africa), speaking in her capacity as chairman of the drafting group, read out the amendments to the draft resolution that had been proposed. Preambular paragraph 2bis should read, “Recognizing that these gains, when complemented by further investments in new cost-effective interventions, provide an opportunity to further reduce the high burden of malaria and accelerate towards elimination”. In the fifth preambular paragraph, the reference to United Nations General Assembly resolution 68/308 had been deleted, as had the phrase “such as in Latin America” in the seventh preambular paragraph. The eighth preambular paragraph had been amended to read as follows: “Cognizant that a reduction in the malaria burden can improve social conditions, lift communities out of poverty, and has a positive economic and social impact”. The tenth preambular paragraph should read, “Recognizing that in the interconnected and interdependent world, no country is risk-free from malaria, including countries that have recently eliminated the disease and countries that are non-endemic for malaria”.

In the operative part of the text, to reflect the proposal by the member for Suriname, subparagraph 2(d) should begin, “to intensify national, cross-border, regional and subregional efforts to address ...”. In subparagraph 2(f), the words “and response” had been inserted after “national malaria surveillance”. Subparagraph 2(g) should read: “to promote basic and applied research in malaria and accelerate the rapid development and adoption of quality and cost-effective new tools, in particular vaccines, medicines, diagnostics, surveillance, insecticides and vector control tools to prevent and control malaria and to collaborate on new approaches”.

Dr REYNDERS (Belgium), speaking on behalf of the European Union and its Member States, welcomed the draft strategy and the accompanying draft resolution.

Dr KAMALIAH MOHAMAD NOH (Malaysia) welcomed the draft strategy, which was in line with her country’s existing malaria elimination strategic plan. Malaysia had been providing training on integrated vector management to countries in the Western Pacific Region, including Pacific island States, and the South-East Asia Region, with the support of the Asian Collaborative Training Network for malaria, the Asia Pacific Malaria Elimination Network and WHO. The draft strategy should be adopted by the Health Assembly.

Dr CARBONE (Argentina) recalled that her country, with no indigenous case in the past three years, was in the process of being certified malaria-free. Changes in the disease’s epidemiology were of concern, and all States had to strengthen efforts towards elimination. She supported the three pillars and two supporting elements of the draft strategy, emphasizing the need for an integrated and holistic approach to health and ensuring universal access to malaria prevention and treatment. All sectors, not just health, had to make commitments to a vector-free environment and approach the disease from the point of view of the social determinants of health.

Dr ASSIRI (Saudi Arabia), speaking on behalf of the countries of the Gulf Cooperation Council, strongly supported the draft strategy, which provided the necessary framework for malaria elimination. In the Eastern Mediterranean Region his country and the Islamic Republic of Iran were on track to eliminate malaria, but some countries with endemic malaria had not chosen the disease as a priority for collaboration with WHO, a point that had to be addressed. Recent cross-border transmission had affected several countries in the Region, and he endorsed the proposal by the member for Suriname.

Dr ROA RODRIGUEZ (Panama) said that implementation of the draft resolution would help to reduce malaria in Member States. Panama was working with technical advisors from PAHO on a new strategic eradication plan to replace the 1956 national malaria eradication programme. Her country wished to cosponsor the draft resolution.

Dr GWENIGALE (Liberia) noted that WHO's technical role was to advise on certain diseases, yet other organizations such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Roll Back Malaria Partnership were working on, and raising money for, those same diseases. Would those and other similar organizations provide funding for WHO's activities or contribute to the response to the problem?

Dr BEJTJA (Albania) supported the draft strategy. The statement in the draft resolution that no country was free from the risk of malaria was pertinent for countries in south-eastern Europe, where cross-border imported cases had been recorded and the vector was present. More research was needed on the behaviour of the vector and the choice of insecticide to be used; often disease prevention had to be balanced against environmental protection. More human resources were needed for diagnosis, treatment and surveillance, and regional or international centres on tropical medicine should be implicated in their training.

Ms PENEVEYRE (Switzerland)¹ praised the consultative process on the draft strategy, which should be adopted by the Health Assembly. Malaria control activities had made unprecedented progress, but the gains had to be maintained and consolidated, and emerging challenges required new approaches and additional funding. The draft strategy provided a framework that enabled countries to adapt their national programmes to their local epidemiological situations and to identify the resources required for malaria elimination. Given the increasing incidence of resistance to medicines and insecticides, her country would continue to support research and development of new methods of prevention, diagnosis, treatment and epidemiological surveillance, encouraging their integration into national health systems. A strengthened community role was essential in ensuring the access of poor and marginalized populations to surveillance, prevention, diagnosis and treatment, but required a better analysis of the social, economic and environmental determinants of health.

Dr MOSCATO (Italy)¹ noted the progress made in reducing the global malaria burden through synergies between international and national efforts, and the increase in related funding. Malaria control and elimination programmes were helping many countries to meet targets under Millennium Development Goals 4 (Reduce child mortality) and 6 (Combat HIV/AIDS, malaria and other diseases), but many cases and deaths were still being reported. She endorsed the draft resolution. The reintroduction of malaria was a threat in parts of Europe owing to increased population mobility. The new targets in the draft strategy could be attained using existing cost-effective interventions and new tools being developed, but would require greater financial mobilization. The Secretariat should provide greater support to Member States to implement the draft strategy, for example by mobilizing the necessary human and financial resources at all levels of the Organization and reporting in detail on the impact of the assistance provided.

Dr SURIYA WONGKONGKATHEP (Thailand)¹ commended the draft strategy and draft resolution. Resistance of *P. falciparum* to artemisinin was emerging in the Greater Mekong subregion, and combating that was therefore the focus of collaborative efforts, with particular regard to strengthening border health systems. National and international elimination strategies should include political and financial commitments at all levels, and recognize the importance of primary health care for vulnerable populations, integrated health systems, and access to diagnostic tools, medicines and vaccines. He called on WHO and development partners to urge policy-makers to recognize the impact of malaria, promote country ownership, and include malaria elimination in national health systems. WHO should work to accelerate and increase the affordability of malaria vaccines and treatment.

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

Ms PALMIER (Canada)¹ agreed that the Health Assembly should endorse the draft strategy, which was in line with her country's approach and its commitment to supporting prevention and treatment, particularly for those most vulnerable to malaria. She welcomed the emphasis on data-driven programme development under pillar 3 of the draft strategy and supported the ongoing search for innovative financing models for its implementation.

Mr PRAKASH (India)¹ commended the draft strategy. Although national strategies should be tailor-made, intersectoral collaboration on vector control was essential. Asymptomatic human reservoirs of plasmodia had to be tackled, and Member States had to ensure full treatment coverage. In the face of resistance of *P. falciparum* to artemisinin, the Government had already replaced treatment using artesunate-sulfadoxine-pyrimethamine combinations with artemether-lumefantrine in north-eastern states and had strengthened surveillance and early detection; bivalent diagnostic kits had proved very useful. Insecticide resistance was another major concern. Successful vector control should not lead to a decrease in the number of entomologists, as their work was vital for other diseases, especially in view of climate change. Anti-malaria programmes required ongoing financial support in order to achieve the ambitious targets set out in the draft strategy. Referring to paragraph 48 of the draft strategy, he took it that artemisinin combination therapy should be used only for those patients with uncomplicated *P. falciparum* malaria, not for every case of uncomplicated malaria. His country wished to sponsor the draft resolution.

Mr MEUNIER (France)¹ welcomed the draft strategy. France remained committed to malaria control and eradication, supporting efforts to fight resistance on several continents. The identification of a marker of resistance to artemisinin by French researchers was a significant step that would allow monitoring of trends. France provided financial support to international funding mechanisms in order to promote universal access to malaria prevention and treatment and the development of innovative and more effective tools. Diagnostic testing was essential for malaria and other illnesses, particularly where initial symptoms could be similar. The outbreak of Ebola virus disease had demonstrated the importance of universal access to prevention, diagnosis and treatment. The link between climate change and malaria should be given more emphasis in both the draft strategy and the draft resolution.

Mr KÜMMEL (Germany)¹ welcomed the draft strategy and its three pillars, which included equal access, country ownership and community and private sector involvement. The importance of an integrated approach should be emphasized under pillar 1, in order to ensure synergies with other health interventions without duplicating work. Pillar 2 should take into account the human and environmental side effects of chemicals used in vector control, and stress integrated vector management within social and health systems. Under supporting element 2, cooperation with the education sector should be prioritized as schoolchildren were central to changing attitudes and behaviours.

Ms RUIZ VARGAS (Mexico),¹ noting that her country had met the malaria targets set by the Health Assembly for 2015, endorsed the draft strategy, which provided a framework for national elimination programmes. Progress towards a malaria-free world was not a series of independent phases, but a continuous process, and required stratification of risks and interventions.

Dr EL BERRI (Morocco)¹ commended the relevance of the draft strategy. His country had been free of locally acquired cases of malaria since 2005, but the potential for reintroduction existed owing to increased migration and cross-border travel. A national strategy developed in 2011 to prevent reintroduction focused on surveillance, prevention, and integrated vector management.

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

Mr HADIA IHMAIDAT (Libya)¹ said that the lack in his country of simple and effective malaria diagnostic tools and basic medicines had led to high mortality rates. The WHO Model List of Essential Medicines failed to include anti-malaria medicines. He asked for Libya to be reclassified in order to qualify for additional assistance from WHO.

Mrs ADAM (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, said the draft strategy focused too narrowly on vertical programmes, despite WHO's past recognition of their shortcomings. The draft strategy should emphasize health system strengthening to ensure effective and comprehensive primary health care services for malaria diagnosis, treatment and vector control. Current malaria strategies did not address the social determinants of the disease, particularly in rural and poor communities. Integrated vector management did not feature prominently in WHO's Global Malaria Programme or the Roll Back Malaria Partnership's action plan, and the risk of creating opportunities for other vectors through reliance on vector control without broad development strategies needed evaluation.

Dr NAKATANI (Assistant Director-General) welcomed the support for the draft strategy. Responding to comments by Member States, he recognized the importance of surveillance and focused investment in eliminating malaria. Those elements were contained under pillar 3 of the draft strategy. Cross-border collaboration and political commitment to combat cross-border transmission were essential, as referred to in paragraph 58 of the draft strategy. Integrated vector control would ensure that investments were used efficiently and effectively. Paragraph 97 of the draft strategy referred to the need to train sufficient human resources, which he agreed included in particular entomologists. The Secretariat intended to review the draft strategy every five years, as malaria research and development included work on a vaccine and investment in new insecticides.

With regard to financial resources, WHO was working with the Roll Back Malaria Partnership on a second global malaria action plan, and was investigating global resources requirements and the foci for future malaria investment. Such partnerships on malaria had been effective in the past and would continue to be so. The Secretariat would present a budget request for a proportion of the total expenditure, as other income would come from domestic financing and official development assistance. With regard to WHO's relationship with other stakeholders in combating malaria, in simplified terms, the Roll Back Malaria Partnership worked to increase political support in donor and endemic countries and the Global Fund to Fight AIDS, Tuberculosis and Malaria purchased commodities at the recommendation of the Secretariat and Member States. He had noted the proposal to create practical links with the education sector, which would be taken into account when the draft strategy was being implemented.

The DIRECTOR-GENERAL emphasized integrated disease surveillance and agreed on the need for better use of resources through the integrated disease surveillance mechanism, citing the example of its application for poliomyelitis. Strong primary health care systems and integrated vector management were vital in the effective and timely treatment and control of malaria and would remain the focus of WHO's efforts. Regarding the question about the funding of and relationship between the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Roll Back Malaria Partnership and WHO, she stressed that each organization had its own roles and responsibilities, but would often share information or resources. WHO was not an implementing agency; it developed guidelines and supported countries to build national capacity, the guidelines being used by the Global Fund for its assessments of country programmes. The Roll Back Malaria Partnership was an important advocacy mechanism, raising funds and political attention. All three organizations would continue to collaborate closely in order to provide the best response to combating malaria.

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

The resolution, as amended, was adopted.¹

Dengue: prevention and control: Item 9.2 of the Agenda (Document EB136/24)

Mr SEY (Gambia), speaking on behalf of the Member States of the African Region, said that, even though reporting was poor, 22 of them had recorded cases or outbreaks of dengue in recent years. Although most reported cases were of acute febrile illness, there were concerns that the rate of haemorrhagic complications would increase – a particular risk in countries with weak health systems. Countries in the Region had made some progress towards combating the disease, but the main challenge remained rapid detection and early diagnosis of cases of dengue in order to facilitate implementation of preventive measures. A multisectoral approach, including surveillance and monitoring, must form part of the response to neglected tropical diseases and priority should be given to vector control. As trials of dengue vaccine were at an advanced stage, high-burden countries should be assisted in gaining access to supplies.

Dr KAMALIAH MOHAMAD NOH (Malaysia) outlined the worsening dengue situation in Malaysia, where the clinical spectrum had shifted to a more severe disease. The health system was being severely stretched in the face of prolonged outbreaks and lacked effective tools and resources, despite community empowerment and political support at the highest level.

Dr ASSIRI (Saudi Arabia), speaking on behalf of the Member States of the Eastern Mediterranean Region, confirmed that dengue was an emerging disease in the Region, with repeated outbreaks in urban centres and vectors expanding into rural areas. Coordinated efforts by governments, international organizations and other partners would be required to accelerate implementation of the global strategy, and local communities must be actively engaged in prevention and control initiatives. He called for renewed global commitments to dengue prevention and control. The recommendations of the Strategic Advisory Group of Experts on immunization on the public health potential of the dengue fever vaccine must be implemented.

Mr. VARGA (Croatia) said that the transmission of dengue had increased significantly in urban and semi-urban areas and Europe faced the serious threat of possible outbreaks of dengue as well as other vector-borne diseases such as chikungunya and West Nile fever. He cited climate change and its impact on health as additional reasons to tackle emerging health threats linked to neglected tropical diseases. He called for WHO's assistance and support to build national capacities in order to raise public awareness, implement preventive measures, detect cases and treat patients suffering from vector-borne illnesses.

Dr BARBOSA DA SILVA (Brazil) said that integrated dengue control programmes were required to mobilize public and private partners and local communities. Progress achieved through implementation of the global strategy should be closely monitored in order to identify obstacles and share good practices internationally. Primary health care should be integrated in national dengue responses in order to facilitate rapid detection of severe cases and provide appropriate care. Strategic partnerships needed to be promoted to encourage more initiatives on vaccine development and new tools such as biological vector control. Vulnerable countries needed to be prepared for outbreaks of chikungunya, which was transmitted by the same vectors.

¹ Resolution EB136.R1.

Dr CHANG Jile (China) said that the number of dengue cases had risen sharply in China, particularly in 2014, posing significant prevention and control challenges. His Government had strengthened its monitoring and reporting mechanisms in response and would further improve its vector control strategies.

Dr EERSEL (Suriname) said that the Caribbean region, including Suriname, had recently experienced its first epidemic of chikungunya, which was spreading across Central and South America and caused a high incidence of chronic arthritis in infected patients. The spread of the *Aedes* vector of both dengue and chikungunya to some 150 countries demanded urgent research into novel vector control strategies and vaccine development.

Mr WOLFE (United States of America) said that to attain the goals of the global strategy WHO should work with technical partners to update its guidelines for dengue diagnosis, treatment, prevention and control issued in 2009. Doing so would help countries to improve diagnosis, case management, integrated surveillance and sustainable vector control as set out in the global strategy.

Ms MEL'NIKOVA (Russian Federation) said that, although dengue was not endemic in her country, its global prevalence and the spread of its vectors demanded vigilance. She identified control measures that were necessary, including control of travellers from affected countries at points of entry and vector surveillance. Success of the global strategy depended on measures such as information campaigns, resource mobilization, partnerships and cooperation, monitoring and assessment.

Dr SHIMIZU (Japan) said that the reappearance of dengue in Japan in 2014 was part of a global trend in which an increasing number of infectious diseases were emerging and re-emerging as a result of globalization, changing climate, deteriorating environments, breakdown in public safety and antimicrobial resistance.

Dr GONZALES FERNANDEZ (Cuba) concurred with the need for health system strengthening, vector surveillance and research, including vaccine development. Local communities and primary health care workers had a vital contribution prevention and control of dengue, particularly through surveillance activities. *Aedes aegypti* was widespread in some cities in Cuba as a result of urbanization, trade and travel.

Mr RASHEED (Maldives), noting the changing epidemiology and poor reporting of dengue, said that the progress towards safe and effective vaccines needed measures to improve their accessibility in most-affected countries. The successful implementation of dengue programmes required multisectoral support at national level and international and regional collaboration. The global strategy provided a comprehensive framework for action, but achievement of collective goals needed better cooperation between Member States, the Secretariat and health partners.

Dr CARBONE (Argentina) asked for a precise definition of the concept of "sentinel sites" for the surveillance of dengue mentioned in the report. Constant surveillance throughout the year, even during inter-epidemic periods, was the best approach. Although the progress in vaccine development was welcome, optimism had to be tempered by two facts: in clinical trials the serotype 2 element of the vaccine was only 50% effective and the serotype 1 element barely more so, and the effectiveness of a vaccination programme would be determined by the cost of the vaccine. The prospect of an available vaccine should therefore not diminish work on social and environmental strategies to control *Aedes aegypti*. She concurred with the member for Cuba on the need for grassroots and community involvement and highlighted the proposals contained in paragraph 12(c) on basic operational and implementation research.

Dr ASADI-LARI (Islamic Republic of Iran) stressed the importance of preventing the emergence of dengue through strict vector control and research in that area. Vector control for dengue fundamentally differed from that for malaria, and health care workers engaged in vector control activities needed specific training in each. Increasing incidence rates of dengue in one country should alert its neighbours. Regulations governing international trade were needed to prevent the transfer of vectors or their dried eggs, and the preparation of guidelines would be valuable in that respect. Successful experiences of eradication of vectors, for example *Aedes aegypti* in the Region of the Americas, should be rapidly documented and widely disseminated. Rapid diagnostic tests with a high sensitivity and specificity, as well as a risk stratification map, would also be valuable.

Mr PRAKASH (India),¹ referring to the mention of insecticide-treated materials in paragraph 12(c) of the report, pointed out that, as the *Aedes* vector of dengue was diurnal, insecticidal bed nets, would be necessary only for use in hospitals or for people who slept during the day. In India, experience had shown that early diagnosis (with high sensitivity and specificity tests, included those for both antigen and antibody) and case management were crucial. The report could have drawn attention to those two tests and despite the importance of the timing of their use, namely, antigen tests during the first five days of illness and antibody tests subsequently.

Dr ATTAYA LIMWATTANAYINGYONG (Thailand)¹ said that shift in cases of dengue from children to adults warranted a re-appraisal of clinical classifications used around the world. She requested the Director-General to establish a working group to undertake a systematic review and prepare a harmonized classification, taking into account the practicability and usefulness of existing classifications in clinical management and research. That classification should be applicable in countries with differing health system capacities. In anticipation of the imminent availability of a vaccine, she urged the Secretariat to prepare guidelines for vaccine use in different epidemiological and health system contexts.

Dr SARIWATI (Indonesia)¹ described the actions her Government was taking to achieve the goals of the global strategy, including encouraging community involvement in the destruction of mosquito breeding sites at the household level. Such actions had reduced the annual number of cases, but the total number remained high, partly owing to the impact of climate change. She recommended promotion of multisectoral collaboration, education programmes and community involvement.

Ms RUIZ VARGAS (Mexico)¹ described some of the measures being taken in her country to reduce the incidence of dengue in line with WHO's call for a reduction of 20% by 2020, including integrated surveillance, community participation, vector control and planned use of the new vaccine when it became available. However, better coordination between different government sectors across the country and concerted action were needed. She called on WHO to provide effective leadership in tackling the disease.

Dr NAKATANI (Assistant Director-General) agreed that climate change was affecting vector-borne diseases, including dengue. WHO was working with partners, including national regulatory authorities, for review of the dengue vaccine. The regional offices for the Americas and South-East Asia were preparing guidelines on chikungunya; further advice would be sought from the Strategic and Technical Advisory Group on Neglected Tropical Diseases at a meeting in April about potential synergies in dealing simultaneously with dengue and chikungunya. The revision of the guidelines on dengue should be issued by the end of the year. The insecticide-treated materials referred to in paragraph 12(c) were curtains and window screens and did not include bed nets. With regard to diagnostics for early detection, rapid diagnostic kits were available. On the subject of classification,

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

the Secretariat was collecting evidence and would organize a meeting to discuss classification when sufficient information was available.

The Board noted the report.

Global Vaccine Action Plan: Item 9.3 of the Agenda (Document EB136/25)

Dr ALWOTAYAN (Kuwait), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that Member States needed to redouble their efforts in the face of poor vaccination coverage in some of the countries. The quality of immunization data needed improvement, with investment and input from independent technical advisory groups. Countries affected by civil unrest or natural disasters needed support from WHO and global strategies to continue to deliver immunization services. Countries hosting large numbers of refugees needed access to vaccines at affordable prices. The issue of affordability and availability of vaccines required further dialogue with manufacturers. She called for the convening of a side meeting for countries with low vaccination coverage during the Sixty-eighth World Health Assembly.

Dr MOHAMAD NOH (Malaysia) said that her Government would endeavour to achieve the five goals of the Global Vaccine Action Plan, with the proviso that the introduction of new and improved vaccines should be country-specific. Although its adherents were small in number, the anti-vaccine lobby was powerful and effective. Hence, good communication strategies promoting vaccination should be part of the Action Plan.

Dr KUPA (Democratic Republic of the Congo), speaking on behalf of the Member States of the African Region, said that vaccination coverage was failing to meet targets. Coverage rates were low and the introduction of new vaccines had been slow. The outbreaks of Ebola virus disease had disrupted vaccination programmes in both the affected and neighbouring countries. Nevertheless, there had been some remarkable achievements: no case of poliomyelitis had been reported during the past six months.

The Regional Office and regional vaccination experts had elaborated a regional strategic plan for the period 2014–2020. The challenges facing the Region included a lack of systematic vaccination programmes, weak health systems and inadequate financial resources. Measures to be taken included putting in place at country level mechanisms for coordinating the work of partners; the physical and functional rehabilitation of health systems with competent health care staff; capitalizing on successful initiatives such as that for polio eradication; and mobilization by Member States of financial resources.

Mr VARGA (Croatia) expressed support for both the global and the European vaccine action plans. Shortages of certain vaccines had adversely affected immunization programmes in some European countries, including Croatia. Uptake had also suffered as a result of the actions of anti-vaccine groups. In that regard, WHO might consider strengthening its role as mediator between the vaccine industry and national immunization programmes.

Dr GONZALEZ FERNANDEZ (Cuba) noted the considerable progress since adoption of the Action Plan towards eradicating poliomyelitis and controlling measles, rubella and neonatal tetanus. However, ensuring vaccine accessibility and safety remained a problem. The national immunization programme in Cuba had aimed at eliminating poliomyelitis, diphtheria, measles, rubella, neonatal tetanus and hepatitis B. In order to reach the goals set out in the Action plan, it was vital to enlist the support of entities in both the private and public sectors, focus on hard-to-reach areas, exchange best practices, and secure political commitment and financial resources.

Dr CHANG Jile (China) commended the Secretariat's work on the Global Vaccine Action Plan. He welcomed the 2014 Assessment Report by the Strategic Advisory Group of Experts on immunization, with its description of progress made and the difficulties encountered. As it had emerged that greater cooperation was needed between Member States and regions in sharing technical information and results, the Secretariat should reinforce its technical support and mobilize more resources in order to support developing countries and those with large populations to promote the use of new high-quality, low-cost vaccines. A precondition for the participation of civil society organizations in vaccination services should be that they abide by national legislation. It was inappropriate for WHO to establish uniform rules.

Mr COTTERELL (Australia) welcomed the focus on improving global immunization rates; that would be an important indicator of WHO's performance at country level. He expressed doubts about the sustainability of vaccine financing and encouraged WHO to prioritize sustainable funding in its dialogue with countries on immunization. He broadly supported the recommendations of the Strategic Advisory Group of Experts on immunization, and called for technical assistance to be provided to countries with routine vaccination coverage of less than 80% and urged WHO, in collaboration with UNICEF, to review and strengthen the support provided for routine immunization in the Pacific region, where immunization rates remained worryingly low.

Dr AMMAR (Lebanon) said that assessing the progress in implementing the Action Plan was central to the monitoring, evaluation and accountability process. Health ministers of countries with low immunization coverage rates should share their concerns with the WHO regional offices in order to enhance accountability, overcome obstacles and fill funding gaps. The proposal of the Strategic Advisory Group of Experts on immunization for the convening of an informal meeting during the forthcoming Health Assembly was welcome, but more immediate efforts must be made to repair the catastrophic effects of the conflict in the Syrian Arab Republic on children's immunization. The financial burden of providing vaccines to displaced Syrians in Lebanon had become untenable and the high price of vaccines combined with increased needs was delaying the introduction of pneumococcal, rotavirus and hepatitis A vaccines into the Lebanese national vaccine schedule. He called on WHO to increase the assistance and support it provided during armed conflicts so as to counteract the devastating effects on health and immunization coverage.

Dr FRIEDEN (United States of America) said that progress made towards eradicating poliomyelitis in Africa (no case in more than six months) and the Middle East (no case in more than nine months) must be backed up by intensive surveillance. The heavy burden of the disease in Pakistan (85% of the world's cases) must be reduced; not to do so would waste US\$ 1000 million in annual contributions to global polio eradication programmes. Preparations for withdrawal of oral polio vaccine type 2 by the end of 2015 must be complete. Priority must be given to strengthening routine immunization programmes which provide the basis for ensuring eradication and optimizing the impact of the inactivated poliovirus vaccine, due to be introduced by the end of 2015.

Ms MEL'NIKOVA (Russian Federation) underlined the need for WHO to monitor systematically progress made towards achieving global immunization targets and provide feedback on the success of national immunization action plans. In that regard, accurate data on immunization coverage and surveillance were essential. Lack of sustainable and predictable funding remained a major obstacle to the achievement of the Action plan's objectives, particularly for low-income countries. Her country, for its part, had made significant contributions to strengthening the national immunization programmes in the Commonwealth of Independent States. She urged WHO to establish robust mechanisms for providing additional assistance for national immunization programmes during emergency situations, such as epidemics, civil unrest and natural disasters.

Dr ASADI-LARI (Islamic Republic of Iran) said that multisectoral national immunization technical advisory groups should assume responsibility for monitoring and evaluating the national vaccine action plans. Stronger regional advisory groups could help countries in this regard. Priority should be given to reaching disadvantaged groups in order to improve routine immunization coverage rates; his country had given that a high priority. He called on WHO and other international organizations to strengthen their decision-making mechanisms for rapid response vaccination campaigns (especially for measles and poliomyelitis), to increase their provision of technical and financial support to high-burden countries and to ensure that immunization activities continued during complex emergencies.

Ms ROA RODRIGUEZ (Panama) said that her country had implemented numerous policies and enacted legislation to meet the Action Plan's objectives and had introduced the latest vaccines into its routine immunization programme for all age groups and sectors of the population. WHO should concentrate its efforts on supporting Member States that were facing problems in raising their rates of vaccination coverage.

Mr KIM Chang Min (Democratic People's Republic of Korea) said that his country had made significant progress towards increasing national coverage for routine vaccines under the Expanded Programme on Immunization and had added several new vaccines to its national vaccination schedule. He expressed concern, however, at the affordability of vaccines. Continued global assistance would be required to guarantee immunization coverage in low-income countries and prevent any reoccurrence of previously eradicated diseases. He therefore urged WHO to address the issue of vaccine availability and affordability at the earliest possible opportunity.

Dr BARBOSA DA SILVA (Brazil) expressed support for the recommendation by the Strategic Advisory Group of Experts to improve the quality of data on immunization coverage and surveillance. His country remained committed to implementing the Action Plan and he welcomed the efforts of the GAVI Alliance to guarantee universal access to vaccines in the Region of the Americas.

Dr CARBONE (Argentina), outlining her country's immunization achievements, said that vaccines were acquired for the entire population through either PAHO's Revolving Fund, which provided the lowest price on the market, or public tenders. Although centralized mechanisms for purchasing vaccines such as the Revolving Fund were crucial, the inflexibility of certain suppliers had led to vaccine shortages in some countries, compelling them to buy on a decentralized basis so as not to jeopardize universal immunization coverage.

Ms CORLUKA (Canada)¹ expressed concern that countries were failing to reach targets for reducing preventable child mortality. She asked WHO how donors could ensure the successful realization of the recommendations by supporting stakeholders. She requested that future global vaccine action plans should highlight the priorities, risks and mitigation measures for the forthcoming year and address improved access to affordable medicines. She also requested clarification of the extent to which efforts to implement the Global Vaccine Action Plan were tied to overall activities to strengthen the health system, how the Action Plan tackled tiered pricing in order to secure the lowest possible vaccine prices, the leadership roles of key stakeholders involved in its implementation, and whether dedicated funds would be set aside for implementing the recommendations.

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

Mr MATUTE HERNANDEZ (Colombia)¹ said that his country had been expanding its vaccination programmes in recent years and had been certified as free of endemic transmission of measles, rubella and congenital rubella syndrome. All programmes were entirely financed from the State budget and conformed to WHO's recommendations. Expressing concern that vaccines accounted for a large proportion of the general health care budget, he requested that due attention be paid to the recommendation by the Strategic Advisory Group of Experts on the transparency of information on vaccine pricing and supply. He also asked WHO to invite the PAHO Revolving Fund and other relevant regional entities involved in global vaccine distribution to the proposed side meeting for countries with routine vaccination coverage of less than 80% during the next World Health Assembly.

Dr ATTAYA LIMWATTANAYINGYONG (Thailand)¹ requested WHO and development partners to help countries to strengthen both management of immunization programmes and human resources for immunization at all levels, as many countries faced shortages of immunization personnel. She called on WHO and development partners to support that work and initiatives to boost financial sustainability and access to immunization, for instance through the expansion of vaccine-production capacities in developing countries.

Ms RUIZ VARGAS (Mexico)¹ said that universal vaccination coverage was a priority in her country and a key element of the strategy to reduce child mortality. Mexico had introduced new vaccinations into its immunization programme – one of the largest universal and free vaccination programmes in the Americas.

Mr KÜMMEL (Germany)¹ agreed with the assessment report's conclusions, in particular the recommendation regarding fully integrating vaccination into all aspects of the health care system and to reduce missed opportunities to vaccinate. Vaccination was one of Germany's health priorities for the Group of 7 summit scheduled to be held in June 2015. A GAVI Alliance replenishment conference was due to be held in Berlin the next day to mobilize an additional US\$ 7500 million to ensure that more children in the poorest countries had access to the standard vaccinations recommended by WHO.

Mr HADIA IHMAIDAT (Libya)¹ said that his country was wracked by basic infrastructural problems; it struggled to implement the Action Plan. The supply of several vaccines had dried up four weeks previously, the south of the country was largely inaccessible, transportation in the country was not safe, there was no Internet and reporting was hindered by poor communication lines. What could WHO do to assist? Did the country have to wait for poliovirus to arrive?

Ms ERNOULT (Médecins Sans Frontières International), speaking at the invitation of the CHAIRMAN, said that a recent report confirmed that overall prices of vaccines were rising astronomically.² Countries losing eligibility for donor support from the GAVI Alliance would face significant difficulties in affording vaccines and potentially tough decisions on which vaccines to exclude from national programmes. Member States should make vaccine price information available to WHO and technical partners and advocate prioritizing vaccination in humanitarian emergencies, more affordable new vaccines and access by humanitarian organizations to the lowest global prices.

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

² Médecins Sans Frontières Access Campaign. The right shot: bringing down barriers to affordable and adapted vaccines. Geneva: MSF, 2nd edn, 2015 (http://www.msfaccess.org/sites/default/files/MSF_assets/Vaccines/Docs/VAX_The_Right_Shot_Report_2ndEd_2015.pdf).

Mrs MARTINS (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, said that the domination of vaccination assistance by the GAVI Alliance perpetuated the vertical programmatic approach to global health priorities. Although the Strategic Advisory Group of Experts on immunization had recommended that the Action Plan's secretariat agencies should seek help from participants at the World Economic Forum to implement the Action Plan, such support would entrench that vertical approach. The proposal for greater formal involvement by civil society organizations in the delivery and improvement of vaccination services would further disintegrate primary health care systems.

The assessment report included no reference to comprehensive primary health care, social determinants of health, or an assessment of the scope of support for technology transfer, local production and pooled regional procurement as core actions to make vaccines more affordable. The opportunity cost of introducing new vaccines should be measured in terms of the costs of failing to meet health outcomes.

Mr AQIL JEENAH (International Pharmaceutical Students' Federation), speaking at the invitation of the CHAIRMAN, said that WHO should prioritize demystifying the subject of vaccination for the general population. Similarly, given increasing outbreaks of vaccine-preventable diseases in developed countries, he questioned why some developed countries with means had not implemented mandatory vaccination programmes.

Ms BIGGER (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that achieving immunization goals required an enabling environment conducive to technological innovation. She encouraged the continued progressive transition from support of the GAVI Alliance towards fully self-sufficient and evidence-based immunization programmes based on the unique needs of the country. Although many countries had made immunization a priority, it was ultimately a shared responsibility to reach the 20% of children worldwide who were not immunized. The role of research-based vaccine manufacturers was to create new solutions for preventing the spread of diseases.

Ms LAMAZIÈRE (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, expressed concern at the limited progress towards immunization targets set for 2015. Immunization was arguably the simplest essential health service to provide, as it did not require staff to be within permanent reach of communities and did not need to be provided as urgently as some treatment services. The recent focus on fundraising for the GAVI Alliance represented only one part of the immunization world, as nearly all vaccine costs were covered by taxes and public spending. Immunization was the flagship of universal health coverage and, provided that there was political will, the guarantee of universal essential vaccinations would represent a further step towards essential health services for all.

Dr OKWO-BELE (Department of Immunization, Vaccines and Biologicals) said that, although WHO had made great progress towards poliomyelitis eradication, completing the task remained a distant goal, particularly in Pakistan. Headway had also been made to reduce measles mortality in some regions, such as the Region of the Americas, but other regions had experienced delays. Further effort was required if regions were to be certified as measles-free. WHO fully supported the view of immunization as an integral part of primary health care and the need to step up cooperation to improve service delivery. Taking note of the methods used by Argentina and Cuba to secure universal immunization, WHO was working with partners to ensure vaccine affordability for middle-income countries not covered by the GAVI Alliance at the next meeting of the Strategic Advisory Group of Experts on immunization. Although the costs of a solid global platform to facilitate access to vaccines among middle-income countries would not be as high as for countries covered by the GAVI Alliance, WHO would require additional funding from governments and development partners.

Turning to immunization during humanitarian emergencies, he said that guidelines already existed and would be disseminated to affected countries, although capacity would also need to be built in order to facilitate their implementation. With regard to the facilitation of access to vaccines in Libya, owing to the complexity of the country's situation, the Secretariat would contact the Libyan delegation individually through the Regional Office. WHO considered anti-vaccination groups to be a matter of serious concern. Guidance would soon be disseminated to help each country facing such opposition to understand the reasons vaccines were refused and devise tailored responses.

The Board took note of the report.

The meeting rose at 18:15.

THIRD MEETING

Tuesday, 27 January 2015, at 09:00

Chairman: Mr M.H. SHAREEF (Maldives)

1. STAFFING MATTERS: Item 14 of the Agenda

The meeting was held in open session until 10:20, when it resumed in public session.

Appointment of the Regional Director for Africa: Item 14.1 of the Agenda (Document EB136/43)

At the request of the CHAIRMAN, Mr JEON Man-bok (Republic of Korea), Rapporteur, read out the following resolution adopted by the Board in open session:¹

The Executive Board,

Considering the provisions of Article 52 of the Constitution of the World Health Organization;

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

1. APPOINTS Dr Matshidiso Rebecca Moeti as Regional Director for Africa as from 1 February 2015;
2. AUTHORIZES the Director-General to issue to Dr Matshidiso Rebecca Moeti a contract for a period of five years from 1 February 2015 subject to the provisions of the Staff Regulations and Staff Rules.

The CHAIRMAN congratulated Dr Matshidiso Rebecca Moeti on her appointment and conveyed the Board's best wishes for her success in her post.

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

Dr MOETI (Regional Director-Elect for Africa) thanked the Executive Board for trusting her to lead the African Region and pledged to work together with Member States to make better health for all in Africa a reality. As the daughter of two physicians in a township in Johannesburg during apartheid, she had, from an early age, been acutely aware of the need for justice and equity in health. During a lengthy career in the health system in Botswana, followed by posts with UNICEF, UNAIDS and WHO, she had witnessed considerable progress in public health in Africa. Many challenges remained, however, as the recent outbreak of Ebola virus disease had demonstrated. She welcomed the bold and comprehensive resolution adopted by the Executive Board on that issue at its third special session.² Efforts to overcome the outbreak must focus not only on identifying chains of transmission, treating

¹ Resolution EB136.R2.

² Resolution EBSS3.R1.

all cases and reaching a zero incidence rate, but also on providing the technical support and advocacy required to rebuild the systems destroyed by the epidemic.

As Regional Director, her priorities would include improving health security by strengthening preparedness and response to epidemic-prone communicable diseases, taking the lessons learnt from the Ebola virus disease outbreak. She would emphasize the importance of upholding commitments under the International Health Regulations (2005) and maintaining international solidarity in order to reduce collective vulnerability in an interconnected world. She also intended to pursue fundraising efforts for the African Public Health Emergency Fund and would take concerted action to promote equity in health care, robust and resilient national health systems, and universal health coverage in the Region. She would endeavour to ensure that work to attain the Millennium Development Goals was concluded, while pursuing the post-2015 sustainable development agenda. In that regard, particular attention would be paid to noncommunicable disease prevention, and tackling the social determinants of health. With regard to reform, she hoped to fast track certain areas, such as the improvement of recruitment and performance management practices in order to improve transparency and accountability. She expressed determination to ensure financial accountability to Member States. She acknowledged the strong foundations for progress, upon which she pledged to build, which had been laid by her predecessors.

The DIRECTOR-GENERAL congratulated Dr Moeti on her appointment and assured her of her full support. Dr Chan urged all Member States to support Dr Moeti's efforts to deliver on the promises made in her manifesto, in a spirit of solidarity with Africa. She looked forward to working with Dr Moeti to fulfil their joint commitment to serve the Organization.

Congratulations to Dr Moeti were also expressed by Ms MATSOSO (South Africa) on behalf of the Member States of the African Region, Mr MISKINS (Lithuania) on behalf of the Member States of the European Region, Dr NCHABI KAMWI (Namibia), Professor OMI (Japan), Dr FRIEDEN (United States of America), Dr REN Minghui (China), Dr ASADI-LARI (Islamic Republic of Iran) on behalf of the Member States of the Eastern Mediterranean Region, Dr GONZÁLEZ FERNANDEZ (Cuba), Mr SHAREEF (Maldives) on behalf of the Member States of the South-East Asia Region, Dr CARBONE (Argentina), Dr BARBOZA DE SILVA (Brazil), Mr BOWLES (Australia), Mr JEON Man-bok (Republic of Korea) and Ms ROA RODRIGUEZ (Panama).

Expression of appreciation to the outgoing Regional Director for Africa

At the invitation of the CHAIRMAN, Mr JEON Man-bok (Republic of Korea), Rapporteur, read out the following resolution adopted by the Board in open session:¹

The Executive Board,

Desiring, on the occasion of the retirement of Dr Luis Gomes Sambo as Regional Director for Africa, to express its appreciation of his services to the World Health Organization;

Mindful of his lifelong devotion to the cause of international health, and recalling especially his 10 years of service as Regional Director for Africa;

Recalling resolution AFR/RC64/R2, adopted by the Regional Committee for Africa, which designates Dr Luis Gomes Sambo as Regional Director Emeritus,

1. EXPRESSES its profound gratitude and appreciation to Dr Luis Gomes Sambo for his invaluable contribution to the work of WHO;

¹ Resolution EB136.R3.

2. ADDRESSES to him on this occasion its sincere good wishes for many further years of service to humanity.

The DIRECTOR-GENERAL expressed her appreciation to Dr Sambo and acknowledged the remarkable progress in health in the African Region during his 10-year tenure, particularly with regard to reducing infant and child mortality from diseases such as malaria, measles and poliomyelitis. The end of his mandate as Regional Director for Africa was not synonymous with the end of his service to public health in Africa, and she wished him every success in his future endeavours.

Her sentiments were echoed by Ms MATSOSO (South Africa) on behalf of the Member States of the African Region, Dr NCHABI KAMWI (Namibia), Professor OMI (Japan), Dr REN Minghui (China), Dr ASADI-LARI (Islamic Republic of Iran) on behalf of the Member States of the Eastern Mediterranean Region, Dr GONZÁLEZ FERNANDEZ (Cuba), Mr SHAREEF (Maldives) on behalf of the Member States of the South-East Asia Region, Dr CARBONE (Argentina), Dr BARBOZA DE SILVA (Brazil), Mr BOWLES (Australia), Mr JEON Man-bok (Republic of Korea) and Ms ROA RODRIGUEZ (Panama).

Dr SAMBO (Regional Director for Africa) recalled the political changes that had occurred since he had first attended a session of the Board as a young medical doctor in January 1978: some African States had yet to become free nations while others were adjusting to independence. The allocation for the African Region in the programme budget had risen from US\$ 101 million in the biennium 1978–1979, representing some 55% of the regular budget, to US\$ 1300 million (or less than 20% of the regular budget) in the current biennium. In 1978, the extremely high communicable disease burden from measles, poliomyelitis and pertussis, among others, had severely impacted well-being and productivity in African countries.

At that session in 1978, the Board had discussed WHO's role at the country level and its contribution to the International Drinking Water Supply and Sanitation Decade (1981–1990). The Board had expressed concern about malaria in sub-Saharan Africa, a situation that had received little attention from the world community, but one which had remained on the agenda of the Board to the present day. He had been inspired by the speeches of the then Director-General, Dr Mahler, and had been persuaded by the Regional Director for Africa at that time, Dr Quenum, to focus on public health. The substantial progress in health development in Africa, including a reduction in the disease burden and improved maternal health and child survival, had been strongly influenced by the Millennium Development Goals. The fact that there had been no reported case of poliomyelitis in the African Region in the previous six months was an indication of the significant strides made in combating the disease and illustrated the tangible results that were possible when the international community recognized public health priorities and committed sufficient resources to them.

Despite best efforts in the Region, outbreaks of the Ebola virus disease had continued to occur in Africa since 1976, linked to social, cultural and behavioural factors. The current outbreaks had exposed the weak components in national health systems and brought to light global inequalities in health, underlining the need for WHO to have greater capacity to respond to global health threats. The epidemic had also provided a learning opportunity for global health partners, national governments and communities, as highlighted by the special session of the Executive Board on Ebola. He paid tribute to all health workers who had given their lives to save others and to all health workers still involved in the Ebola response operations in West Africa, and expressed appreciation of the help received from international partners.

Thirty-seven years after his first contact with the Board, many public health problems persisted and new ones had emerged. A holistic response provided the best way to address the broad and complex African health agenda. African States must invest much more in health system reforms in order to increase resilience to fast-changing environments, and international health partnerships and financing must also provide more support. He sincerely congratulated his successor, Dr Moeti, and thanked the dedicated and talented colleagues who had supported him. It had been an honour and a

pleasure to serve as Regional Director for Africa and he would continue to make his contribution for the health of humankind.

Appointment of the Regional Director for Europe: Item 14.2 of the Agenda (Document EB136/44)

At the request of the CHAIRMAN, Mr JEON Man-bok (Republic of Korea), Rapporteur, read out the following resolution adopted by the Board in open session:¹

The Executive Board,

Considering the provisions of Article 52 of the Constitution of the World Health Organization;

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

1. REAPPOINTS Ms Zsuzsanna Jakab as Regional Director for Europe as from 1 February 2015;
2. AUTHORIZES the Director-General to issue to Ms Zsuzsanna Jakab a contract for a period of five years from 1 February 2015, subject to the provisions of the Staff Regulations and Staff Rules.

The CHAIRMAN congratulated Ms Jakab on her reappointment, and conveyed the Board's best wishes for her continued success in the Region.

Ms JAKAB (Regional Director for Europe) thanked the Executive Board and the Member States of the European Region for the trust and confidence they had placed in her in appointing her for a second term and assured them that she would continue to work hard to meet the needs of the Region. Although good progress had been made in several areas during her first term, challenges remained, in particular with respect to health inequalities. She drew attention to the new European health policy framework, Health 2020, which provided for whole-of-government, whole-of-society and health-in-all policies approaches. She also underscored the importance of multisectoral collaboration in order to address all determinants of health, promote the achievement of universal health coverage, and strengthen integrated, coordinated, people-centred health care.

Over the next five years, the strong focus on noncommunicable diseases would continue, with a view to building on the results already achieved, for example in the reduction of cardiovascular disease, and attaining some of the global targets by 2025. As some 80% of premature mortality was preventable, the Region stood to achieve a huge health gain by addressing the underlying causes, particularly inequity. With respect to communicable diseases, tuberculosis and HIV would remain priorities, as would the establishment of a harmonized surveillance system for antimicrobial resistance, particularly in countries in the eastern part of the Region. Good progress had been made towards the elimination of malaria. The Region would continue its work on vector-borne diseases. The European Vaccine Action Plan 2015–2020 provided a framework for immunization to control vaccine-preventable diseases, which were a big challenge for the Region. She was pleased to report that, over the previous year, the Region had retained its poliomyelitis-free status.

The economic crisis had impacted health and health systems, thus emphasizing the importance of health systems strengthening and efforts to strengthen the population-based dimension of public health. The Regional Office had undertaken substantial work in response to the increased demands from Member States for WHO's support. Health security and building the core capacities required by the International Health Regulations (2005) remained high priorities. The Regional Office would

¹ Resolution EB136.R4.

continue to support the global response to the Ebola virus disease outbreak and would assess and strengthen preparedness across the Region. The European Environment and Health Process (2010–2016) served as a good model for working across sectoral boundaries and continued to yield positive results.

The European Region was playing an important role in the WHO reform process. It had immediately implemented decisions taken by the governing bodies, and contributed new initiatives. She drew attention to the good progress made on governance issues, noting, in particular, the development of a rolling agenda, which enabled the Regional Committee for Europe to take a medium- and long-term view on agenda items. The management and administration of the Regional Office had been strengthened for increased efficiency, transparency and accountability, and its financial sustainability had been improved.

The DIRECTOR-GENERAL welcomed the reappointment of Ms Jakab, which was clear confirmation of the Regional Director's excellent leadership. In the light of Ms Jakab's track record, there was no doubt that she would deliver on her mandate. Ms Jakab was a dynamic member of the Global Policy Group, established in 2007 as a forum through which the seven major offices could act collectively to translate into actions the policies and directions set by Member States.

As elected officials, the Director-General and regional directors were accountable to Member States, and must be able to explain exactly how funds were used, and the linkage between resources, activities and results. Member States should hold the Secretariat to account, and vice versa. The Organization belonged to its Member States; they should behave like shareholders, not visitors. Member States' engagement with the Organization had increased dramatically in recent years, and she hoped that it would continue to do so.

Congratulations were also expressed by Mr VARGA (Croatia) on behalf of the Member States of the European Region, Dr AKSEL'ROD (Russian Federation), Dr GRABAUSKAS (Lithuania), Mr SHAREEF (Maldives) on behalf of the Member States of the South-East Asia Region, Ms ROA RODRIGUEZ (Panama), Dr AMMAR (Lebanon), Dr NCHABI KAMWI (Namibia) on behalf of the Member States of the African Region, Mr CASALS ALÍS (Andorra), Dr CARBONE (Argentina), Dr REYNDERS (Belgium), Dr BEJTJA (Albania), Mr BOWLES (Australia), Ms MATSOSO (South Africa), Dr BARBOZA DE SILVA JÚNIOR (Brazil), Mr KOLKER (United States of America), Dr ASADI-LARI (Islamic Republic of Iran) on behalf of the Member States of the Eastern Mediterranean Region, and Mr ADHIKARI (Nepal).

Dr FRIEDEN (United States of America), pledging continued support for WHO including intensive Government-wide effort to control Ebola and build strong health systems, said that drastic improvements were needed to support countries to realize ambitious plans.

Human resources management was the single most important element of WHO reform and essential to ensure that the Organization was fit for purpose. Without any reference to the candidates appointed that day, he stressed that WHO reform examine the process for the selection of regional directors to ensure that the best people were chosen on the basis of merit.

Ms MATSOSO (South Africa), speaking on behalf of the Member States of the African Region, expressed concern at the previous speaker's comments, which appeared to question the competence of the newly appointed or reappointed regional directors. Any issues concerning reform should be raised under the appropriate agenda item.

Dr FRIEDEN (United States of America) emphasized that his comments had been meant in a general context and apologized if it had been understood that he was casting doubt on the suitability of the newly appointed or reappointed regional directors, both of whom had the full support of Member States.

2. WHO REFORM: Item 5 of the Agenda

Framework of engagement with non-State actors: Item 5.1 of the Agenda (Documents EB136/5 and EB136/INF./2)

The CHAIRMAN drew attention to the following draft decision proposed by Argentina:

The Executive Board, having considered the report of the Secretariat on the framework of engagement with non-State actors (document EB136/5) and having taken note of the PBAC report to the Executive Board (document EB136/3) and the framework of engagement with non-State actors Information on regional committee debates (document EB136/INF./2),

(PP1) Noting that the Director-General of WHO requested Member States to submit their proposals on the Framework of engagement with non-State actors;

(PP2) Reiterating the importance of this Framework in the context of WHO reform and the progress that this milestone would signify for the governance of WHO and control by Member States, and to be able to make progress in seeking funding in a transparent manner, enshrined in a consensus document adopted in an intergovernmental context;

(PP3) Considering that it has not been possible to adopt the Framework in spite of the numerous improvements that have been made to it,

(OP1) DECIDES to:

- (1) stress the importance of recognizing the right of Member States to participate in the drafting of the Framework of engagement with non-State actors, by facilitating and delivering input directly so that the Framework can be approved by the Sixty-eighth World Health Assembly in 2015;
- (2) highlight the need to immediately establish a drafting process, in close consultation with, and open to, all Member States, no later than February 2015;
- (3) request the Director-General to:
 - (a) consolidate all proposals emanating from the consultation process on the Framework and to include them in the documentation to be presented to the Sixty-eighth World Health Assembly;
 - (b) identify resources to conduct the consultations, especially with regard to ensuring participation by developing or least-developed countries;
 - (c) report to the Sixty-ninth World Health Assembly, through the 138th Session of the Executive Board in January 2016, on the progress made by Member States and the Secretariat towards implementing this decision.

The financial and administrative implications of the draft decision for the Secretariat were as follows:

1. Decision: Framework of engagement with non-State actors			
2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf) Category: 6. Corporate services/enabling functions <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> Programme area(s): Leadership and governance </td> <td style="width: 50%; vertical-align: top;"> Outcome: 6.1. Greater coherence in global health, with WHO taking the lead in enabling the many different actors to play an active and effective role in contributing to the health of all people Output: 6.1.2. Effective engagement with other stakeholders in building a common health agenda that responds to Member States' priorities </td> </tr> </table> <p>How would this decision contribute to the achievement of the outcome(s) of the above programme area(s)? The decision will enable the Sixty-eighth World Health Assembly to approve the framework of engagement with non-State actors</p> <p>Does the Programme budget already include the outputs and deliverables requested in this decision? (Yes/no) Yes.</p>		Programme area(s): Leadership and governance	Outcome: 6.1. Greater coherence in global health, with WHO taking the lead in enabling the many different actors to play an active and effective role in contributing to the health of all people Output: 6.1.2. Effective engagement with other stakeholders in building a common health agenda that responds to Member States' priorities
Programme area(s): Leadership and governance	Outcome: 6.1. Greater coherence in global health, with WHO taking the lead in enabling the many different actors to play an active and effective role in contributing to the health of all people Output: 6.1.2. Effective engagement with other stakeholders in building a common health agenda that responds to Member States' priorities		
3. Estimated cost and staffing implications in relation to the Programme budget			
(a) Total cost Indicate (i) the lifespan of the decision during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000). (i) Four months (covering the period February–May 2015). (ii) Total: US\$ 350 000 for the three-day open-ended intergovernmental meeting (staff: US\$ nil; activities: US\$ 350 000).			
(b) Cost for the biennium 2014–2015 Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000). Total: US\$ 350 000 (staff: US\$ nil; activities: US\$ 350 000). Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant. Headquarters. Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no) Yes. If “no”, indicate how much is not included.			
(c) Staffing implications Could the decision 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).

Not applicable.

Dr REN Minghui (China), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, said that the Committee had welcomed the report on the framework of engagement with non-State actors (document EB136/5) and the information on regional committee debates in document EB136/INF./2. In view of the need to develop a clear policy on conflict of interest, the Committee had recommended that the Executive Board note the report by the Secretariat and continue its discussion of the item.

Mr KOLKER (United States of America) welcomed the expanded sections in the draft framework on conflict of interest and emphasized the need for due diligence before WHO's significant engagement with non-State actors. The policy should provide the necessary flexibility to allow WHO to act swiftly if necessary, for example in situations such as the Ebola virus disease outbreak. WHO's independence and impartiality must be upheld.

The scrutiny given to the private sector made arbitrary distinctions that ran counter to WHO's appropriate engagement with all types of non-State actors. WHO might therefore consider and adapt the transparent policies on conflict of interest common to various types of non-State actor developed by other global health organizations. Public–private partnerships between nongovernmental organizations and private sector entities could provide useful models, in particular for developing countries, and WHO's engagement with public–private partnerships should not be restricted solely on the basis of the business model. Transparency and integrity were crucial to maintaining trust in WHO, and active engagement would ensure that WHO remained relevant and developed norms and standards that were actually implemented. He noted with satisfaction that the Programme, Budget and Administration Committee would provide oversight of engagement.

Although he could support the adoption of the draft framework in its current form, he encouraged the convening of a drafting group during the current session, with a view to finalizing the draft framework for submission to the Sixty-eighth World Health Assembly in May 2015.

Dr AKSEL'ROD (Russian Federation) said that engagement with non-State actors should be based on principles that would protect WHO's independence and reputation and would retain the leading role of Member States in the decision-making process. She welcomed the Secretariat's response to and clarification of the questions raised in the regional committee debates, and underscored the importance of ensuring that mechanisms addressing conflict of interest were fail-safe. Given the importance of engagement with non-State actors, she approved the draft framework in its current form, provided that there was an opportunity for review, following appropriate assessment, after two years.

Dr BARBOSA DA SILVA (Brazil) said that, in developing a framework of engagement with non-State actors, it was important to ensure that Member States played a central role in the decision-making process. He agreed that risk assessment for conflict of interest should be transparent and entail full participation of Member States; the oversight of engagement by the Programme, Budget and Administration Committee was welcome. Financial contributions for phase 3 of the normative work from private sector actors with commercial interests would be acceptable provided that those resources were directed to implementation activities. Clear parameters were needed concerning the participation of non-State actors in WHO's consultations and other meetings. He supported the proposed establishment of a drafting group.

Ms MATSOSO (South Africa), speaking on behalf of the Member States of the African Region, said that limited progress had been made on the draft framework: the document was largely descriptive and further work was needed to ensure clarity in several areas of concern, such as risk management. Furthermore, some suggestions from the regional committees, including those concerning boundaries, had not been fully addressed. Clear operational definitions were required, as was further work on the criteria for the grouping of non-State actors. She supported the draft decision but sought clarification of its status with respect to decision WHA67(14), which also concerned the framework of engagement with non-State actors.

The meeting rose at 12:30.

FOURTH MEETING

Tuesday, 27 January 2015, at 14:35

Chairman: Mr M.H. SHAREEF (Maldives)

WHO REFORM: Item 5 of the Agenda (continued)

Framework of engagement with non-State actors: Item 5.1 of the Agenda (Documents EB136/5 and EB136/INF./2) (continued)

Dr OMI (Japan) expressed concern at the proposal in the draft framework that WHO should no longer accept secondments from academic institutions. For many years, WHO had advocated working closely with civil society, bearing in mind possible conflicts of interest, and the Ebola crisis had demonstrated the need to work with many entities. Relationships with universities should be encouraged. Secondments from academic institutions should be continued; if not, he wanted the Secretariat to explain the rationale for its decision.

Dr REN Minghui (China) appreciated the timely manner in which the concerns raised by Member States had been incorporated into the draft framework. The document was comprehensive although some details required improvement. He supported the draft decision put forward by the member for Argentina and would submit proposed changes to the draft framework in writing.

Dr CARBONE (Argentina) stressed the importance of the framework in the context of the WHO reform process and its potential to improve the governance of the Organization. The document had been much improved following feedback from Member States and by inclusion of the proposal for oversight by the Programme, Budget and Administration Committee. Although some points remained to be clarified, implementation of the framework should not be delayed. The draft decision submitted by her country with the support of various Member States, reflected comments made during the Committee's meeting and proposed that the consultation process should be completed so that the draft framework could be submitted to the Sixty-eighth World Health Assembly for approval.

Dr GONZÁLEZ FERNANDEZ (Cuba) agreed that WHO's engagement with non-State actors should be guided by five principles, including demonstration of a clear benefit to public health; respect of WHO's intergovernmental nature; and they were actively managed so as to mitigate any form of risk to WHO (including conflicts of interest). With respect to paragraph 21 of the draft framework, it was unclear how non-State actors could provide support to policy-making at the national level without interfering in government activities. The interaction between the engagement coordination group and the Programme, Budget and Administration Committee in reviewing collaboration with the non-State actors every three years should be clarified. He did not agree with the statement in paragraph 55 that regional committees might grant accreditation to their meetings to non-State actors that were not in official relations. He did, however, agree with the statement (paragraph 46) that WHO should not accept secondments from non-State actors, which he took to include philanthropic foundations and academic institutions.

Mr ADHIKARI (Nepal), speaking on behalf of the Member States of the South-East Asia Region, recalled that engagement with non-State actors should facilitate the fulfilment of WHO's mandate through a better use of resources. The revised draft framework met some previously raised

concerns but conflict of interest was not dealt with adequately, with no specific prevention measures set out. He called for: a clear explanation of definitions of and criteria for philanthropic foundations; guidance on how to avoid donor influence; and clarification about engagement at levels below country offices, recognizing the need for a responsible delegation of authority and adequate safeguarding and monitoring measures. Engagement should be limited to normative functions, should not be used to cover human resources costs, and must not compromise the integrity, neutrality, reputation and leadership of WHO. Accordingly, WHO should not engage with the tobacco or arms industries, and should limit its involvement with infant formula and processed food industries. Those concerns and other comments by Member States of the Region should be taken into account in the further revision of the draft framework.

Dr ASADI-LARI (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, reiterated the paramount importance of the draft framework for WHO. Consultations had clarified many issues but had raised new questions. The draft framework needed further revision before submission to the Sixty-eighth World Health Assembly. He supported the draft decision.

Mr BOWLES (Australia) said that the framework for engagement must protect WHO's integrity and its fundamental role in global norm and standard setting. He appreciated the thorough consultative process and welcomed the addition of an evaluation mechanism and the strengthened sections on managing conflict of interest and conducting due diligence. He sought assurance that the decision not to accept secondments from non-State actors would not affect WHO's ability to mobilize the world's best technical experts when necessary. Finalization of the draft framework should be a priority; any further refinements could be identified and made once the framework was being implemented. The evaluation process, the strengthened oversight and the mechanism to discontinue engagement with a non-State actor should allay the concerns of Member States regarding implementation. He supported submission of the draft framework to the Sixty-eighth World Health Assembly.

Dr GRABAUSKAS (Lithuania), speaking on behalf of Denmark, Estonia, Finland, Iceland, Latvia, Lithuania, Norway and Sweden, commended the clear structure of the revised draft framework which took into account Member States' concerns. It established uniform rules and clear expectations for non-State actors, facilitating interaction while managing risks and protecting WHO's reputation. He welcomed the strengthened mechanisms for oversight and Member States' involvement therein, and the publication of a register of non-State actors. He recommended adoption of the framework by the Sixty-eighth World Health Assembly, and noted the possibility of evaluation and review after two years to address the lessons learnt from implementation.

Dr AMMAR (Lebanon) welcomed the report and revised draft framework. Although there were benefits to be derived from engagement with non-State actors, the risk involved in interactions concerning funding, information generation, knowledge management, research and support to policy-making at the national level should not be underestimated. He sought clarification about who would initiate the process of engagement with a particular non-State actor and the means of so doing.

Dr EERSEL (Suriname) said that the draft framework, which provided a good basis for engagement with various types of non-State actors, should be flexible rather than overly prescriptive. She agreed that the implementation of the framework should be periodically evaluated and welcomed the reference (paragraph 44) to those non-State actors with which WHO would not engage or should exercise particular caution. As nearly all industries affected human health in some way, the second sentence of that paragraph should be amended to read "... industries whose products or activities are harmful to human health ...". Clear rules of engagement would also be required. She supported the draft decision.

Dr NOOR HISHAM ABDULLAH (Malaysia) reaffirmed that collaboration with multiple stakeholders was essential in fulfilling WHO's mandate and welcomed the improvements in the draft framework relating to competitive neutrality, non-compliance, conflict of interest and oversight. He supported the draft decision.

Dame Sally DAVIES (United Kingdom of Great Britain and Northern Ireland) said that engagement with non-State actors must not compromise WHO's good name and its right to lead on global public health. The framework should encourage more, not less, engagement with non-State actors and provide a clear understanding of objectives and limitations of such engagement. She supported the position of the member for Australia. She welcomed the draft decision. The current discussion should enable the text to be improved sufficiently for the draft framework to be approved by the Sixty-eighth World Health Assembly.

Ms MATSOSO (South Africa) asked whether the proposed amendments to the draft decision would be discussed, and repeated her question in the previous meeting on the status of any decision on the framework of engagement taken during the Board's current session in relation to decision WHA67(14).

Mr BURCI (Legal Counsel) recalled that decision WHA67(14) had requested the regional committees to submit a report on their deliberations to the Sixty-eighth World Health Assembly, through the Executive Board, and the Director-General to submit a paper to the Board at its 136th session. As decision WHA67(14) provided for no further action beyond the current session of the Board, the draft decision proposed by the member for Argentina was not inconsistent with it.

Professor AL-ADAWY (Egypt), agreeing on the need to move forward as quickly as possible, supported the draft decision.

Ms ROA RODRIGUEZ (Panama) said that measures to promote transparency in WHO's interaction with non-State actors should be a priority within WHO reform. Conflicts of interest were a concern, and she welcomed the inclusion of due diligence as a preventive mechanism. Although the draft framework had been much improved, some technical elements and procedures required clarification. Engagement with non-State actors had many benefits, but it was essential to prevent donors, not only the tobacco and arms industries, from interfering in the development and implementation of global public health policy. She supported the draft decision. Member States and the Secretariat should continue their efforts with a view to submitting for approval by the Sixty-eighth World Health Assembly a framework for engagement that enjoyed broad consensus.

Dr KUPA (Democratic Republic of the Congo) stressed the importance of engagement with non-State actors but sufficient time was needed to elaborate the benefits and identify risks and ways to manage them. He supported the draft decision.

Mr SEY (Gambia) said the document required further revision before submission to the Health Assembly. He supported the draft decision.

Mr JEON Man-bok (Republic of Korea) also supported the draft decision. The broad diversity of non-State actors and their objectives, activities and interests, underlined the need for a clear evaluation system to review implementation of the draft framework. He urged WHO to define clearly the rights and roles of stakeholders, and incorporate contributions of non-State actors in advancing global health priorities.

Mr GHILAGABER (Eritrea) said that further clarification was required on several points, notably the issue of conflicts of interest. As the draft framework would need further work, he supported the draft decision.

Dr FORSTER (Namibia), acknowledging the process of elaborating the draft framework, said that he recognized the challenge of striking a balance between the appropriate level of assessment required for engagement with non-State actors and the fact that risk could never be fully eliminated. Further detail on some crucial issues was required and he therefore supported the draft decision.

Ms GONZÁLEZ (Uruguay),¹ speaking on behalf of the Member States of the Union of South American States, welcomed the efforts as part of WHO reform to establish a framework for engagement with non-State actors, key elements of which included transparency, risk management, defining conflict of interest, and allocation of funds from private sector entities. The revised text, although much improved, failed to set out sufficiently detailed criteria for the various categories of non-State actors or the specific types of engagement with each category. The draft framework should include guidelines on how WHO should define its interaction with non-State actors, whether through official relations, alliances or the framework of engagement. Having noted that decision-making should remain the sole purview of Member States, she supported the proposal for the establishment of a drafting process, as contained in the draft decision.

Mr PUSP (India)¹ said that, although he recognized the potential contribution of non-State actors, conflict of interest must be avoided. Some Member States' concerns – about secondments, due diligence, monitoring and evaluation – had been met in the revised draft framework. However, it should include a comprehensive policy on conflict of interest. Greater clarity was required on application of the framework to existing partnership policies, the criteria and definition of “at arm's length”, the applicability of provisions of private sector policy to non-private sector entities, and the pooling of contributions from multiple sources. He expressed concern about collaboration with private sector entities in information gathering and the acceptance of financing from private sector entities that had even an indirect interest in the project outcome. Noting that due diligence should be conducted in the public domain, he said that a ban on engagement might also apply to organizations with indirect links to the tobacco and arms industries; it might not be sufficient to state that WHO should exercise particular caution when engaging with other industries affecting human health. The revised draft framework needed further work, and he supported the draft decision.

Dr DAHN (Liberia) agreed that the draft framework needed further revision before submission to the Sixty-eighth World Health Assembly.

Ms SURIWAN THAIPRAYOON (Thailand),¹ recognizing the role of non-State actors in global health development, expressed concern about the receipt of financial resources from private sector entities, given the importance of maintaining the accountability and independence of WHO. She supported the statements made by the members for Suriname and India, and the draft decision.

Mr REALINI (Monaco)¹ noted that the revised draft framework would be a useful tool for effective and transparent engagement with non-State actors. Although not perfect, it was ready for use and could be evaluated and amended if necessary after a period of implementation. He called on the Board to recommend the draft framework for adoption by the Health Assembly.

Mr ROSALES LOZADA (Plurinational State of Bolivia)¹ said that all precautions must be taken to protect the intergovernmental nature of WHO. The draft framework lacked information on protecting WHO's norm and standard-setting activities from undue influence and failed to provide adequately for data collection and capacity building. The participation by private sector entities in WHO's meetings should be limited and due diligence should be conducted in the public domain. The cessation of secondments from non-State actors was a positive change, but he noted with concern that

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

the draft WHO policy and operational procedure on engagement with private sector entities provided for private sector funding of WHO staff salaries, particularly since Member States were prohibited from doing so. He supported the draft decision.

Mr SEGARD (Canada)¹ said that the Canadian Government had been able to formulate an effective and successful non-State actor policy that respected the integrity of governmental decision-making activities, by considering each partnership on a case-by-case basis. Similarly, WHO should establish tools to transparently manage its engagement with non-State actors. Canada therefore welcomed the draft framework, which should be presented to the Sixty-eighth World Health Assembly for approval.

Dr BARNARD (Netherlands)¹ welcomed the revised text, with its clear rules on engagement with all non-State actors and introduction of oversight and evaluation mechanisms. It was imperative to strike a balance between promoting engagement with non-State actors and protecting the integrity of WHO's work, particularly to prevent conflicts of interest. He disagreed with the decision that WHO would not accept secondments from non-State actors. Member States should be given more time to discuss and refine the draft framework before its submission to the Sixty-eighth World Health Assembly.

Mr KÜMMEL (Germany)¹ said that non-State actors made a significant contribution to shaping global health and could provide valuable support to help WHO to play its global health leadership role. Germany did not consider that adoption of the draft framework would infringe on the independence of WHO activities or on the decision-making power of Member States, but was willing to refine further the draft framework during the current Executive Board session.

Mr MATUTE HERNANDEZ (Colombia)¹ said that, although the draft framework was much improved, further refinement was necessary of, for instance, the categorization of non-State actors, the potential for conflicts of interest and the functions of the intended oversight and evaluation mechanisms. He supported the draft decision.

Mr GALINDO (Bolivarian Republic of Venezuela)¹ said that further consultations on the draft framework would help to clarify any remaining concerns. Member States should consider, in particular, the operational viability of the draft framework, the feasibility of monitoring and evaluation as well as benefits and risks. His country, which welcomed WHO's collaboration with private sector entities in the development of health-related technology, including vaccines, considered due diligence, transparency and avoidance of conflicts of interest to be some of the elements vital to the success of WHO's engagement with non-State actors.

Mr BOISNEL (France)¹ supported the draft framework in its current form. The text could be improved, but such further refinement could be made after the framework's implementation. Every effort should be made to ensure that the draft framework could be adopted at the Sixty-eighth World Health Assembly, provided that the work involved was effective, not too intensive or expensive. He did not agree with the proposal in the draft decision to continue the discussion to the Board's 138th session in January 2016.

Ms CARBONE (Argentina) said that her country remained committed to reaching consensus on the draft framework in a timely fashion and commented on the value of informal consultations.

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

Ms KUSYNOVÁ (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN and on behalf of FDI World Dental Federation, the International Council of Nurses and the World Confederation for Physical Therapy, said that all eligible non-State actors should have the opportunity to participate in WHO's activities on an equal basis, especially as "at arm's length" was not defined. She applauded the introduction in the draft framework of risk assessment and management, although such actions might be difficult to sustain given the increasing workload on WHO staff members. Paragraphs 53(a) and 54 of the text were inconsistent; she urged that non-State actors in official relations should be able to designate a delegation of more than one person. Noting that consideration should be given to participation through remote virtual access, as was available for some of WHO's meetings, she sought clarification of the timeline and process for implementation of the framework.

Ms LIGHTBOURNE (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, welcomed the progress towards a framework for engagement with non-State actors, particularly the recent proposals to increase transparency and accountability. Patients had a right to be involved in decisions about health care. She supported the suggestion to categorize and define different stakeholder groups and emphasized that the framework must provide consistent and appropriate criteria for effective engagement by the full range of non-State actors. Publications of details of WHO's engagements with non-State actors, including meetings and documentation, would be valuable.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, welcomed the continued work on a framework that allowed WHO to provide leadership in global health by engaging with various actors with no conflict of interest. Collaborative approaches were integral to work towards shared global health goals. Transparent engagement should be linked to the concept of accountability so as to assess the tangible contributions of non-State actors towards the achievement of WHO objectives. Before the framework entered into force it could be tested against existing best practice in WHO's interactions with non-State actors. He would welcome the preparation of public guidelines clarifying the implementation and application of the draft framework, and emphasized that potential conflicts of interest should be managed in a robust, clear and transparent manner.

Dr LHOTSKA (International Baby Food Action Network), speaking at the invitation of the CHAIRMAN, said that the draft framework should distinguish between public-interest and market-led non-State actors. It also presented a misconception of conflict of interest theory. She cautioned against allowing engagement with actors whose primary aims were not in conformity with the spirit of the WHO Constitution and urged Member States to establish an expert open-ended working group to finalize the draft framework prior to its adoption.

Mrs MEURS (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, said that the failure of the draft framework to clarify the rationale for widening engagement with the private sector and conflict of interest safeguards risked opening up new channels for corporate influence. She called for an expert technical consultation on conflicts of interest safeguards. The long-term solution to an overreliance on private donor funding and resulting conflicts of interest would be for Member States to lift the longstanding freeze on assessed contributions.

Mr ESTÊVÃO (International Pharmaceutical Students' Federation), speaking at the invitation of the CHAIRMAN, welcomed the draft framework. He called for the inclusion of youth organizations on the WHO register of non-State actors and the identification of common areas of work in order to define possible areas of collaboration.

The DIRECTOR-GENERAL said that the discussions had revealed divided opinions: one group composed of both Board members and representatives of Member States could adopt the draft framework, with evaluation to be carried out in two years. The second group thought the framework required further work and, therefore, supported the proposal put forward by the member for Argentina. She proposed that a group of interested countries, under the chairmanship of Argentina, should begin work immediately and report on the progress made to the Board before the end of the current session. The Board would then provide guidance. She thanked both groups for expressing their appreciation to the Secretariat for the improved draft.

The CHAIRMAN said that he took it that the Board agreed with that proposal.

It was so agreed.

(For adoption of the draft decision, see summary record of the eleventh meeting, section 2.)

Method of work of the governing bodies: Item 5.2 of the Agenda (Document EB136/6)

Dr AMMAR (Lebanon) recalled the Board's discussions at its 134th session on the heavy agenda and the promise by Member States to exercise self-discipline. Re-opening the debate was unlikely to change the situation. He agreed on the need to limit the number of reports per resolution to three, but there should be some flexibility in the case of resolutions and decisions that took longer to implement. He welcomed the proposals concerning early discussion on draft resolutions and reduction in the length of pre-session documents.

Mr BOWLES (Australia) expressed broad support for the recommendations in the report, in particular efforts to better manage the agenda, on which he sought feedback on the Secretariat's experience, especially concerning new agenda items. Reporting requirements needed to be flexible, but reforms should not reduce transparency and accountability in the work of the governing bodies and Secretariat. He sought clarification on which other reports the Secretariat was proposing to reduce, as progress reports were already considered by the Health Assembly only. He strongly supported the proposals contained in paragraphs 7, 8 and 9 of the report but called for further improvements in the timely distribution of documentation. Early access to some draft resolutions before the current session had ensured careful consideration of the issues at stake and fostered an inclusive approach to drafting text, although the burden on Geneva-based representatives, and potential for Member States to feel excluded without representation in Geneva, had to be borne in mind. Attendance at side events, a vital part of Health Assemblies, had become unmanageable for smaller delegations. In principle, he supported option (b) in paragraph 12, provided it did not deter less developed countries from initiating events, and option (c), although he had concerns about its practicality. How would those approaches be implemented?

Dr MATCHOCK MAHOURI (Chad), speaking on behalf of the Member States of the African Region, said that agendas must be managed through use of selection criteria acceptable to all, respect of the right of Member States to raise matters of concern, and to limit supplementary items to the minimum. Although reporting was a requirement for previously adopted resolutions and decisions, henceforth the number and volume of reports should be reduced without altering the content. The deadline for the introduction of draft resolutions should be revised and new technologies, such as videoconferencing, should be introduced for working groups with suitable financial and technical support to countries. Sufficient time should be allocated for regional representatives to speak at governing body meetings. For the side events to the Health Assembly, he recommended option (a).

Dr REYNDERS (Belgium), speaking on behalf of the European Union and its Member States, said that the Ebola crisis demonstrated the urgency of accelerating the implementation of reforms to allow the Organization to respond to public health emergencies, while fulfilling its normative

mandate. The focus therefore had to be on human resources management, internal communication and managerial accountability at all three organizational levels. Genuine commitment by the Secretariat to evaluation would facilitate such processes. Member States must improve their self-discipline and Officers of the Board should follow the relevant provisions of decision WHA65(9) on WHO reform. Agendas must be shortened. Accountability demanded comprehensive reporting on the implementation of resolutions and adequate time must be allocated in the Health Assembly for that purpose. He supported the proposals on early discussion of draft resolutions, urging an inclusive approach towards non-State actors as valuable partners in global health. Innovative public administration solutions and outsourcing of some services would improve effectiveness and efficiency, as would a more coordinated approach to side-events at the Health Assembly.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) welcomed the common-sense approach of the report, which articulated the prerequisites for productive meetings – some proposals were not novel. The reporting requirements for existing resolutions should be reviewed and there should be a process for the sunseting of resolutions, including drawing from best practice across the Organization. It was important to continue the tradition of side events at Health Assemblies but without losing sight of the main business. In order to improve further the functioning of governing body meetings, Member States had to exercise restraint and not overload the agenda, and the Secretariat had to show leadership; she requested it to guide Member States to find the best way forward.

The CHAIRMAN commented that, in comparison with some other United Nations bodies, WHO's governing body meetings were much more efficient as a result of reforms.

Mr KOLKER (United States of America) said that he was encouraged by the reforms already adopted, supported the proposed improvements and urged the Secretariat to implement those within its remit. In particular, there should be greater flexibility in reporting requirements; the dominance of items on the agenda because of reporting requirements must be reduced. He supported the early consideration of draft resolutions, the value of which approach had been proven with drafting of the resolution on Ebola adopted during the special session, and the strict application of the relevant provisions of decision WHA65(9). Health Assembly side events were valuable and attracted stakeholders who strongly supported WHO's work; however, the number of such events had become overwhelming and streamlining was required. To that end, options (a) and (b) in paragraph 12 were worth pursuing whereas option (c) might be too restrictive.

Mrs VALLINI (Brazil) supported the measures proposed, in particular, those related to early discussion of draft resolutions and the use of virtual consultations, as practised in regional discussions. The proposal to limit the number of side events (option (c)), however, was not acceptable as such events played an important part in strengthening exchanges on a multiplicity of issues.

Dr AKSEL'ROD (Russian Federation) expressed continuing concern about the preparation of the agenda, as well as the management of governing body sessions, not least the proliferation of evening meetings. She recommended the introduction of a regional filter mechanism to identify issues of purely regional interest that could be dealt with by regional committees, thereby lightening the load placed on governing body meetings at the global level.

Dr MAGALLANES (Argentina) said that the report represented an advance. Agendas were too long, but the right of Member States to raise questions of interest must be respected. He agreed with the proposal for reducing the number of reports, the timely distribution of documents and the establishment of a webpage for statements. The proposal for a maximum number of side events was acceptable provided the number decided on was adequate.

Dr BEJTJA (Albania) welcomed the proposals. Reporting requirements for resolutions and decisions should be limited to biennial reports. The timely distribution of documents could be enhanced by distillation of the content and early discussion of draft resolutions. Side events were needed, but costs might be shared with nongovernmental organizations in official relations with WHO.

Ms RU Lixia (China) commended the report and noted an improvement at the current session in the conduct of the proceedings. In principle, she supported reducing the number of agenda items, encouraging early discussion of draft resolutions, establishing a webpage for statements, and a more flexible approach to reporting based on the importance and urgency of the topic. The Secretariat should consider developing a method for managing side events taking account of the organizers, topics and costs, for submission to the Board. Nongovernmental organizations not in official relations with WHO and companies should not participate in side events. Governments and organizations that jointly conducted side events should share the costs, and topics should be consistent with WHO's core business and agenda.

Mr RASHEED (Maldives) said that there was an evident need to strengthen the strategic role of the governing bodies and increase their inclusiveness, transparency and efficiency. He supported the proposals on managing the number of agenda items, early discussion of resolutions and decisions and establishment of a webpage for statements. His country's delegations had difficulty in participating in side events, which were a source of rich discussion. He preferred option (c), as the financial implications of option (a) could be onerous for some Member States. However, if most Board members supported option (a), it was important to ensure that the matter was managed in a way that did not compromise the integrity of WHO.

Ms ROA RODRIGUEZ (Panama) commended the proposals, in particular those aimed at promoting manageable agendas, introducing realistic reporting requirements, encouraging early discussion of draft resolutions and establishing a webpage for statements. The number of side events needed to be large enough to facilitate exchanges between the different participants, including Member States, in particular those with small delegations. She did not consider that option (c) was really feasible and requested the Secretariat to propose further options.

Dr ASADI-LARI (Islamic Republic of Iran) emphasized the need to receive draft resolutions well in advance to enable their proper consideration. The provision of standard templates for documents could improve quality and reduce their length. With regard to reporting requirements, regional committees should be more involved in reviewing and discussing draft resolutions and could usefully follow the example of the Regional Committee for the Eastern Mediterranean, which had established an ad hoc group to consider, and where necessary, sunset certain resolutions. Consideration might also be given to establishing an open-ended working group which would make further recommendations for submission to the Board at its 137th session.

Mr SEGARD (Canada)¹ said that issuing draft resolutions in advance of meetings was a prerequisite for the efficient management of agendas. He welcomed the establishment of a webpage for the early posting of statements, but it should be linked to the record in order to pre-empt repetition and allow more time for discussion of key issues. The approach adopted by the Regional Committee for the Eastern Mediterranean to sunset resolutions could offer benefits to the rest of the Organization. He would also welcome further details on the modalities for limiting the number of side events at Health Assemblies.

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

Mr REALINI (Monaco)¹ said that further and more drastic measures were needed to manage the agendas. The proposal regarding reporting requirements was acceptable but he called for an evaluation of existing resolutions in order to sunset those that were no longer pertinent or of interest; the European Region's experience offered a good model. He agreed with the early discussion of draft resolutions and the establishment of a webpage, on which statements should remain available for some time. A reduction in the number of agenda items would facilitate the timely distribution of documents. Regarding the proposals for side events, he sought clarification regarding: the cost of a one-day session; the feasibility of passing on the cost if the organizer was a small nongovernmental organization or a low-income country; and the criteria and procedure to be followed in introducing a limit on the number of side events.

Dr THAKSAPHON THAMARANGSI (Thailand)¹ said that, if poorly managed, early discussion of draft resolutions could restrict the involvement of resource-limited Member States and undermine the unique participatory and inclusive spirit of the Health Assembly. He would therefore support such early discussion for the purposes of information and preparation, not for decision-making. Side events, including informal ones, should contribute to the Health Assembly's main processes. None of the proposals was the answer, but out of them he preferred option (c) and requested the Secretariat to establish an inclusive and flexible mechanism based on clear criteria related to global health policies for limiting the number of side events.

Mr DIKMEN (Turkey)¹ requested further information on the cost implications of an electronic voting system. Although he recognized the need to avoid overcrowded agendas, limiting the number of agenda items might encourage a focus on short-term, rather than long-term, health challenges. He supported the establishment of a webpage for statements and the early discussion of draft resolutions. As current proposals on side events could increase costs or limit benefits for low-income countries, he asked for further options; until then the status quo should be maintained.

Dr ROOVÄLI (Estonia)¹ said that regional and country offices should be given special attention to ensure that they did not remain outside the reform process. Limiting the number of side events was not acceptable, and she suggested following the model used by the United Nations, whereby the costs of side events were borne by the organizers.

Mr SCHWARZ (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, welcomed the efforts made to increase transparency, including the introduction of a webpage for statements and webcasting. All side events should relate directly to items on the agenda, and not simply showcase individual organizations, programmes or partnerships. Holding a separate one-day session carried the risk that it became a promotional event, accessible only to those who could afford the organizational and travel costs. As an alternative, the Secretariat should organize public hearings before or during the World Health Assembly. He also trusted that nongovernmental organizations would continue to be given their own space within the Palais des Nations.

The DIRECTOR-GENERAL acknowledged that discussion of the method of work of the governing bodies as part of WHO reform had been on the agenda for several years and that many Member States wanted the process to proceed more rapidly. The Organization belonged to Member States and it was their sovereign right to propose new agenda items. The difficulty for the Secretariat was that some Member States objected to limiting agenda items whereas others complained that there were too many items. Although the Secretariat did its best to accommodate the two viewpoints, the change in behaviour must come from Member States.

She encouraged regions to take the lead in sunseting resolutions. The Secretariat would then make a comparison and consider similar action at headquarters, if appropriate. In the meantime, the Secretariat would implement the proposals in the report falling within its authority. The Secretariat would also carefully review the summary record of members' suggestions in the discussion.

The Board took note of the report.

Overview of reform implementation: Item 5.3 of the Agenda (Document EB136/7)

The CHAIRMAN drew attention to a draft decision proposed by Mexico and Panama, which read:

The Executive Board,

Recalling WHO relevant documents and agreements on WHO Reform;

Having considered the report of the Secretariat on the Overview of Reform Implementation,

(PP1) Recognizing that the pillar of WHO governance reform is essential to bringing the transformational reform process to the desired outcome that the governing bodies have been working on for more than four years;

(PP2) Recognizing also that a comprehensive, integrated and holistic approach is critical in the WHO Reform agenda;

(PP3) Recognizing further that significant progress has been made in areas of the WHO Reform such as priority setting, planning and budgeting, while the governance pillar should benefit from the same progress through dedicated Member State and Secretariat engagement;

(PP4) Having considered also the recent IEOAC report that states that slow progress on Governance Reform could impede the overall WHO reform agenda, decided the following,

(1) TO ESTABLISH an Open-Ended Working Group on Governance Reform/OEWG, to complete its work by the Sixty-ninth World Health Assembly, and to provide any recommendations to the Sixty-eighth World Health Assembly, with the following mandate:

- (a) to review the progress made in the governance reform agenda of the Organization and its coherence with other reform processes;
- (b) to address, but not be limited to, the working methods of the Governing Bodies, including the proposals brought from the Secretariat to the 136th Executive Board which require further discussion, and also the functioning of the Executive Board Bureau and agenda-setting issues;
- (c) to follow up on the strategic resource and budget space allocation working group recommendation to examine the role and functions of all three levels of the Organization, in particular looking at improving practices around regional director selection;
- (d) to present recommendations, through governing bodies, on the areas of opportunity within the institutional framework to strengthen the coherence and the alignment to the priorities of the Organization.

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

1. Decision: Overview of reform implementation	
2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf) Category: 6. Corporate services/enabling functions Programme area(s): Leadership and governance Outcome: 6.1. Greater coherence in global health, with WHO taking the lead in enabling the many different actors to play an active and effective role in contributing to the health of all people Output: 6.1.4. Integration of WHO reform into the work of the Organization How would this decision contribute to the achievement of the outcome(s) of the above programme area(s)? The decision will accelerate progress in the area of governance reform. Does the Programme budget already include the outputs and deliverables requested in this decision? (Yes/no) Yes.	
3. Estimated cost and staffing implications in relation to the Programme budget	
(a) Total cost Indicate (i) the lifespan of the decision during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000). (i) Until May 2016. (ii) Total: US\$ 350 000 for each meeting of the proposed open-ended working group, assuming each meeting will last three days (staff: US\$ nil; activities: US\$ 350 000).	
(b) Cost for the biennium 2014–2015 Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000). Total: US\$ 350 000 (staff: US\$ nil; activities: US\$ 350 000). The above cost is estimated for one meeting of three days. Any additional meeting day or additional meeting would need to be costed separately. Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant. Headquarters. Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no) Yes. If “no”, indicate how much is not included.	
(c) Staffing implications Could the decision 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)

No.

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

The funding gap is US\$ 350 000. It will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

Dr REN Minghui (China), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, said that the Committee had requested the Secretariat to provide information at the Committee’s next meeting in May 2015 on the impact of the response to the Ebola virus disease outbreak on the Programme budget 2014–2015 in terms of finance, staff and results.

Several Member States had proposed the establishment of an open-ended working group of Member States in order to accelerate progress and enhance coherence in the governance reforms, and had identified areas where additional efforts were needed. The Committee had recommended that the Executive Board note the report contained in document EB136/7.

Mr CORRALES HIDALGO (Panama), introducing the draft decision, noted that the slow progress of governance reform was a source of frustration and could impede the overall reform agenda. The draft decision was proposing the establishment of an open-ended working group on governance reform that would include Member States and representatives of the three levels of the Organization with a view to accelerating the pace of the reform.

Dr CHAND (Nepal) supported the proposal for the establishment of an open-ended working group, provided that it included members from all six WHO regions. With regard to the selection of regional directors, he recalled that the process in the South-East Asia Region had been revised in 2013 to include a thorough interview process. The process was fair, representative and democratic, guaranteeing the appointment of a Regional Director who had knowledge of the Region and the support of all its Member States.

Ms MATSOSO (South Africa) praised the Secretariat for the impressive and encouraging progress in reform outputs reaching the implementation stage. She expressed concern that, apart from an African Union comment, she had not heard a statement about the contribution that individual African countries had provided, within their means, in response to the Ebola virus disease crisis.

She welcomed the draft decision and appreciated the reference to the selection of regional directors. Member States of the African Region had asked her to raise their concerns about the manner in which that issue had been raised in the discussions at the current session with an apparent focus on just one candidate.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) said that progress was needed towards realizing the concept of “One WHO”; the different levels of the Organization needed to communicate with each other and learn from each other’s best practices and mistakes. Although it was important to set priorities, WHO should not be afraid of revisiting and adjusting them through a Member State-driven process, should a new public health situation arise.

With regard to the draft decision, she said that she shared the frustration of many Member States at the slow progress of governance reform. Emphasis on an effective approach was good, but any Member State discussion or working group must have a clear timetable and terms of reference, and should not seek to cover all areas of governance reform.

Mr GONZÁLEZ FERNANDEZ (Cuba), noting that the outbreak of Ebola virus disease had hindered progress in certain areas of reform, most notably governance reform, acknowledged that some progress had been made. Although the financing dialogue had increased the availability of funds, their continued unequal distribution across different programme areas should be addressed. The Ebola

outbreak had highlighted WHO's lack of capacity to respond to crises; the resolution adopted by the Executive Board at its third special session was a step forward in that regard.

Mr HEREDIA (Mexico),¹ speaking on behalf of the Member States of the Region of the Americas, said that the slow speed of governance reform was worrisome and could impede the overall reform agenda. Member States collectively had to bear significant responsibility for that slow pace, which must be accelerated through increased collaboration between Member States and the Secretariat. The consultations on non-State actors and those of the Working Group on Strategic Budget Space Allocation exemplified the success of intersessional work. The Member States invited the Board to agree on an efficient method of work involving them and representatives of all three levels of the Organization to expedite progress on governance reform. He supported the establishment of an open-ended working group, as proposed in the draft decision.

Dr AMMAR (Lebanon), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that more needed to be done, particularly in terms of strengthening country programmes and WHO country presence. Evaluation of some country offices in the Region had resulted in significant changes to their structure and performance and he welcomed similar undertakings in other regions. In terms of funding, he commended the Regional Director of the Eastern Mediterranean Region for deciding to use a portion of the regional budget from the Regional Office to increase country allocations, despite the limited resources available. However, more funding was needed and Member States called for an overall increase in segment 1 of the draft proposed programme budget 2016–2017.

With regard to human resources reform, the Regional Office had previously introduced a rotation scheme within the region, which had stagnated as a result of limited posts available for rotation. He therefore welcomed the decision of the Programme, Budget and Administration Committee regarding the implementation of mobility and rotation across the Organization. He recognized the need to revise and standardize the process for the selection of regional directors; an intergovernmental working group, or one comprising Member States, could be set up to review current practices and identify criteria, including strong leadership, managerial skills and a distinguished track record in public health, to ensure a wide base of candidates.

Dr FRIEDEN (United States of America) reiterated that his call for reform of the selection of the regional directors cast no doubt on the current leadership. He expressed support for the draft decision and the suggestion made by the member for Lebanon regarding the establishment of an intergovernmental working group to strengthen the appointment process for the regional directors using a merit-based approach and in line with Article 52 of WHO's Constitution. It was also important to continue to improve the human resources of WHO; his proposals included standardizing and improving recruitment practices across all three levels of the Organization; making recruitment more transparent and technically focused; making hiring practices more accountable at all levels; ensuring that hiring panels avoided impropriety and the appearance of impropriety; and making contracts more open to external candidates. The urgency of the need to improve rapidly human resource management reflected the recognition of and commitment to the Organization.

Dr DAHN (Liberia), speaking on behalf of the Member States of the African Region, agreed that the evolving nature of the Ebola virus disease outbreak would guide planning efforts to ensure the provision of previously agreed deliverables. However, more support was needed to accelerate the reforms, particularly those related to improving the capacity of WHO to respond to public health emergencies of international concern. She strongly supported the reform process, which should not become protracted or be allowed to overshadow the core functions of the Organization. Although WHO was criticized for not responding promptly to the current crisis, it was important to note that the

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

Organization was only just recovering from the substantial budget shortfall in 2012 that had sparked the reform process and had resulted in a mass exodus of qualified staff members who had provided technical assistance to countries. More should be done to make the financing of WHO more secure and flexible and ensure adequate funding for core functions.

Mr BOWLES (Australia) noted the impact of the outbreak of Ebola virus disease on implementing reforms; the crisis reinforced the need for reform. Progress had been made in Western Pacific Region, including performance at the country level and reforms to the process for electing the Regional Director. Further reform of the operation of the governing bodies and the appointment of regional directors was necessary. Accountability and leadership were essential for improving performance across the Organization, and One WHO needed common processes. He would prefer to use existing governing body processes rather than establish an open-ended working group. However, should such a working group be established, its scope, structure, terms of reference and time frame must be clearly defined with accountability the heart of its outcome.

Dr AKSEL'ROD (Russian Federation) observed that, despite the Ebola virus disease outbreak, progress had been made in many areas of reform. She welcomed the improved coordinated resource mobilization, but considered that a more realistic programme budget that better reflected the priorities at country level was needed for the period 2016–2017. Her country could support the establishment of a working group, provided that the goals, scope and time frame were clearly defined. With regard to the election of the regional directors, each Region should retain its independence.

Mrs VALLINI (Brazil) said that governance needed to be strengthened to enable WHO to fulfil its mandate based on the principles of transparency and efficiency. She supported the establishment of an open-ended working group, which should not focus solely on the election process for the regional directors. The phrase “in particular looking at improving practices around regional director selection;” should therefore be deleted from subparagraph 1(c) of the draft decision.

Mr MAGALLANES (Argentina), noting with satisfaction that the needs and priorities at country level were better reflected in the programme budget, said that more information in that regard should be included in the next report on reform. He supported the draft decision.

Dr ASSIRI (Saudi Arabia) said that WHO's implementation of its mandate had faced numerous impediments, including a fixed, rather than flexible, budget space; lack of expertise at the regional level, which could be addressed by the rotation and mobility policy; the imposition of different agendas by partners; and failure to increase the technical support segment of the budget. Member States needed to be fully engaged in the debate on reform.

Mr KIM Chang Min (Democratic People's Republic of Korea) said that his country strongly supported the current process for the appointment of the Regional Director, as it was fully transparent and accountable to the Member States of the South-East Asia Region and to WHO as a whole. There were other ways to improve the governance and efficiency of the Organization.

Mr CORRALES HIDALGO (Panama) said that he understood the concerns expressed about the scope, time frame and terms of reference of the open-ended working group and was willing to consult informally with Member States on the matter.

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

The meeting rose at 18:05.

FIFTH MEETING

Wednesday, 28 January 2015, at 09:10

Chairman: Mr M.H. SHAREEF (Maldives)

1. PROGRAMME AND BUDGET MATTERS: Item 11 of the Agenda

Implementation and financing of Programme budget 2014–2015: update: Item 11.1 of the Agenda (Document EB136/33 Rev.1)

Dr REN Minghui (China), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, drew attention to section 2.1 of the Committee's report,¹ which detailed its consideration of the update on the implementation and financing of the Programme budget 2014–2015 provided by the Secretariat.

The Board noted the report.

Proposed programme budget 2016–2017: Item 11.2 of the Agenda (Documents EB136/3, EB136/34, EB136/34 Corr.1 and EB136/INF./3)

Dr REN Minghui (China), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, referred to section 2.2 of the Committee's report,¹ which detailed the Committee's comments on the Proposed programme budget 2016–2017 and acknowledged the corporate approach and robust process used in its preparation. Member States had not been unwilling to consider the three budget scenarios put forward, which included increases to the budget, but had stressed that more time was needed to consult widely on them.

Dr OMI (Japan) said that the first scenario was preferable. The necessary activities had been implemented within the budgetary range US\$ 3.7–3.9 billion in the previous three bienniums and it was expected that the first scenario would remain within the US\$ 4 billion indicated in the Twelfth General Programme of Work, 2014–2019.

Mr ADHIKARI (Nepal), speaking on behalf of the Member States of the South-East Asia Region, said that a zero growth budget was tantamount to negative growth because of inflation in respect of human resource and programme implementation costs. The Proposed programme budget 2016–2017 would coincide with the first year of the post-2015 sustainable development agenda, the need to complete unfinished Millennium Development Goals, additional efforts to manage the aftermath of the Ebola crisis, preparedness for natural disasters and climate change, and the consequent health system strengthening. He therefore preferred the third scenario, which reflected the budget increases proposed by several major offices, based on recommendations from regional committees, but it would need resource mobilization.

¹ Document EB136/3.

Dr REYNDERS (Belgium), speaking on behalf of the European Union and its Member States, welcomed the Proposed programme budget but urged its timely publication; the next version was expected by the end of April 2015. He acknowledged the progress achieved in improving results-based management and strongly supported the break with the practice of setting priorities based on precedent. However, the current draft did not include an adequate costing of outputs. The next version should include budgeted outputs, the cost implications of recent Health Assembly resolutions and the costs for implementing the proposed global action plan on antimicrobial resistance. Which areas of work had been reduced to allow implementation of the new resolutions? Furthermore, in decision WHA67(8) the Health Assembly had stipulated that the Director-General should submit proposals to the Programme, Budget and Administration Committee on handling the costs of resolutions not covered by the programme budget.

He welcomed the budgetary shifts that reflected the strengthening of capacities for preparedness, surveillance and response. Further information was needed on how the Proposed programme budget 2016–2017 would reflect the financial implications of the outbreak of Ebola virus disease. The three budget scenarios presented foresaw an increase over the approved Programme budget 2014–2015. In the third option, which additional outputs would be funded by the increase of US\$ 122 million proposed by some of the major offices? How did the Secretariat envisage financing the budget increases in those options? How would it allocate budget space to the major offices if no clear consensus was reached on strategic budget space allocation?

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland), commenting on the shifts in funding set out in Table 1 of document EB136/34, observed that the planned decrease in financing for communicable diseases was a brave proposal in light of the recent outbreak of Ebola virus disease, although it might be offset by the increases allocated for surveillance and response. The governing bodies must be convinced that that balance was right. The proposed programme budget was the principal prioritization tool for global health for the forthcoming biennium and any decisions taken in relation to it must be communicated. She expected to receive the final draft by the end of April, as promised, because governments would require sufficient time to consult internally on which scenario to approve.

Ms BLACKWOOD (United States of America) said that the Proposed programme budget 2016–2017 constituted a stronger framework for a budget based on alignment with the Twelfth General Programme of Work, 2014–2019 and strengthened shared understanding of the issues, expected results and ownership across the three levels of the Organization. The programme budget was the basis for technical programming, accountability, transparency, financing and resource mobilization. The current proposal was better than previous texts in its demonstration of the main challenges and priorities and its emphasis on outcomes not inputs. WHO's priorities had been defined with greater precision and the focus on a robust planning process sharpened.

She, too, had noted the shift in priorities, in particular the decreased amounts allocated to communicable diseases, even though, gratifyingly, that was offset by an increase for preparedness, surveillance and response. She queried whether the baseline increase for emergencies from the biennium 2014–2015 was realistic. Her Government's policy objective for international organizations was zero nominal growth in assessed budgets, as WHO had experienced for several years. The work done on WHO reform had led to cost savings and efficiencies and she appreciated the commitment to continue that work. She requested further information before the Health Assembly on how the budget process would align with overall priority-setting in the General Programme of Work and a detailed breakdown in the fully costed budget, with the assumptions underlying the adjustments.

Dr AMMAR (Lebanon) noted that the proposed budget structure maintained the same historical breakdown by major office, whereas the principal objective of reform was to make WHO more effective at country level. Recent experience, including the outbreak of the Ebola virus disease, had revealed the urgent need to strengthen country offices and build more resilient health systems, actions that could be achieved only with increased funding.

In order to cope with all health challenges, including global security, WHO needed a larger overall budget, and he reiterated the call for all countries to support the proposal by the regional offices for Africa and the Eastern Mediterranean for assessed contributions to be increased. Although the budget covered responses to emergencies such as conflicts and outbreaks in the acute phase, attention should also be given to investment in improving longer-term health indicators that were adversely affected by crises. Such issues should be accounted for in category 4 on health systems.

Mr BOWLES (Australia) said that, having examined the three scenarios put forward by the Secretariat and having listened to the views of Member States, he wanted to understand the rationale behind the budget increases proposed in the second and third scenarios and the prospects for resource mobilization to the levels indicated in those options, given the funding experience in the previous biennium. He endorsed the comments and questions put forward by the member for Belgium.

Dr GONZÁLEZ FERNANDEZ (Cuba) supported the approach used to develop the budget priorities but asked about the rationale for reducing the allocations to vaccine-preventable diseases, health and the environment, and integrated people-centred health services and for increasing the amount allocated to health systems information and evidence. Adjustments should be made in those areas before the Proposed programme budget was submitted to the Health Assembly.

Dr ROUSHDY (Egypt) said that the programme budget, which had been held to zero nominal growth for some time, should be increased in order to fund the technical assistance required by low- and medium-income countries. An increase should be incorporated into the final version.

Ms MATSOSO (South Africa), speaking on behalf of the Member States of the African Region, welcomed the adoption of a bottom-up planning approach that reflected priorities at both regional and country levels. The overall shape of the budget was unchanged but there had been a shift in some staff costs and adjustments had been made to accommodate implementation of the resolution on Ebola adopted at the special session. She appealed for an increase in assessed contributions and underlined the need to focus on health threats such as HIV/AIDS and tuberculosis. Member States would continue to monitor the financial implications of resolutions and prioritize their implementation.

Ms VALLINI (Brazil) said that the late publication of the documents had restricted delegations' time to prepare or to examine documents on other important issues, such as the working methods of the governing bodies. The Proposed programme budget did not appear to specify exactly how funding would be earmarked for Ebola virus disease. It was important to ensure that all Member States had the opportunity to deliberate, and speak, on such crucial topics, for example through the virtual meetings that had contributed to the elaboration of the Twelfth General Programme of Work, 2014–2019.

Mr BEJTJA (Albania) welcomed the progress made towards bottom-up identification of priorities and the preparations to sharpen the focus of work at country level. The impact of the outbreak of Ebola virus disease on the draft programme budget remained to be clarified.

Mr SEGARD (Canada)¹ acknowledged the bottom-up approach and the incorporation of comments from the regional committees, and expected further improvements as WHO reform progressed. Nevertheless, the programme budget remained an imperfect planning tool because Member States could impose new financial demands on WHO during bienniums.

He recognized the need for WHO to protect the resources it required for programme implementation. However, the third budget scenario presented was not accompanied by an indication of what results WHO would achieve with the additional programme funds. That information should be

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provided before the next Health Assembly. He approved of the mainstreaming of gender, equity and human rights issues in all programmes, which would help WHO's work to reach the most vulnerable.

Mr BOISNEL (France)¹ praised the bottom-up planning process and the overall balance struck in the draft budget. The strategic emphasis on preparedness, surveillance and response was positive, as WHO would face other crises, like the outbreak of Ebola virus disease. He sought additional information on how the proposed scenarios would be financed, but strongly preferred the first budget scenario. If another scenario were to be chosen, it would be important to stick to zero nominal growth for assessed contributions; any budget increases should be funded by voluntary contributions. Commendable efforts had been made to hold to zero nominal growth in the previous few years; they should be continued into 2016–2017.

Ms PENEVEYRE (Switzerland)¹ expressed high satisfaction with the overall results of the bottom-up planning. Further work should go into cooperation strategies with countries and their implementation plans, allowing for greater consideration of country- and regional-level needs and priorities. She argued for more flexible financing of WHO so that funding could be aligned with the priorities defined in the programme budget. More of the regular budget should be devoted to preparedness for, and response to, pandemics and humanitarian emergencies. She asked for information about managing the financial implications of resolutions, pursuant to decision WHA67(8).

Mr ALAKHDER (Libya)¹ concurred with other speakers' concern that the outbreak of Ebola virus disease was not the only emergency requiring urgent action by WHO. More attention must be paid to conflict zones and the masses of refugees and sick people they generated. Libya was convulsed by armed conflicts, and its health system was practically non-existent. The international community should address such issues; in particular, WHO should allocate a greater share of its budget to his country.

Ms SANGA (United Republic of Tanzania)¹ asked about the process for reviewing the Proposed programme budget at the Sixty-eighth World Health Assembly, and whether Member States would have the opportunity to provide input. She expressed concern in view of the fact that even despite virtual consultations on the newborn health action plan in 2014 comments had not been reacted upon. She would submit comments on the content of the Proposed programme budget in writing but asked about the proposed indicators on sexual and reproductive health at country level under category 3 of the budget.

Mr GULDVOG (Norway)¹ supported the overall profile of the Proposed programme budget, but emphasized that the final version must take into consideration the implications of the response to the outbreak of Ebola virus disease. The bottom-up approach to planning allowed priorities to be set against country and regional needs, but it was not a substitute for clear, global priorities, which had to be decided by WHO's leadership and governing bodies. The value of document EB136/INF./3 on the process of developing the Proposed programme budget proposal could be enhanced by inclusion of information about the deliberations of the Global Policy Group and their impact on the proposed budget. All United Nations organizations should strengthen their internal oversight capacities; that was particularly true of WHO, given the uncertainties associated with direct financial cooperation. The proposed reduction for risk management was therefore of concern. Costed deliverables were needed, and the Secretariat should provide Member States with the estimates used, in order to facilitate discussions on the budget. The proposed funding reduction for climate and health should be reversed in view of calls for WHO to increase its engagement in the area.

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

Mr KÜMMEL (Germany)¹ endorsed the views of the previous speaker. He affirmed that the programme budget was WHO's main instrument of accountability. Although the Programme budget 2014–2015 would almost certainly be fully funded by the end of the biennium, there was still considerable misalignment of funding between programme areas. The format of the current budget had not helped to avoid misalignment of resources with priorities; what changes to the format had been, or would be, implemented to rectify the matter? Little information was provided on how the programme budget would be funded. Member States had put the Secretariat in a difficult situation with their discussions in the Board contrasting with their adoption of so many resolutions. There were three options for resolutions adopted that required additional finances: the Secretariat could be allowed to raise the necessary funds through, for example, voluntary contributions; Member States could determine which specific programmes should be cut back; or the decision could be made not to adopt resolutions if neither of the first two options was allowed.

Dr TROEDSSON (Assistant Director-General) assured members that the revised text would be available well before the Health Assembly and that the document would include more detailed costing information for outputs. The Secretariat would set up a dedicated website for Member States to provide input beforehand. Concerning the financial implications of resolutions, the Secretariat would prepare for the Proposed programme budget 2016–2017 a table similar to that in the annex to document EB136/33 Rev.1, which related to the Programme budget 2014–2015. Given that the costs not included in the Programme budget 2014–2015 amounted to some US\$ 39.6 million, it was expected that the impact for the next biennium would be manageable. The Secretariat would keep the governing bodies informed on which resolutions could be accommodated and those which could not.

With regard to funding for resolution EBSS3.R1 on Ebola adopted at the special session, the costing only took into account the current control measures for the ongoing outbreak in West Africa in 2015. There had not been time to cost the implications for biennium 2016–2017; that would be done in time for the Sixty-eighth World Health Assembly.

Concerning the additional US\$ 122 million under budget scenario three requested by Member States through the regional committees, more than one third would go to category 5 (Preparedness, surveillance and response) and about 25% would go to category 1 (Communicable diseases).

In terms of how the proposed budget increases envisaged under scenario three would be financed, Member States had to understand how thinking about the management of the programme budget had shifted. The vision was one plan and one budget: the aim was to align voluntary contributions with priorities, and then use the flexible funds to cover shortfalls. The overarching policy was to keep all major offices and budget centres operational throughout the biennium. An increase of US\$ 200 million for additional staff costs and requested activities was not aspirational. A budget of about US\$ 4.3 billion nevertheless posed two issues: how it would be financed (although it was a realistic, achievable increase) and implementation capacity (whether WHO could absorb the funding and meet country, regional and global needs).

The proposed reduction in funding of category 1 (Communicable diseases), which excluded Ebola, was part of a strategic shift. In the past, the programme budget had covered implementation support at country level. However, most countries had graduated from that, and also had other partners that provided financial support. WHO wanted to shift the focus to upstream policy and technical support. The new focus would not require any less technical support, but it would require less financial support.

The representative of Norway was right: bottom-up planning must not compromise normative work. There were two bottom-up processes: a country-level process through which countries identified their needs, and a global process of normative work, whereby programme areas identified global priorities. Both sets of priorities were then consolidated through programme area and category networks. The approach did not compromise normative work.

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It was important to be more rigorous in making and reporting cost savings and efficiency savings. A separate report on the matter could be produced if desired.

Speakers from several Member States in the Eastern Mediterranean Region had understandably requested sufficient support. The issue was often not merely a question of funding, but of the Secretariat enhancing its performance in general at country level – better functioning and equipped country offices.

The programme budget was indeed the Organization's main accountability tool, applicable at all three levels of the Organization. The Secretariat would be accountable for delivering what was agreed in the programme budget, and would resource it accordingly; earmarked and flexible funds were being pooled to provide full funding. WHO must be able to respond to additional, event-driven situations, like the outbreak of Ebola virus disease, but funding for those would not come from the core budget.

Dr BUSTREO (Assistant Director-General) added that some indicators for country office deliverables on sexual and reproductive health had already been agreed, notably those concerning family planning, sexually transmitted infections, and newborn and child health. Others would reflect the indicators defined for the updated Global Strategy for Women's and Children's Health, a process in which WHO would play a leading role.

Ms MATSOSO (South Africa) asked for information on the internal control process for Direct Financial Cooperation, which had huge budgetary implications. The level of resources involved could fund significant achievements at the country level.

Dr TROEDSSON (Assistant Director-General) said that new guidelines for Direct Financial Cooperation, which amounted to some US\$ 400–500 million, would improve monitoring and ensure that Direct Financial Cooperation between a regional or country office and a government should be linked to a deliverable in the programme budget.

Dr SANGA (United Republic of Tanzania)¹ requested a working definition of the proposed indicators on sexual and reproductive health for country office deliverables. Experience in previous years indicated that documents approved by the Board could not be opened up for amendment and discussion during the Health Assembly, leaving the participants with the impression that their role was mere rubberstamping; that could explain why some of them preferred to attend side events rather than the meetings themselves. Would the Proposed programme budget 2016–2017 be open for discussion during the Health Assembly in May 2015? When proposals by Member States made at the consultation stage were not accepted for inclusion in a document, it would be useful to know why.

The DIRECTOR-GENERAL said that input to the Proposed programme budget should be provided as soon as possible, as Member States were due to receive a revised draft by the end of April. In any case, the drafting process was ongoing and the document would remain a draft until the point at which it was approved by the Health Assembly.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) recalled that, at the Sixty-seventh World Health Assembly, she had drawn distinctions between the different types of documents that were submitted to the Health Assembly in order to prevent a report by the Secretariat – a finished document – being opened up for discussion. She agreed with the representative of the United Republic of Tanzania that it would be useful to know why a Member State's suggestions had been rejected.

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The CHAIRMAN added that different types of documents were submitted with different expected actions. Draft documents were open for discussion and amendment during the Health Assembly.

The DIRECTOR-GENERAL observed that certain issues arose during discussion of every programme budget. WHO reform affected the preparation of the programme budget, and the combination of bottom-up and top-down approaches would give a better sense of where the Organization's money should be spent. The improved process was iterative; it started with Member States and continued with input from the Secretariat. Priority-setting, the prerogative of Member States, was a consensus-based process. Member States might, therefore, not receive everything they had requested, since different regions and countries had different needs. The budget process was also iterative in that comments from the six regional committees on the initial draft produced different, Member State-driven scenarios. Once the final Programme budget was approved, the next step in the process was launched: resource mobilization. The financing dialogue improved the alignment and, to some extent, the predictability of funding. The desire expressed by the member for the United States of America, which was the Organization's biggest supporter, for a fully funded budget was a change of direction for WHO, as past budgets had typically been funded to the level of 20%. The commitment to work towards a fully funded budget was an improvement that had been introduced by Member States.

Any budget presented to Member States involved estimating the potential resources, in accordance with the macroeconomic situation and Member States' past commitments, in order to provide a well-founded estimate of projected income. The ability to implement the Organization's programme should also be taken into account. Money should not be wasted, but in a standards-setting organization such as WHO, quality of work was crucial to delivering results. Henceforth, before the end of each biennium, money that was not delivering results should be reallocated to offices that were producing results at all three levels of the Organization.

With regard to budgetary discipline, she thanked the representative of Germany for pointing out that Member States were putting the Secretariat in a difficult position. Both the Secretariat and, more importantly, Member States had to change their ways; if they did not work together they could not improve the Organization. Member States were aware of the programme budget and the Organization's priorities and wanted to direct money towards those priorities, yet continued to adopt resolutions, each of which came with a cost. If a stable budget was to be maintained and the additional assignments set out in resolutions accepted, some areas would see a decrease in funds. It would be helpful if Member States could provide guidance on which areas could be decreased in order to fund additional work, but she would take on that task, provided that Member States allowed her the flexibility to do so without complaint. In the case of crisis situations, such as the outbreak of Ebola virus disease, that occur after the Programme budget had been approved, the Secretariat should be allowed to bring in additional resources and to reallocate funds, despite the effect that would have on some programmes. She appealed for creative ideas from Member States for budget planning, resource mobilization and allocation, and delivering results.

Direct Financial Cooperation must be linked to deliverables and, as a form of close collaboration between Member States and the Secretariat, to performance. Auditors criticized the Organization for failing to deliver on time, but it was actually Member States that did not honour their commitments to produce results and report in a timely manner. In the past, WHO staff had taken criticism on behalf of Member States, a practice that she was determined to change. In the future, payments would be stopped if results were not delivered within the agreed time frame, just as Member States would cut their contributions to the Organization if it did not produce results.

She was being honest and frank with Member States in order to address difficult issues and improve the Organization. The Organization needed to move faster and deeper on reform, and she remained optimistic, given the collective commitment and energy demonstrated over the previous three years. She thanked all Member States for their guidance.

Dr ASADI-LARI (Islamic Republic of Iran), speaking on behalf of Executive Board members from the Eastern Mediterranean Region, accepted the Board's decision on the Proposed programme budget 2016–2017 but noted that no good reason had been given for not taking into consideration the strong arguments in favour of, first, increasing the budget and, secondly, substantially strengthening operational segment 1 (country-level technical cooperation). The situation in many countries in the Region and in Africa called for intensive support to respond to public health threats and provide assistance for the reconstruction of health systems.

Dr OMI (Japan) agreed fully with the Director-General's comments regarding the need for behavioural change by both the Secretariat and Member States. Despite repeated requests for the timely submission of documents produced by the Secretariat, many documents were not made available to Member States in good time. Meanwhile Member States, his own country included, often appeared to forget that resolutions were a means to an end and that results were actually achieved through their implementation.

Mr ALAKHDER (Libya)¹ commended the Director-General's strong and persuasive leadership of WHO.

The DIRECTOR-GENERAL said that the issue of increasing operational segment 1 (country-level technical cooperation) would be addressed under agenda item 11.3 (strategic budget space allocation). She recalled that agreement at the Board did not automatically mean agreement at the Health Assembly.

The Proposed programme budget 2016–2017 had been issued late because of a change in its development process. The process for the next proposed programme budget would be less intensive and the document would therefore be issued in a more timely manner. When negotiations could not be completed on time, the translation and production of documents were inevitably delayed. In future, Member States would be informed of such cases, in order to avoid undue criticism of the Secretariat.

Resolutions usually contained two sections, one that requested action on the part of the Director-General, which was monitored as part of WHO's accountability, and one aimed at Member States for implementation. Member States across the board, including high-income countries, had poor records when it came to the implementation of resolutions. She asked Member States to reflect on how effective and efficient they were in their work on implementing resolutions.

The CHAIRMAN said that he understood that the Secretariat would take into account the comments made when finalizing the Proposed programme budget 2016–2017 for consideration at the Health Assembly in May 2015.

It was so agreed.

Strategic budget space allocation: Item 11.3 of the agenda (Document EB136/35)

Dr REN Minghui (China), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, said that the Committee had considered the report of the Working Group on Strategic Budget Space Allocation and discussed the proposed methodology.² It had recommended that the Board accept the Working Group's recommendations for operational segments 2, 3 and 4 and request the Secretariat to submit a plan of implementation for those segments to the Board through the Committee at its meeting in May 2015. The Committee also recommended that the Board discuss segment 1 (technical cooperation at country level) further at its current session.

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

² Document EB136/3.

Dr ASSIRI (Saudi Arabia), speaking on behalf of the Member States of the Eastern Mediterranean Region and of the Cooperation Council for the Arab States of the Gulf, commended the Working Group's work but expressed concern regarding data gaps, which could skew the assessment of countries' health needs. Similarly, outdated data could leave some regions at a disadvantage when the methodology was applied: data from the Eastern Mediterranean Region had been collected before the crisis in that Region, and would not accurately reflect the current health situation, which had been severely affected by conflict. He cautioned that the methodology for segment 1 should not be discussed in isolation from the other segments, since the budget would need to be balanced. Funding for crisis situations should be kept separate from funding for the rest of the Organization's work. A substantial increase in segment 1 funding would be in line with the Organization's reform objectives.

Ms ROA RODRIGUEZ (Panama), speaking on behalf of the Member States of the Region of the Americas, welcomed the new methodology for strategic budget space allocation, which should increase transparency and accountability at the three levels of the Organization. She endorsed the recommendations of the Programme, Budget and Administration Committee with regard to segments 2, 3 and 4, and the methodology proposed for segment 1, provided that it was based on reliable data and flexible. Further progress was vital and the new methodology could be considered a prototype on which to build. Guidance on implementation, as requested by the Committee, would be particularly useful.

Dr OMI (Japan) said that, given the rationale of "One WHO", with one budget for the three levels of the Organization, he had been surprised to note the recommendation to discuss segment 1 alone. All four segments should be discussed together in detail, and care taken not to make any hasty decisions on the methodology.

Mr CASALS ALÍ (Andorra) said that the methodology for segment 1 would increase the technical cooperation capacity for all six regions. An equitable budget space allocation system was essential.

Dr ABDULGHAFOR (Kuwait) described the severe impact of the worsening crisis in the Middle East on the health situation in several countries, in particular the Syrian Arab Republic, Jordan and Lebanon, owing to large-scale displacement and the destruction of infrastructure. Progress in development had been reversed, poverty had deepened and health care had declined. Health data from the region were outdated and did not reflect the acute need for support. Any budget allocated on the basis of those data would be insufficient. Backward-looking indicators should therefore be avoided.

Dr PAVIĆ ŠIMETIN (Croatia) acknowledged that defining the new methodology was a complex process, particularly given that previous attempts at evidence-based allocation of funds had not been altogether successful. She looked forward to receiving the implementation plan, as requested by the Programme, Budget and Administration Committee. It was to be hoped that the conclusions of the deliberations would have a positive impact on the budget levels presented in the revised Proposed programme budget 2016–2017.

Dr AMMAR (Lebanon) agreed with the member for Kuwait that budget space should be allocated on the basis of projected needs rather than outdated data. The rising poverty and political conflicts in the Eastern Mediterranean Region would doubtless have a severe impact on health for many years to come, placing considerable strain on health services. The Working Group had made good progress towards a basic model that could be adjusted gradually by updating databases and using more predictive indicators.

Dr BEJTJA (Albania) endorsed the proposed methodology, including that for segment 1. Given the urgent need for a fair and equitable system of resource allocation, he agreed with the previous speaker that the methodology should be accepted as a basic model that could be adjusted over time.

Dr AKSEL'ROD (Russian Federation) acknowledged the efforts of the working group of the Standing Committee of the Regional Committee for Europe, which had contributed significantly to the deliberations of the Working Group on Strategic Budget Space Allocation. She agreed with the proposed methodology for segment 1, but disagreed that the status quo should be maintained for the other three segments. Any further discussion required to ensure a fair and equitable distribution of resources must take place quickly, to allow it to be taken into account in the Proposed programme budget 2016–2017. Consideration should be given to the model used in the European Region, in which technical cooperation was provided not just to individual countries, but also to groups of countries, subregional groups and the Region as a whole. That approach ensured optimum use of available resources.

Mr JEON Man-bok (Republic of Korea), supporting the principles and approach established to formulate the methodology, asked how they had been applied, as the requirement to allocate resources to areas where WHO could make the greatest impact did not seem to have been met. There was consensus on the importance of the availability, timeliness and quality of data, but the question arose as to how budget space would be allocated if the data were not as reliable as they should be. Resource allocation was a complex matter, closely linked to other reform initiatives, and the methodology should therefore be rooted in the guiding principles and based on the needs and priorities of Member States.

Dr MATCHOCK MAHOURI (Chad), speaking on behalf of the Member States of the African Region, said that priority should be given to segments 1 and 4 but that the methodology for all segments should be discussed during the Board's current session. The methodology had to be based on the six guiding principles. He took note of the general recommendations. The work should be continued.

Dr FORSTER (Namibia) agreed that further work was required. In the guiding principles, with the encouraging inclusion of "fairness and equity", the latter should be more explicitly defined. How would equity be applied? Performance management was an integral part of results-based management. A further guiding principle might usefully be added to incorporate an element of flexibility and responsiveness, despite the quest for greater rigour in budgeting processes.

He welcomed the methodology for segment 1, supporting composite model 5, although the Working Group needed to do a sensitivity analysis before deciding on the transition period. Segments 3 and 4 needed some revision, and he disagreed that the current allocation system for segment 3 should remain unchanged until the end of the reform process; change in administration and management were pivotal to reform. He supported the Working Group's general recommendations.

Dr REN Minghui (China) said that strategic budget space allocation should support countries in greatest need and must be based on reliable data. He questioned the sustainability of the indicators chosen and the use of previous years' data to calculate future budget allocations. The issue should remain under discussion, whether in the existing Working Group or in a new group to be established by the Board.

Mr ROUSHDY (Egypt) said that, although natural disaster indicators could be significant for some regions, they were not applicable to all. Political risk factors, however, were extremely important and should also be taken into account. Fairness and equity were important and every region should receive its fair share of allocations. However, the current situation in some regions could not be ignored and all calculations and work should be based on up-to-date data.

Mr RASHEED (Maldives), speaking on behalf of the Member States of the South-East Asia Region, asked whether the new models, allocations and methodology accurately reflected the health needs of the regions, given the weaknesses in the data. Concerns also existed about the strength of the indicators. Most developing countries had no institutional capacity to produce good data on

disability-adjusted life years. More accurate and available indicators, such as health workforce density and hospital bed density (more appropriate than high population density), infant and child mortality rates, and burden of disease, and those that differentiated the relative health needs of countries should be considered. Data gaps in the composite models were another serious concern, demanding exploration of alternative indicators with better data availability. The use of adjustments in indicators where data were unavailable should be further evaluated. The methodology and indicators required additional review in order to devise a model that reflected the actual needs of the regions, based on robust and recent data indicators. He proposed that the Working Group or a technical team refine the process and improve the indicators, and present a report to the Sixty-Eighth World Health Assembly.

Dr CHAND (Nepal) drew attention to major public health challenges faced in the South-East Asia Region, such as high rates of poverty, malnutrition, infant mortality, tuberculosis and HIV infection as well as poor sanitation, poor access to health care, widespread malaria and an emerging epidemic of noncommunicable diseases. He noted that Member States were divided on the value of composite model 5 (V). For any model, the technical specifications must be accurate, precise and accepted by the experts. Doubts had been expressed about the current accuracy of the model, according to which, for example, the European Region recorded a higher disease burden than the South-East Asia Region. The Secretariat should take more time to complete the work on segment 1, so as to enable Member States to agree on the technical aspects of the model. The work should not lead to a divided WHO but contribute towards a single effective Organization.

Ms BLACKWOOD (United States of America) said that the methodology being phased in was most appropriate to help the regions to adjust to resource-level changes. The gap since the last consideration of strategic budget space allocation in 2007 was too long; the subject, including the question of the best available data, should be considered at more regular intervals.

Mr KIM Chang Min (Democratic People's Republic of Korea) affirmed that the selected indicators did not represent the reality and needs of the regions. Allocation of resources should be based on concrete and rational indicators to reflect the real needs, health gaps and financial capacities of the Member States and the regions. The methodology should be revisited to produce a sound allocation, with the participation of economists in the formulation exercise. A robust and fair allocation table, once completed, could be used as a prototype for WHO's future planning of budgets.

Mr MAGALLANES (Argentina) supported the guiding principles for a transparent and inclusive process to establish the budget space allocation methodology, and underscored the importance of flexibility in allocating and reallocating funds wherever necessary. However, fixed formulas or models were not suitable for WHO. Regarding the criteria for segment 1, he welcomed the technical work on different allocation models as well as the information session held the previous week. It was to be hoped that further work and discussions would be clarifying and instructive. The allocation of budget space must be objective and have a solid technical base in order to ensure the transparency and accountability of the Organization.

Dr GRABAUSKAS (Lithuania) recorded his appreciation of the support for the principles of the methodology elaborated by the Working Group and which deserved broad support. The methodology represented a considerable step forward and was a sound instrument for implementing an objective distribution of funds, especially for segment 1. Maintaining the status quo was not an option.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) endorsed the comments of the members for Croatia and Namibia. She agreed that strategic budget space allocation had to be objective and evidence-based. Improvement of the selected indicators and data quality and availability should be a continuous process. Misgivings had been voiced about the impact of any new basis for segment 1 on the situation in regions and countries. That was an intensely political aspect of the discussions that had to be approached with great care. She asked the Secretariat to submit options for

possible implementation, including different time periods for introducing changes, with information on their potential effect.

Mr BOWLES (Australia) agreed that all four segments should be considered together. Although segment 1 was important, the fact that regional offices and occasionally headquarters also delivered assistance directly to Member States had to be taken into account. The matching of budgets and functions at headquarters and regional level should be examined more closely.

The work to support the methodology could never be perfect. Choices had to be made about weights applied to the set of indicators and scaling factors in the model, and more detailed work was needed to ensure the relevance of such parameters across all regions. The methodology should be viewed simply as a model and be applied in principle but with recognition of the limitations of the underpinning indicators and data. A sensitivity analysis was required. Judgement must be applied in interpreting and implementing the model. Flexibility for the Director-General and regional directors in applying the methodology was also important. He expressed concern about WHO's budget stability and welcomed the principle of incremental transition towards the allocation models. Any change to regional budgets must be handled strategically so as not to interrupt core functions.

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

2. NONCOMMUNICABLE DISEASES

Global burden of epilepsy and the need for coordinated action at the country level to address its health, social and public knowledge implications: Item 6.6 of the Agenda (Document EB136/13)

Ms ROSE-ODUYEMI (Office of the Governing Bodies and External Relations) announced that an informal drafting group would meet to consider a proposed draft resolution on the subject.

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

The meeting rose at 12:30.

SIXTH MEETING

Wednesday, 28 January 2015, at 14:35

Chairman: Mr M.H. SHAREEF (Maldives)

1. PROGRAMME AND BUDGET MATTERS: Item 11 of the Agenda (continued)

Strategic budget space allocation: Item 11.3 of the Agenda (Document EB136/35) (continued from the fifth meeting, section 1)

Ms VALLINI (Brazil) said that the strategic budget space allocation methodology should be based on accurate and up-to-date data and must respond to regional and national health needs. More consultations should be held on operational segment 1, to allow for a more equitable, transparent and accountable allocation of resources for technical cooperation at country level. Efforts must also be made to ensure that the methodology had sufficient overall flexibility to respond to health emergencies as well as the priorities of the General Programme of Work.

Dr NOOR HISHAM ABDULLAH (Malaysia) stated that the two options for segment 1 were to accept the proposal and expand the number of indicators used or to maintain the status quo and rely on only gross domestic product (GDP) and life expectancy (model A) as indicators. He recommended acceptance of the guiding principles of the methodology and suggested a periodic evaluation of the appropriateness of any new indicators following their adoption. During the transition period, he proposed using a percentage range between the methodology of model A and composite model 5 (V). For regions that would receive less funding, model 5 (V) could be used as the minimum value and model A as the maximum value, and vice versa for regions that would receive more funding. In cases where the total percentage allocation (for all segments) might exceed 100%, the additional amount could be transferred on a case-by-case basis, thereby providing the desired flexibility.

Dr CUYPERS (Belgium), speaking in his capacity as Chair of the Working Group on Strategic Budget Space Allocation, recalled that the Programme, Budget and Administration Committee had reached consensus on the recommendations for segments 2, 3 and 4.¹ He outlined the extensive and inclusive process of work in the Working Group. Despite it having spent two days intensively discussing indicators for segment 1, concerns had been expressed in both the Committee and the Board about the proposed methodology for segment 1, namely concerning the appropriateness of the indicators, the quality and availability of data, and the need for flexibility and periodicity in implementing the changes in resource allocation. As opinions were divided and to assuage doubts about the appropriateness of the indicators, he stressed that the “basket” of five indicators proposed under model 5 (V) were the most robust and accurate indicators available to estimate per capita health needs. He further stressed that the decision had been agreed upon not only by the Working Group and its supporting technical experts but also by representatives of all WHO regions and regional offices. One key value in the WHO reform process was the need to take decisions based on scientific evidence.

Speaking as the member for Belgium, he said that the Board had to decide on the information available. It had been established that adding new indicators would not change the model significantly. Further discussions would only serve to weaken the mandate of the present and all future working

¹ Document EB136/3.

groups if the Board did not follow the recommendations of the initial Working Group which were based on scientific evidence. He therefore urged the Board to adopt the proposed methodology for strategic budget space allocation and conduct regular evaluations of its performance with a view to making refinements in the light of feedback.

Mr ISMAIL MOHAMMAD SABIN (Iraq)¹ noted that the Regional Office for the Eastern Mediterranean had acted swiftly and effectively in cooperating with his country's health authorities in their efforts to cope with the aftermath of the terrorist attacks that continued to plague Iraq. Those efforts consisted of both the delivery of essential health services to millions of internally displaced persons and the provision of medical treatment to the many victims who had been permanently disabled or incapacitated for work. His Government had allocated US\$ 830 million in assistance to internally displaced families and greatly appreciated WHO's work, in particular that to prevent epidemics and the deterioration of public health. The Organization's subsequent budgets should allocate funds for dealing with crisis situations, which should also form part of the financial dialogue in order to avoid any conflation of development programmes with emergency programmes.

Mr KÜMMEL (Germany)¹ commented that no indicators or data were perfect. The Working Group had been tasked with devising a specific model of budget allocation based on scientific evidence, which it had successfully done. The data and indicators selected were the best available and had received the unconditional support of WHO's regional representatives. The new methodology should therefore be adopted at the earliest possible opportunity. The proposal should only be rejected if there were evidence to suggest that the existing indicators provided a more robust and equitable budget space allocation than those proposed by the Working Group.

Mr REDDY (India)¹ affirmed that the strategic budget space allocation methodology should take into account the health needs of all regions, through the use of valid and robust indicators capable of measuring intercountry variations and health needs more accurately. The Working Group's budget allocation calculations seemed to be at odds with the global health reality, particularly in the South-East Asia Region which, according to WHO's regional estimates of disease and injury for 2000–2012, had the highest percentage of disease burden. There had also been a failure to consider social determinants of health, particularly poverty, during the budget space allocation exercise. He was therefore at a loss to understand the reduction in allocation to the Region proposed in segment 1 and called for the establishment of a new working group to identify better and more robust indicators, including input from at least one technical expert per region.

Mr DIKMEN (Turkey)¹ welcomed the development of an evidence-based methodology that focused on universal health coverage but said that a biennial review of the methodology should be conducted to ensure that present and future health challenges were adequately met. He also proposed including tobacco usage rates as an indicator, in order to tackle the future challenges of noncommunicable diseases. The methodology could help to improve national data collection systems to ensure that the most accurate data were used when allocating resources.

Dr THAKSAPHON THAMARANGSI (Thailand)¹ said that the methodology must be sufficiently flexible to allow for a more effective and equitable budget allocation, and shared concerns about the accuracy and appropriateness of the indicators proposed by the Working Group, which failed in some instances to reflect the true health requirements of certain regions, and the accuracy and timeliness of data. He called for further consultations to discuss suitable indicators and to consider the budget space allocation methodology for all segments of the programme as a whole.

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

Mr GULDVOG (Norway)¹ supported the general recommendations of the Working Group and agreed that any satisfactory model for strategic budget space allocation required a budget with a complete results chain, costing of deliverables and clear division of labour. Improvements in performance should be taken into account when making resource allocation decisions, and sufficient flexibility must be provided to ensure that WHO could respond to future health challenges. More emphasis should also be given to adequate resources for WHO headquarters, so that the Organization could effectively fulfil its mandate.

Mr BOISNEL (France)¹ welcomed the efforts of the broadly representative Working Group to develop a robust and scientific methodology for strategic budget space allocation. He urged all Member States to adopt the proposed model as a positive step forward in WHO reform. Further consultations would not contribute to the finalization of the Proposed programme budget 2016–2017.

Ms ROA RODRIGUEZ (Panama) stressed the importance of allocating resources based on the best available data. Her country supported the adoption of the methodology proposed by the Working Group; maintaining the current system would not provide the flexibility in resource allocation required for the effective functioning of the Organization.

Mr ALIMUZZAMAN (Bangladesh)¹ said that strategic budget space allocation based on an evidence-based needs analysis was imperative for country-level and regional development. The health of people in densely populated regions like South-East Asia should not be the subject of approximations when other more accurate indicators were available. More work was required to ensure that all the guiding principles were put into practice in the methodology, and discussions should therefore be continued.

Ms DOAN PHUONG THAO (Viet Nam)¹ expressed concern that: the division of WHO's work into four operational segments was a new tool whose validity had not yet been proven; there should be a discussion to determine whether the current allocation of 23% to technical cooperation at country level was appropriate; and the situation of emerging middle-income countries was not fully considered. The proposed shift of resources was significant, and she urged the Working Group and the Secretariat to revisit those issues.

Mrs MOHAMED LAFIR (Sri Lanka)¹ said that Member States had recently highlighted the importance of bottom-up planning and strengthening country offices, both of which should therefore be reflected in the budget allocation for country-level work. The recent outbreak of Ebola virus disease, conflicts and humanitarian crises in the Eastern Mediterranean Region, and the health challenges faced by the South-East Asia Region should all be taken into account when directing WHO budgetary resources. The report of the Working Group envisaged unequal increases for certain regions and decreases for others; she asked about the rationale behind those inequalities. Given that the proposed methodology was still a prototype, she strongly suggested that further work should be done to develop a model that would meet the genuine requirements of developing countries.

Ms ALARCON (Colombia)¹ expressed support for the proposed methodology, which should ensure the fair and objective strategic allocation of budget space on the basis of common criteria, which would strengthen transparency and accountability. The opportunity to advance one component of WHO reform should not be missed.

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

Mr SEGARD (Canada)¹ said that the proposed methodology represented a further technological advance for the Organization. Some refinement would be needed in the future, but he could support the model in its current form.

Mrs CABALLERO ABRAHAM (Mexico)¹ said that the composition and working method of the Working Group meant that equal consideration had been given to the specific needs of each region. In addition, the proposed methodology, including segment 1 and the indicators proposed by the Working Group, had been discussed by the regional committees. The report reflected the outcome of those deliberations. The aim had been to design a new methodology based on sound scientific evidence with clear, objective indicators that could be applied in all six regions and headquarters. The scientific evidence had been analysed in technical meetings, in order to ensure transparency and accountability. With guidance from representatives of the six regions, and after in-depth analysis of those elements, the Working Group had reached consensus on the text before the Board. Maintaining the status quo would be detrimental to the whole reform process.

Mr CASALS ALÍS (Andorra), agreeing that the status quo should not continue, noted that the recommended methodology was based on scientific evidence and would ensure that the next programme budget would include the flexibility that Member States had called for.

The DIRECTOR-GENERAL commended the attention paid by Member States to reformulation of the budget and expressed appreciation to members of the Working Group for achieving an almost impossible task. There was general agreement on using the best available scientific indicators and data and meeting the needs of each region. She had been tasked by Member States to present a comprehensive One-WHO budget that was transparent, fair and strategic. The methodology before the Board should not be allowed to divide the Organization. It should not be forgotten that, until donors provided funding, strategic budget space allocation remained an abstract concept. Approval of the methodology was just the first step; much hard work would follow in terms of coordinated, Organization-wide resource mobilization and fair allocation. The members of the Working Group, who represented all six regions, had carried out admirable work. If their suggestions were continually rejected, it was unlikely that other countries would volunteer to serve on working groups in future. She confirmed that the Working Group had discussed all four segments and acknowledged that the format might need to be adjusted to show more clearly the cross-linkages between them. The Working Group had reached agreement on segments 2, 3 and 4; with regard to segment 1, she agreed that the proposed percentage allocation of 23% was insufficient for the purpose. However, the segment should not be viewed in isolation: much of the work done by regional offices under segments 2 and 3 contributed to segment 1. For instance, some 400 staff members had been despatched from the regional offices and headquarters to provide technical support to the three affected countries during the Ebola virus disease outbreak; the salaries of WHO representatives were shown under segment 3; and response to emergency events was included under segment 4, which did not have a specific allocation because of the unpredictable nature of such events. Additional sources of funding that benefited countries experiencing difficulties, of which many were in the Middle East, included the Central Emergency Response Fund administered by the United Nations Office for the Coordination of Humanitarian Affairs, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance and numerous pledging conferences. The total revenue of countries from development partners and United Nations agencies had yet to be estimated. Experience had shown the difficulty of devising models or indicators that satisfied all six regions. Whichever model was finally used for segment 1, inevitable changes would mean budget increases for some regions and decreases for others. There could be no doubt, however, that the status quo was not an option. Furthermore, a decision was urgently needed if Member States were to receive the Proposed programme budget 2016–2017 by the end of April. She

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

therefore proposed that segments 2, 3 and 4 should be applied immediately and that segment 1 should await the outcome of her consultations with regional directors to find a flexible, sensitive and fair solution. The Working Group would continue to examine the indicators and data, as well as other areas on which she had made commitments, including costing, results-based resource allocation, the linking of results and deliverables, and transparency and accountability.

The CHAIRMAN said that the concerns expressed by Member States had focused on whether the outcomes, based on scientific evidence, were equitable. Speaking as the member for the Maldives, he supported the Director-General's proposal.

Dr AMMAR (Lebanon) suggested factoring in political instability as an indicator, since certain Member States of the Eastern Mediterranean Region did not have data reflecting the latest situation owing to the political crises that they were experiencing. The proposal was, however, a good starting point for the evidence-based allocation of budget space.

Mr ROUSHDY (Egypt)¹ asked which figures would be used for the calculations: the average from the 2006 validation mechanism or those from composite model 5 (V)? If the latter, would they be the original figures from that composite model or the ones revised to reflect statistics on birth in the presence of skilled attendants for high-income countries?

Dr REN Minghui (China) highlighted the unwillingness of Member States to maintain the status quo. Although the Member States of the Western Pacific Region were dissatisfied with the results of the analysis, they did not wish to divide the Organization. The conclusions of the discussion on strategic budget space allocation could be harmful and might send the wrong message that high-income regions with better overall health would need more technical support from WHO. He asked for the Director-General's proposal to be distributed in writing.

Ms MATSOSO (South Africa), Mr BOWLES (Australia), Mr RASHEED (Maldives) and Ms ROA RODRIGUEZ (Panama) agreed with the proposal because it would give the Secretariat the flexibility to incorporate new ideas in due course.

Dr OMI (Japan) agreed that continuing the status quo was out of the question and that discussions should build on previous ones, rather than starting from scratch, and take into account the Working Group's previous recommendations. The Director-General and regional directors should also have the flexibility to decide whether to adhere to those recommendations.

The DIRECTOR-GENERAL, expressing appreciation for Board members' support for her proposal, confirmed that it would be presented to Member States in the form of a decision. Replying to the member for Egypt, she said that she could not have pre-empted members' agreement to move in a particular direction and she had therefore not yet worked on the details of the model to be used.

In response to Mr CASALS ALÍS (Andorra), the DIRECTOR-GENERAL said that she took it that Member States wanted the Working Group to continue improving the modelling and the quality of the data. She had not asked its members whether they wanted to continue but would hold informal consultations to determine the Working Group's exact composition.

Mr RASHEED (Maldives) said that he would consult within the South-East Asia Region on the Director-General's proposal.

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

Mrs VALLINI (Brazil) supported the Director-General's proposal and asked for the continuation of Mexico's representation in the Working Group.

Ms MATSOSO (South Africa) said that she would consult within the African Region on the Director-General's proposal and proposed that Cameroon should continue as a member of the Working Group.

Dr CHAND (Nepal) said that Member States of the South-East Asia Region were struggling to face the challenge of communicable and noncommunicable diseases and were vulnerable to natural and human-made disasters and climate change. To sustain its public health achievements, the Region required increased health investment, with more technical and financial support from international organizations and the donor community. How could it be ensured that ongoing programmes were protected from lack of resources?

The DIRECTOR-GENERAL said that she could not give such an assurance. Although she could not speak for other donors, WHO would provide fair, transparent and equitable support. Cross-linkages from segments 2, 3 and 4 would yield additional resources for segment 1. Indeed, 48% of the funds received by WHO from all sources went to the country level of the Organization, with full transparency about the delivery of results. Member States had made the right decision to move ahead, as maintaining the status quo would have taken the Organization back five years.

(For continuation of the discussion and adoption of a decision, see the summary record of the twelfth meeting, section 1.)

2. WHO REFORM: Item 5 of the Agenda (continued)

Overview of reform implementation: Item 5.3 of the Agenda (Document EB136/7) (continued from the fourth meeting)

Dr OMI (Japan) said that the Regional Committee for the Western Pacific Region had adopted a new code of conduct that was fair and transparent for the nomination of its Regional Director, which restricted or discouraged bilateral visits by candidates to Member States and favoured electoral campaigns. The Regional Committee considered that important governance issues, such as the appointment of regional directors, should be the responsibility of the Executive Board. Ceding such decisions to an open-ended working group could undermine the Board's responsibility, while participation would be a challenge for countries with limited human and financial resources.

Mr KIM Chang Min (Democratic People's Republic of Korea) said that due consideration should be given to respect of WHO's Constitution; Article 52 stated that the regional committees were responsible for the selection of the regional directors. The regional committee acted in the interests of the region, and its mandate and the principle of self-determination should be respected. Reform was necessary for development and to avoid stagnation, and it was important to identify and attend to problems. However, care should be taken not to make changes for change's sake.

Ms KUIVASNIEMI (Finland),¹ noting that more work on WHO reform was required at country level, requested further information on the functioning of country offices, including their size and funding, and strategies linked to enhancing unified reporting of results, financial management and

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

transparency. With regard to the nomination of regional directors, the Regional Committee for Europe had adopted a similar code of conduct to that mentioned by the member from Japan.

Mr REALINI (Monaco)¹ said that WHO reform should fully reflect the new parameters and lessons learned from the outbreak of Ebola virus disease, not least the changes at all three levels of the Organization, based on a thorough examination of the governance of the regional offices and their connection to headquarters. It was to be hoped that all future discussions would be informed by additional information on internal governance at WHO.

Ms KOCHLEF (Tunisia)¹ said that the Mediterranean Centre for Health Risk Reduction, which had been built at WHO's request, had been in operation in Tunisia since 2012. Given that the Centre was still underused, she asked WHO to take the relevant decisions as soon as possible to put the Centre to good use.

Ms EL BERRAK (Morocco)¹ said that programme implementation mechanisms should be reviewed in order to strike a balance between respecting procedures and avoiding delays in implementation. The process for election of regional directors was unique within the United Nations system and should be maintained, but it should be examined to identify and redress weak points, with emphasis on transparency, fairness and consensus. She supported the establishment of an intergovernmental working group with balanced and equitable representation of all regions.

Mr KÜMMEL (Germany)¹ said that four priority areas for reform needed further work, namely corporate alignment, human resources, country office performance and internal communication. Corporate alignment was a major challenge for the decentralized Organization. Accountability was clearly defined in the WHO Constitution: Article 31 stated that the Director-General was the chief technical and administrative officer of the Organization as a whole, not just headquarters, with power and accountability. However, in order to be held accountable, the Director-General had to have the means to implement her decisions effectively throughout the entire Organization, through delegated authority and a clear chain of command. The response to the outbreak of Ebola virus disease had demonstrated that the chain of command required improvement. He welcomed the "accountability compact" that had been introduced between the Director-General and the assistant directors-general, which included clear performance objectives and which should be extended to include the regional directors. He asked for feedback on that proposal.

Ms ALARCON (Colombia)¹ supported the draft decision; the establishment of an open-ended working group would enable progress to be made on the issue.

Mr CANDIA IBARRA (Paraguay)¹ said that, although much work remained on governance reform, progress was being made. His country wished to sponsor the draft decision.

Mr DIKMEN (Turkey) said that the reform process was having a positive impact on WHO; nevertheless, efforts needed to be further accelerated in terms of streamlining the roles and responsibilities of the three levels of the Organization and strengthening the accountability mechanism. Country offices required adequate financial and human resources to operate in the rapidly changing global health environment and to be able to provide the technical expertise required to build resilient health systems.

Ms BARRIA (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, said that, although progress had been

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

made, the outbreak of Ebola virus disease had highlighted various issues related to WHO's capacity and functioning and how WHO had been unable to promote resilient health systems in the affected countries. She encouraged Member States to request an evaluation of the impact that cuts in human resources had had on the Organization's response capacity. They should also take action to resolve WHO's financial crisis, particularly the freeze on assessed contributions.

The DIRECTOR-GENERAL said that three key issues had been raised: performance at country level; the process used to nominate regional directors; and accountability. With regard to performance, in response to requests made both during the discussion of the current agenda item and at the third special session of the Board, one single report could be produced, in order to avoid duplication of work. Although each region had a different approach to the nomination of its regional director, at the behest of Member States she had already taken steps to analyse the processes and align them as much as possible. All candidates were required to share their vision and priorities with Member States during the selection process. Member States had since made further proposals – establishment of an intergovernmental working group or open-ended working group, or continuation of the work within the Board; she needed more guidance.

The accountability compact that had been agreed between her and the assistant directors-general was based on the fact that she, rather than the governing bodies, appointed them. The Director-General was nominated by the Board and appointed by the Health Assembly, to both of which bodies she was accountable. The regional directors were accountable to the regional committees that nominated them and the Board which appointed them. In practice, the regional directors were also accountable to the Director-General and were expected to deliver results, although there was no written accountability compact with them. She would be pleased to follow the wishes of Member States about an accountability compact with the regional directors.

Dr ALWAN (Regional Director for the Eastern Mediterranean) added that Article 51 of WHO's Constitution stated that the regional office should be the administrative organ of the regional committee, meaning that the regional directors were accountable to regional committees; that happened in practice. The regional directors were also accountable to the Director-General, who, indeed, was the chief technical and administrative officer of the entire Organization, and to the Executive Board and Health Assembly both directly or through the Director-General.

(For adoption of the decision, see the summary record of the fifteenth meeting, section 2.)

3. COMMUNICABLE DISEASES: Item 9 of the Agenda (continued)

2014 Ebola virus disease outbreak: Item 9.4 of the Agenda (Documents EB136/26, EB136/49, EB136/INF./4, EB136/INF./5, EB136/INF./6, EB136/INF./7 and EB136/INF./8)

The CHAIRMAN recalled that during the Board's third special session, Member States had reviewed the current state of the response to the Ebola virus disease outbreak and had made recommendations on further steps to stop the epidemic. There had also been discussion of how to strengthen the capacity of WHO to prepare for and respond to future large-scale and sustained outbreaks and emergencies. Resolution EBSS/3.R1 had been adopted as a result.

The Board took note of the report on the current context and challenges; stopping the epidemic; and preparedness in non-affected countries and regions contained in document EB136/26.

4. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 8 of the Agenda

Antimicrobial resistance: Item 8.1 of the Agenda (Documents EB136/19 and EB136/20)

Ms MATSOSO (South Africa), speaking on behalf of the Member States of the African Region, underlined the global concern about the spread of antimicrobial resistance. Although some actions had been taken and resolutions adopted, the draft global action plan represented the first comprehensive approach to the problem, and she supported its adoption. Its implementation would help to ensure continuity in the treatment and prevention of infectious diseases and enable the preservation of existing antimicrobial agents. To ensure its effective implementation, however, many countries would need support to create the necessary infrastructure, facilitate responses at the local level, and enable surveillance and monitoring.

Dr ALQATTAN (Kuwait), speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed the fact that all three levels of the Organization had participated in developing the draft global action plan. He endorsed the plan and made an urgent plea for its implementation and for allocation of the necessary financial resources. The plan would help member States of the Region to establish surveillance systems and introduce and implement rules and regulations on the rational use of antimicrobial agents, as called for by the Regional Committee. To ensure closer collaboration between the human health, animal health and food sectors, WHO should actively engage OIE and FAO in implementing the plan. The Director-General should also continue her discussions with the United Nations Secretary-General regarding the organization of a high-level meeting on the topic, in order to increase political commitment.

Dr CUYPERS (Belgium), speaking on behalf of the European Union and its Member States, said that Turkey, the former Yugoslav Republic of Macedonia, Montenegro, Serbia, Albania, Bosnia and Herzegovina, Ukraine, Republic of Moldova and Georgia aligned themselves with his statement. He commended the work of the Secretariat and the Strategic and Technical Advisory Group on antimicrobial resistance and the consultative process in developing the draft global action plan. He agreed with the centrality of the availability and prudent use of effective antibiotics in the plan and the need for diverse approaches. Action should be holistic and engage all relevant sectors through a “One Health” approach to each of the plan’s five objectives. He welcomed the framework for action in the draft plan, and the fact that it recognized the roles of international and national partners in meeting identified national needs and would facilitate resource mobilization. However, the global action plan should be accompanied by an effective monitoring and reporting mechanism to measure progress and impact, as well as national action plans. He invited other Member States to join those in the European Union already participating in the Joint Programming Initiative on Antimicrobial Resistance. He urged the Board to recommend the adoption of the draft global action plan by the Health Assembly.

Dr HARVEY (United Kingdom of Great Britain and Northern Ireland) said that a review of the projected costs of antimicrobial resistance had revealed that without effective action it would account for up to 3.5% of the world’s gross domestic product by 2050, with particular impact on low- and middle-income countries. The draft global action plan was the first step in combating antimicrobial resistance. She welcomed the plan’s format and its recognition of the complex interactions between animal and human medicine, farming and other environmental factors, and the need for a “One Health” approach. She endorsed the call for Member States to develop national action plans within two years, noting its recognition of the need for flexibility to reflect different national circumstances. Antimicrobial resistance should be reflected in the post-2015 sustainable development agenda. She urged support for the draft action plan.

Dr KAMALIAH MOHAMAD NOH (Malaysia) reaffirmed her country’s commitment to combatting antimicrobial resistance by promoting the responsible use of antimicrobials for human and animal health. She recommended submission of the draft global action plan to the Health Assembly in

May 2015 for adoption and supported the priority actions for antimicrobial resistance in the Western Pacific Region.

Mr CHEN Hu (China) noted that work to combat antimicrobial resistance had to involve different sectors, ministries and countries; that would remain a challenge. China had developed guiding principles and a management mechanism for the rational and clinical use of antimicrobial agents, as well as a surveillance network with improved indicators of use of antimicrobials and resistance. He urged the Secretariat's continued global leadership on antimicrobial resistance and to share experience with Member States.

Mr KOLKER (United States of America) commended the progress made in implementing resolution WHA67.25 and supported adoption of the draft global action plan, which would require implementation on farms, in hospitals and at national, regional and international levels. Member States should collect and share data and best practices on the rational use of antimicrobials and infection control and prevention. His President had made combatting antimicrobial resistance a national priority; the National Strategy for Combating Antibiotic-Resistant Bacteria echoed the draft global action plan, and the Global Health Security Agenda would facilitate implementation of the draft global action plan at the international level. In the farming sector, his Government recommended that only "medically important antibiotics", a term defined in domestic legislation, should be targeted for removal from farming practices. Scientific uncertainty should not preclude action, and he would prefer that the draft action plan made reference to a "precautionary approach" to preventing the emergence and spread of antimicrobial resistance rather than the "precautionary principle". He encouraged WHO to assess periodically the pathogens targeted by the draft action plan.

Dr AKSEL'ROD (Russian Federation) said that she spoke also on behalf of the other Member States of the Health Council of the Commonwealth of Independent States: Uzbekistan, Belarus, Kazakhstan, Tajikistan, Kyrgyzstan and Armenia. All the Member States were harmonizing maximum permissible levels of antibiotics in food products of animal origin; carrying out research on antimicrobial resistance, and clinical and economic analyses of antibiotic use; and optimizing treatment protocols for communicable diseases. In order to prevent antimicrobial resistance, the countries were increasing access to the results of microbiological research, monitoring antibiotic resistance, promoting policies for the rational use of antimicrobials, and introducing new antimicrobials. WHO should develop recommendations for each of those areas to help Member States to fight antimicrobial resistance. She supported the draft global action plan and its adoption by the Health Assembly.

Dr GONZÁLEZ FERNANDEZ (Cuba) said that the Region of the Americas was served by a regional antimicrobial resistance surveillance network, of which Cuba was a part. In Cuba the national surveillance mechanism covered primary health care centres and hospitals. Recognizing the impact of antimicrobial resistance on not only human and animal health but also the economy, society and development, he endorsed the draft global action plan for submission to the Sixty-eighth World Health Assembly.

Dr CHAND (Nepal), speaking on behalf of the Member States of the South-East Asia Region, emphasized that alone political will to combat antimicrobial resistance was not enough in low- and middle-income countries; sustainable access to financial and technical resources should also be assured by the draft global action plan. The roles and responsibilities of the various sectors involved had to be clearly defined, as should the expected results and specific implementation targets. Health systems and regulatory mechanisms should better address the rational use of antibiotics in human and animal health, as well as prescription practices and over-the-counter availability of medicines. The draft global action plan had to be based on the principle of fair and equitable sharing of the benefits of collaborative research into natural sources of biodiversity for the development of new antibiotics, and the plan should be aligned with regional declarations or priorities on antimicrobial resistance.

Dr AMMAR (Lebanon) commended the work of the three organizational levels of WHO in promoting work on the subject, developing the draft global action plan, and collaborating with FAO and OIE. Even more intersectoral collaboration, however, was needed. Member States' national action plans would facilitate the establishment of surveillance systems and the allocation of resources, and WHO should continue to coordinate and monitor global efforts. He noted the Secretariat's report and called for the adoption of the draft global action plan by the Health Assembly.

Mr COTTERELL (Australia) commended the extensive consultative process on the draft global action plan and recalled his country's contribution to WHO's work on antimicrobial resistance at the global and regional levels. He supported the draft global action plan and its submission to the Health Assembly for adoption, and he looked forward to working with partners in the Asia-Pacific region.

Dr ASADI-LARI (Islamic Republic of Iran) urged adoption and rapid implementation of the draft global action plan in collaboration with FAO, OIE, World Bank and industry. Such inter-organizational activity should encourage multisectoral commitment and coordination at national and regional levels. Treatment of antimicrobial-resistant infectious diseases with high incidence rates, such as tuberculosis and malaria, particularly in low- and middle-income countries, needed more attention to prevent the further spread of antimicrobial resistance. In addition, there was a need to increase immunization against vaccine-preventable diseases that were currently being treated with antibiotics in order to reduce usage and delay the evolution of resistance. The growth in animal farming and consumption of animal products had led to increasing use of antibiotics, which threatened human and animal health and food safety. The Secretariat should engage with the Strategic and Technical Advisory Group on antimicrobial resistance regarding possible regulation and guidelines on antimicrobial resistance, his country was working on such regulations.

In the text of the draft global action plan, he proposed adding the following sentence to subparagraph 21(2): "Vaccination of health care workers in all settings as an infection prevention measure is recommended". Recalling subparagraph 1(10) of resolution WHA67.25, he proposed adding the text of that subparagraph, with one small amendment, to paragraph 40 of the draft global action plan so that it would read: "Urges Member States to develop antimicrobial resistance surveillance systems in three separate sectors: (i) inpatients in hospitals, which integrated to nosocomial infections surveillance system; (ii) outpatients in all other health care settings and the community; and (iii) animals and non-human usage of antimicrobials". Finally, he proposed adding the following sentence to paragraph 41: "Analyses of antimicrobial resistance trends from surveillance systems can be used to provide treatment and prophylaxis guidelines for reasonable use of antimicrobials in health care settings".

The meeting rose at 17:35.

SEVENTH MEETING

Thursday, 29 January 2015, at 09:05

Chairman: Mr M.H. SHAREEF (Maldives)

PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 8 of the Agenda (continued)

Antimicrobial resistance: Item 8.1 of the Agenda (Documents EB136/19 and EB136/20) (continued)

Dr ASSIRI (Saudi Arabia) said that, despite improvements in the control of antibiotic use in general and the introduction of stewardship programmes in hospitals, low surveillance capacity at country level meant that the magnitude and extent of antimicrobial resistance were not known, especially in resource-poor settings. Intersectoral collaboration, especially between the human health, animal health and food production sectors, and country-level commitment to combat antimicrobial resistance must be strengthened. Consolidated global efforts were needed to implement the action plan.

Ms ROA RODRIGUEZ (Panama) highlighted the importance of education and training to raise awareness among health-care professionals, patients and the public of the serious threat posed by antimicrobial resistance and the need for rational use of antibiotics. The Secretariat and Member States should focus on capacity building and the development of a database on antimicrobial resistance. The draft global action plan should strengthen promotion, monitoring, supervision and evaluation of infection prevention and control, providing for the establishment of national laboratory networks and clearly defined indicators for evaluation.

Mr JEON Man-bok (Republic of Korea), endorsing the comments by the member for Belgium and in particular the member for the United Kingdom of Great Britain and Northern Ireland, said that a long-term global action plan had to be introduced in a stepwise manner, with action plans for each phase of implementation and regular meetings for exchange of experiences and provision of feedback to the Secretariat. His country was scheduled to host the sixth annual meeting of the WHO Advisory Group on Integrated Surveillance of Antimicrobial Resistance in Seoul.

Mrs VALLINI (Brazil), aligning herself with the position stated by the member for the United States of America, emphasized the need for a multidisciplinary, science-based approach, with close exchanges with United Nations stakeholders in the fields of nutrition, agriculture and health.

Given the floor by the CHAIRMAN in response to a request by the previous speaker, Ms BERGARA (Uruguay),¹ speaking on behalf of the Union of South American Nations, said that countries must work for behavioural change, strengthen regulation, increase vaccination coverage and promote the rational use of antibiotics. The global action plan must be intersectoral and integrated with other relevant health strategies. Improvements in health, particularly those related to the Millennium Development Goals, must not be undermined by antimicrobial resistance.

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

Dr EERSEL (Suriname), referring to the urgent need expressed in the global technical strategy for malaria recommended to the Health Assembly for adoption to contain resistance to artemisinin through cross-border collaboration, urged a common set of strategies. Self-medication and the availability of illegally imported antimicrobials purchased without a prescription were major factors in the growth of antimicrobial resistance in many countries. Much work remained through public education, training of health professionals and stricter regulation.

Ms SAMIYA (Maldives), welcoming the encouragement of the United Nations leadership, said that accessibility and affordability of antimicrobials and related new technologies needed to be adequately reflected in the draft action plan. The Member States of the South-East Asia Region had adopted the Jaipur Declaration on Antimicrobial Resistance in 2011, as well as the Regional Strategy on Prevention and Containment of Antimicrobial Resistance 2010–2015, which was consistent with the draft action plan, but she endorsed calls for concerted global efforts. She recommended Member States to adopt the draft action plan at the Health Assembly.

Mr MAGALLANES (Argentina) said that his country was about to publish a national action plan on antimicrobial resistance, in line with the draft global action plan.

Professor AL-ADAWY (Egypt) described activities for surveillance of antibiotic resistance in his country. A plan to control the spread of multidrug-resistant organisms would be launched later in 2015. Challenges included lack of microbiology laboratories and intersectoral coordination. He supported the draft action plan.

Mr PRAKASH (India),¹ welcoming the draft action plan, called for national and international coordination. Before the plan could be adopted, however, several concerns had to be addressed. Although the plan urged development of national action plans within two years of its adoption, it did not assess the financial and other resource implications. Access – not just to antibiotics but also to, for instance, health facilities, care and preventive and diagnostic services – should not be confused with irrational use of antibiotics. Universal access to health care, including antibiotics, should be included as a stand-alone principle in the draft action plan. Research and development of new antibiotics should be accelerated, and its costs delinked from the prices charged for new medicines. The draft action plan should specify that the clinical trials referred to in paragraph 33 would be conducted in line with relevant national laws. He expressed doubt that the Secretariat had the capacity or resources to monitor development and implementation of plans by Member States. He proposed the establishment of a subgroup to deal with such concerns before submission of a final draft to the Health Assembly in May 2015.

Dr BUGTI (Pakistan)¹ called for definition of how developing countries could implement their national action plans, particularly in respect of financial and technical assistance, for establishing monitoring and surveillance systems and for the draft action plan to address capacity building. The costs of research and development into new antimicrobials must be delinked from their price.

Ms SCHMITT (France)¹ called upon the Secretariat to support Member States in introducing simple measures to improve the standard of hygiene in health-care facilities and elsewhere and in promoting the rational use of antibiotics, including education of the public and health care professionals, and the development of new medicines and approaches.

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

Dr BARNARD (Netherlands),¹ acknowledging the rapid development of the draft plan, said that the Ministerial Conference on Antimicrobial Resistance (The Hague, 25 and 26 June 2014) had emphasized the need for a united approach. The country's health and agriculture ministries had collaborated closely, and the use of antibiotics in its veterinary sector had been reduced drastically. The key to success had been adoption of the precautionary-principle approach which was also prominent in the draft action plan. He also welcomed WHO's support for innovative approaches to new antibiotics.

Ms MUSAONBASIOGLU (Turkey)¹ said that, in addition to national action plans based on the draft action plan, concerted regional action that took into account regional specificities and country needs would promote sustainable achievements at global level. Countering antimicrobial resistance needed multisectoral and multicountry collaboration as well as WHO's normative and standard-setting work, convening power and support for the development of new medicines and rapid diagnostic tests.

Dr OMI (Japan) proposed two amendments to objective 4 of the draft global action plan. In the column headed "Member State action", the words "or other suitably trained person authorized in accordance with national legislation, or use under conditions stipulated in the national legislation" should be added in the second bullet point after "veterinary professionals", for consistency with paragraph 34 of the FAO/WHO Codex Alimentarius Code of Practice to Minimize and Contain Antimicrobial Resistance. In the final bullet point, the phrase "in the absence of risk analysis, and reduction in nontherapeutic use of antimicrobials in animal health" should be inserted after the phrase "phasing out of use of antibiotics for animal growth promotion and crop protection" for consistency with paragraph 9 of that Code of Practice.

Mr IVERSEN (Norway)¹ said that the action plan should include a definition and description of the "One Health" approach. Pollution of the environment should be acknowledged as a possible source of antimicrobial resistance, through both human, animal and agricultural use of antimicrobials and directly from pharmaceutical manufacturing processes. Prevention of infection and of the spread of antimicrobial-resistant bacteria should be among the first steps implemented, for instance through improved sanitation and hygiene and the use of vaccination rather than antibiotics. Each action point in the draft document should be linked to an implementation plan that included dates, measurable goals, reporting mechanisms and a budget.

Mr HOLM (Sweden)¹ urged the Board to support the draft action plan and recommend its adoption by the Health Assembly. To raise awareness of and commitment to a global action plan, his country had hosted a high-level technical meeting on surveillance of antimicrobial resistance (Stockholm, 2 and 3 December 2014). A pilot surveillance system would be launched shortly. Antimicrobial resistance should be included in the health goal in the post-2015 sustainable development agenda.

Ms REITENBACH (Germany)¹ said that antimicrobial resistance would be a priority health topic during the German Presidency of the Group of Seven major industrialized nations in 2015. She endorsed the intersectoral approach of the draft action plan and strongly supported recommending its adoption by the Health Assembly.

Ms SITANUN POONPOLSUB (Thailand),¹ similarly supporting the draft action plan, said that the Secretariat and WHO's partners should foster the commitment of policy-makers to its multisectoral implementation and WHO should promote mechanisms to ensure sustainable financial and technical resources for that work, particularly in resource-constrained countries. She requested

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WHO and its partners to accelerate the development of new, affordable antimicrobial medicines, vaccines and diagnostic tools, and support research and development models in which the cost of research and development was delinked from medicine pricing.

Ms RUIZ VARGAS (Mexico)¹ welcomed the draft action plan, including country-level commitments and the collaboration of FAO, OIE and WHO, as a synergistic and multisectoral approach was essential.

Mr SEGARD (Canada),¹ also supporting the draft action plan, which should be adopted by the Health Assembly, described the broad-based action taken in his country to draw up a national strategy to combat antimicrobial resistance. He encouraged other countries to develop their own plans, and welcomed the inclusion of the issue on the agenda of the Group of 7.

Ms ALARCON (Colombia)¹ observed that the draft action plan did not specify detailed measures or time frames for implementation. It would need adaptation at national levels and technical assistance for monitoring and evaluation. Commenting on the objectives, she said that objective 2 should include a standardized surveillance tool for antimicrobial resistance in humans and animals, preferably with technical support available to countries. Objective 3 should include promotion of regional networks for monitoring reduction in the incidence of health-care-associated infection, and development of relevant partnerships. Objective 4 should recognize subregional and national progress and make use of subregional platforms. Objective 5 should provide for greater support for training in order to generate the sustainable investment that would contribute to the development of new medicines, diagnostic tools, vaccines and other interventions.

Dr IHMAIDAT (Libya)¹ said that the objectives in the draft action plan should be more pragmatic and easier to implement at the clinical level, with indicators and targets, possibly for specific antimicrobials, to monitor implementation.

Mr SAGUNI (Indonesia)¹ pointed out that implementation of national action plans could be optimized by a strong commitment to objective 2, by developing a strong antibiotic surveillance network in all sectors, including links between laboratories, technical units in the public and private sectors and educational institutions. As a developing country, Indonesia would face many challenges in implementing the draft global action plan, particularly objectives 3 and 5, because of its weak institutional capacity and limited human resources and infrastructure. Collaboration and technical support from WHO would be needed to develop sustainable mechanisms for combating antimicrobial resistance.

Mr KRANIAS (Greece),¹ agreeing with the proposed framework, emphasized an integrated approach, as the incorrect use of antimicrobial substances in human health, animal husbandry and agriculture led to the development of resistance. Prevention and control should focus on those three areas simultaneously. The global action plan would require commitment at the highest political level and from relevant administrative authorities, as well as proper assessment of epidemiological data from each country.

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

Ms KUSANO (International Council of Nurses), speaking at the invitation of the CHAIRMAN, commended those Member States that permitted nurses to prescribe medicines, which was safe and cost-effective and capitalized on patients' trust in nurses. She called on the Secretariat and Member States to involve nurses in the planning and development of relevant policies and strategies.

Ms KUSYNOVÁ (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, said that the draft action plan would be strengthened by the inclusion of quantified targets and indicators. Objective 3 should include a reference to the Global Vaccine Action Plan, with explicit mention that immunization referred to both patients and health care professionals. Pharmacists should be authorized to give vaccinations, an approach that was proven to be safe and to increase vaccination rates for at-risk and hard-to-reach groups.

Ms BARRIA (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, encouraged inclusion of principles governing the regulation and control of promotional practices by the pharmaceutical and veterinary industries in objective 5. Health ministries should urge other ministries to refuse trade agreements that provided for investor-State dispute settlement, which could limit governments' capacity to regulate for antimicrobial stewardship. The use of antibiotics for animal growth promotion and crop protection must be phased out; vaccination was no solution. Environmental pollution from livestock and industrial waste, hospital disposal and sewage must be monitored and controlled. Objective 4 should include monitoring of hot spots for horizontal resistant gene transfer and should be linked, under objective 2, to monitoring and research into the risks associated with microbial mixing in water and sewage. The plan should also emphasize strong health systems and abjure the term substandard/spurious/falsely-labelled/falsified/counterfeit medical products.

Ms CHUA (Médecins Sans Frontières), speaking at the invitation of the CHAIRMAN, underlined the need for inexpensive and rapid point-of-care tests. In the quest for new antibiotics, research and development costs should be delinked from prices and sales volumes. Pending the availability of new, affordable antibiotics, WHO should encourage regulatory authorities to revise registration policies for old antibiotics that were being brought back into circulation, harmonize their recommended dosage and promote quality assurance in their manufacture. Member States should support innovative investment mechanisms to develop new antibiotics and ensure a public health framework that promotes their usefulness, affordability and accessibility.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, applauded the approach to the United Nations Secretary-General to increase awareness and leadership. Regulations and their enforcement were needed to ensure responsible use of antibiotics. The promotion of vaccination was particularly relevant, as it helped to reduce the volume of antibiotics used. Market models should be established that incentivized innovation and ensured sustainable investment for research and development.

Dr FUKUDA (Assistant Director-General) welcomed the extensive support for the draft global action plan and suggestions for its refinement. He had noted consensus on the need for a multidisciplinary, intersectoral and international approach and to draw on existing work at international, regional and national levels with appropriate harmonization. The subject should be included in the post-2015 sustainable development goals. Not all Member States would be approaching implementation of the action plan from the same starting point; further work would be needed on funding, capacity building and access. In finalizing the draft action plan, account would be taken of the need for research and surveillance, access, irrational use and cost. Cooperation would continue with FAO, OIE and Codex Alimentarius. Responding to the member from Norway, he expressed concern that a discussion of the concept of "One Health" would divert attention from the important work of implementing action.

The next steps would be revision of the text in the light of the Board's comments and then by the Strategic and Technical Advisory Group on antimicrobial resistance before submission to the Health Assembly. The adopted plan would be the start of a long path with broader discussions and new solutions.

The DIRECTOR-GENERAL thanked all the partners and bodies that had contributed to the process of developing the draft action plan and said that she was encouraged by the commitments expressed to take urgent action.

The Board noted the report and steps to be taken to revise the draft global action plan on antimicrobial resistance.

Poliomyelitis: Item 8.2 of the Agenda (Documents EB136/21 and EB136/21 Add.1)

Dr BEJTJA (Albania), speaking on behalf of the Member States of the European Region, said that despite important advances in poliomyelitis eradication in 2014, challenges remained, including armed conflicts and the recent increase in the number of cases in Pakistan. The polio eradication programme had strengthened countries' abilities to cope with infectious diseases, but the recent outbreak of Ebola virus disease had seriously weakened the existing health systems in affected countries: it was important to complete the eradication of poliomyelitis, as additional delays would sap morale and put funding commitments at risk.

The previous week, the Regional Certification Commission had concluded that Israel had interrupted transmission of poliovirus. The crucial stage of phased removal of oral polio vaccines had been reached, and the rapid progress towards introducing inactivated poliovirus vaccine in routine immunization systems was commendable. It was encouraging that preparations were on track to remove type 2 oral polio vaccine by April 2016, provided that political commitment was maintained. The finalization of the global legacy framework demanded a constructive debate about how best to transition the polio eradication infrastructure to other health priorities through nationally led processes.

Dr ASSIRI (Saudi Arabia), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that they prioritized polio eradication, while recognizing the challenges to that task. They supported Pakistan and Afghanistan in implementing their national plans. They were working to ensure that countries in the Middle East that had outbreaks in 2013 and 2014 returned to the status of being polio-free and that all polio-free countries were protected against re-importation of virus. They were committed to implement the recommendations on the coordinated withdrawal of type 2 oral poliovirus vaccines. They recommended the submission of a draft resolution to the Health Assembly in May 2015, calling on all affected Member States to implement to the full strategies to stop poliovirus transmission, propose more rigorous standards for prompt detection and response to any circulating poliovirus, and urge all countries using oral poliovirus vaccine to prepare for and mitigate the risks associated with withdrawal of type 2 oral poliovirus vaccine.

Dr KUPA (Democratic Republic of the Congo), speaking on behalf of the Member States of the African Region, said that, thanks to the concerted efforts of Member States and support from the Secretariat, no new case of poliomyelitis had been reported in the Region for the past six months. Good progress was being made to halting the transmission of wild poliovirus, nevertheless it was important to capitalize on the good practices and experience of countries, ensure coherence in the mobilization of resources, strengthen surveillance and routine vaccination, and ensure needs-based purchasing of vaccines.

Dr TAKIAN (Islamic Republic of Iran) described his country's activities to combat poliomyelitis and maintain its polio-free status, including planning to switch to bivalent oral polio vaccine in 2016. It would soon be producing inactivated poliovirus vaccine. Improved global

environmental and clinical surveillance, cross-border collaboration and enhanced capacity for vaccine production, particularly in developing countries, would be essential for eradication of the disease.

Dr HARVEY (United Kingdom of Great Britain and Northern Ireland), recalling her Government's contributions to the Global Polio Eradication Initiative and the GAVI Alliance, said that, despite recent progress, concerted efforts were still required. Work on surveillance in Africa must be redoubled and Pakistan must ensure immunization of children in areas affected by conflict. The polio eradication infrastructure in Nigeria had enabled that country to contain Ebola virus disease and ensure no case of polio for more than five months. The year 2015 would be crucial.

Dr CHAND (Nepal) recalled that the Heads of State of South Asian countries, at a regional cooperation summit (Kathmandu, 25 and 26 November 2014), had expressed their commitment to eradicating polio, called for solidarity and welcomed the efforts of affected countries in the region.

Mr KOLKER (United States of America) seconded the proposal by the member for Saudi Arabia for the submission of a draft resolution on poliomyelitis to the Health Assembly. The Secretariat should draft a text for prior informal discussions that urged affected Member States to stop poliovirus transmission by the end of 2015, called for stronger standards for detection and response to circulating virus, international coordination of withdrawal of type 2 oral polio vaccine and preparation for that change of vaccine. His Government had increased its financial support for the Global Polio Eradication Initiative. He urged Member States to fill the funding gap faced by the Polio Eradication and Endgame Strategic Plan 2013–2018 for its implementation.

Ms SHI Ying (China) said that China was successfully producing an inactivated poliovirus vaccine, at least one dose of which would be introduced into its routine immunization programme. It also intended to develop multivalent live-attenuated vaccines to counter the high risk of importation of poliovirus from neighbouring countries. WHO should coordinate with international partners to strengthen cooperation and share information, and increase its technical and financial support for endemic and at-risk countries.

Ms MEL'NIKOVA (Russian Federation) said that all Member States affected by the spread of wild polioviruses should fully implement the eradication strategy and the temporary recommendations issued under the International Health Regulations (2005). All countries should ensure that their immunization programmes included at least one dose of inactivated poliovirus vaccine; she welcomed WHO's work with partners to lower the cost of the vaccine and promote technology transfer, but emphasized that long-term support was required. The change-over to bivalent oral poliovirus vaccine in all countries would require thorough preparation and monitoring: a unified reporting protocol should be drawn up for all countries, with a mechanism to verify the accuracy of the information provided. Member States must decide whether they needed their own stockpile of monovalent type 2 oral poliovirus vaccine in addition to the global stockpile and, if so, they must provide proper storage conditions.

Professor AL-ADAWY (Egypt) outlined his Government's main strategies to maintain the country's polio-free status. He recommended accelerating the registration and introduction of bivalent oral polio vaccine and inactivated poliovirus vaccine.

Dr OMI (Japan) warned that the history of global poliomyelitis eradication efforts showed a cycle of reduction in cases followed by a rebound, and that eliminating the last focal point of transmission was the most difficult part of the process. Pakistan was the key country in that regard: he acknowledged the progress, but requested information on the specific strategies adopted and the measures being taken at the federal, provincial and local levels. The WHO poliomyelitis eradication team should make the final push to end the cycle of reduction and rebound.

Mr BOWLES (Australia), acknowledging the progress made to reduce the risk of international spread of wild poliovirus, particularly in Africa and the Middle East, urged Member States to adopt measures to ensure the eradication of the disease as soon as possible. He welcomed the legacy planning process, which could also be applied to other diseases. He supported the draft decision.

Ms ABOOBAKURU (Maldives) said that the Maldives planned to introduce one dose of inactivated poliovirus vaccine into its immunization schedule in March 2015 and to switch to bivalent oral poliovirus vaccine when it became widely available on the market. The South-East Asia Region had received poliomyelitis-free certification thanks to intensive efforts by Member States such as India. The keys to success included education and vaccination campaigns; lessons learned could be applied to Member States with ongoing transmission.

Improving access to health care in general, fostering public trust in the health system and health workers, and creating an appropriate political and social climate had a major impact on driving out the disease. Transmission was continuing in areas that were hard to reach by traditional methods or affected by conflict. Eradication could not be achieved if such realities were ignored or by relying on the health sector alone. She supported the draft decision.

Mr MAGALLANES (Argentina) said that his country, which had been poliomyelitis-free since 1984, planned to change to inactivated poliovirus vaccine but was concerned about the sufficiency of vaccine supply, and about equitable and unhindered access to the global stockpile of monovalent type 2 oral poliovirus vaccine in the event of an outbreak. Oral poliovirus vaccines containing the type 2 component could not be withdrawn globally until all transmission of vaccine-derived type 2 polioviruses had been interrupted. Meanwhile, supplies to cover the first two of the three doses of inactivated vaccine must be guaranteed, with global efforts directed towards full completion of each of the successive steps involved in the coordinated withdrawal process in order to avoid unnecessary risks to the public.

Mr PUSP (India)¹ said that India's attaining polio-free status could not have been achieved without the efforts of 2.5 million polio workers and he outlined the steps being taken to maintain that status, in particular vaccination of eligible children at international borders and planned introduction of inactivated poliovirus vaccine and the switch to bivalent oral polio vaccine in a globally synchronized manner. The spread of wild polioviruses could be interrupted on the global scale only by full implementation of eradication strategies in the remaining infected areas, comprehensive application of the temporary recommendations issued by the Director-General and heightened surveillance. He endorsed the draft decision.

Mr QURESHI (Pakistan),¹ stressing that eradication of polio was a national priority under the direct supervision of the Prime Minister, said that the regrettable increase in poliomyelitis cases in Pakistan in 2014 was due to the unique challenges it faced, relating primarily to counterterrorism activities, areas of conflict and attacks on immunization workers by militants. He thanked the United States of America for its support for the national poliomyelitis eradication programme but noted with concern the statement made by the member for the United States in the discussion of the Global Vaccine Action Plan,² especially in view of fake immunization campaigns, which had set back the country's eradication efforts and created lasting repercussions for the security of its health workers.

The multipronged national strategy applied political, social and religious support and included a network of community workers. The country had rapidly implemented the recommendations issued by the International Health Regulations Emergency Committee and had introduced an emergency action plan and an extensive child immunization campaign. Supplementary immunization campaigns and

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

² See summary record of the second meeting.

vaccination at points of transit from conflict areas were planned for 2015, together with the use of inactivated poliovirus vaccine in high-risk areas. A door-to-door immunization campaign had been reintroduced in South Waziristan. Polio eradication efforts were widely supported in Pakistan. Facing unparalleled challenges, it deserved international support.

Ms GOLBERG (Canada)¹ said that all stakeholders in the Global Polio Partners Group of the Global Polio Eradication Initiative were encouraged by the progress, particularly in Nigeria, towards a poliomyelitis-free Africa and by the evidence of possible interruption of poliovirus type 3. Caution still had to be exercised in view of such remaining challenges as the increase in cases in Pakistan, risks of virus importation, threats to health workers, and funding. Pakistan's technical capacity needs must be clearly identified and supported, and all political commitment translated into tangible results.

Donors were urged to continue their support for poliomyelitis eradication efforts, fulfil their pledges and address funding gaps in the Strategic Plan 2013–2018, in which context Canada looked forward to the forthcoming review of the Plan's budget. She asked about how the Global Polio Eradication Initiative would manage risks to attainment of targets, and underlined that legacy planning held the key to the success of the Initiative, ensuring among other things that investments in poliomyelitis eradication would contribute to broader health interventions, as was happening in relation to the outbreak of Ebola virus disease, and that linkages with routine immunization would be strengthened.

Dr SARIWATI (Indonesia)¹ said that poliomyelitis eradication would require good preparedness and strengthened immunization systems, while affected countries should implement vaccination of travellers. To certify interruption of transmission, the sensitivity of acute flaccid paralysis surveillance should be high. Availability and affordability of inactivated poliovirus vaccine were essential for the sustainability of immunization programmes, and should be taken into consideration together with geographical barriers in determining the switch from trivalent to bivalent oral poliovirus vaccine. She urged WHO to facilitate vaccine technology transfer to developing countries, including Indonesia, that were potential inactivated-vaccine-manufacturing countries.

Ms MUSAONBASIOGLU (Turkey)¹ stated that no case of poliomyelitis had been reported in the Syrian Arab Republic for one year or in Iraq for nine months; however, the situation in the region required vigilance, with continued vaccination campaigns and an effective surveillance system. Turkey had made in-kind contributions and undertaken several rounds of poliomyelitis vaccination of all Syrian children under the age of 5 years in the regions bordering the Syrian Arab Republic.

Ms SANA (Afghanistan)¹ said that through its national emergency action plan Afghanistan had reached the last phase of poliomyelitis eradication. Vaccination was administered through four rounds of national immunization days each year as well as in emergencies. The emergency action plan had been implemented with the active engagement of civil society organizations, parliamentarians, journalists, teachers and religious leaders, although technical support from WHO and other donors was still needed in order to overcome the complex challenges involved.

Dr AHMED BASHEIR (Sudan)¹ said that international cooperation and synchronization of efforts were crucial for her country, with its many borders, extensive population movements and areas of conflict. Sudan needed financial and technical support in order to implement the national immunization campaigns that would allow it to maintain its polio-free status. Sudan had completed preparations for the introduction of inactivated poliovirus vaccine in 2015, although it was challenged by shortfalls in the health system, especially the cold chain.

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

Ms LANTERI (Monaco)¹ said that the progress in Nigeria and the success in India showed what could be done and should encourage other countries such as Pakistan and Afghanistan, which would require continuing support from the international community in order to eradicate poliomyelitis by 2018. Poliomyelitis legacy planning would enable countries to use in other contexts the tools and infrastructure developed for polio eradication.

Mr ALAKHDER (Libya)¹ said that historically successful poliomyelitis vaccination campaigns in Libya had been adversely affected by the damaged health system. An urgent response was needed to remedy the lack of surveillance and reporting systems and the short supply of basic medicines, including vaccines. It was heart-breaking that the health of future generations was being compromised by the failure to provide immunization for children.

Dr ATTAYA LIMWATTANAYINGYONG (Thailand)¹ expressed deep concern at the limited global supply and the cost of inactivated poliovirus vaccine and bivalent oral poliovirus vaccine, particularly for developing countries that were not eligible for support from the GAVI Alliance. Delivery of inactivated poliovirus vaccine would be delayed by national decision-making processes, which had to assess policy guidance, affordability, effectiveness, and health priorities. Production capacity was concentrated among a small number of manufacturers who required long lead times to produce vaccines. Countries should aggregate their needs in order to determine the overall demand. WHO should facilitate global production capacities by supporting the manufacture of vaccines in developing countries and fostering mechanisms to improve their affordability. Timely information on the current situation of supply, demand and price would enable national decision-making and planning. A clear and flexible road map for the switch from trivalent to bivalent oral poliovirus vaccine would assist countries in making the transition.

Ms DIMENT (Rotary International), speaking at the invitation of the CHAIRMAN, said that the lesson from 2014 was that full implementation of vaccination campaigns and strategies resulted in dramatic declines in the numbers of poliomyelitis cases whereas, in areas where access and security were poor and government and community ownership of the process lacking, cases had increased. Fragile gains in the Middle East and Africa should be protected by high-quality surveillance and vaccination efforts that reach every child, with strengthened routine immunization coverage and the rapid introduction of inactivated poliovirus vaccine. The failure to stop poliomyelitis in Pakistan and the export of wild poliovirus to parts of Asia and the Middle East were deeply concerning. Federal and provincial governments in Pakistan must fully implement their immunization plans, and strong action would be required by law enforcement authorities in order to protect health workers. Rotary International would continue to raise funds and awareness to build the trust needed to vaccinate every child, but governments of polio-affected countries should take stronger action. Eradication of poliomyelitis would have health benefits far beyond elimination of a single disease.

Dr ALWAN (Regional Director for the Eastern Mediterranean) underlined the risk to children everywhere while polio remained; the spread of the disease from Pakistan to the Middle East in 2013 had caused paralysis in children in Iraq and the Syrian Arab Republic and triggered an unprecedented and coordinated public health emergency response in the Eastern Mediterranean Region, which had culminated in the vaccination of 27 million children. No case had been reported in recent months in Iraq or the Syrian Arab Republic despite the ongoing conflicts in those countries, a remarkable achievement that had been due to the commitment of governments, health workers, nongovernmental organizations and civil society across the Region.

The virus remained endemic in Pakistan and Afghanistan. Pakistan had intense transmission, which had accounted for 85% of all cases globally in 2014. The Region continued to provide a

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

coordinated response to the spread of the virus. In recent months Pakistan had intensified efforts at provincial and federal levels to prepare a low-season emergency plan for 2015 that would concentrate resources in high-risk areas: it was supported by more than 800 additional WHO personnel. Poliomyelitis eradication was a matter not only for Pakistan, but for the whole Region and the global community, who had come together to tackle it through the Global Polio Eradication Initiative. He assured the member for Japan that poliomyelitis eradication was a daily challenge and that WHO was constantly seeking innovative ways to deliver the highest possible level of support to Pakistan. The Organization was working closely with the Organization of the Islamic Conference, the Islamic Development Bank, the Governments of Saudi Arabia and the United Arab Emirates, and religious leaders.

Dr JAFARI (Polio Operations and Research), acknowledging the guidance and support, said that 2015 would be a defining year for the global poliomyelitis eradication effort. Support from the international community would assist in halting the spread of poliomyelitis in Pakistan and Afghanistan. The Strategic Advisory Group of Experts on immunization had endorsed the five criteria for assessing global readiness to substitute bivalent oral poliovirus vaccine for the type 2-containing trivalent vaccine in April 2016, with introduction of inactivated poliovirus vaccine in immunization programmes before that date. The decisions taken by the Board would pave the way for the final steps to poliomyelitis eradication.

The risk of international spread of virus continued, and progress in implementing the temporary recommendations issued under the International Health Regulations (2005) had been variable; the International Health Regulations Emergency Committee would meet shortly to review the situation again and advise the Director-General on potential further measures. Ensuring sensitive surveillance was an overarching priority and the expansion of environmental surveillance to additional countries would continue in 2015 and 2016. The interruption of transmission in Pakistan and Afghanistan was technically and epidemiologically feasible in 2015, but would depend on full implementation of national emergency action plans and, in the case of Pakistan, of the low-season plan prepared by all levels of government at the end of 2014. Strong international coordination and synchronization would be required for the safe withdrawal of the type 2 component of oral poliovirus vaccine, and countries had already made significant progress in preparing for the introduction of inactivated poliovirus vaccine.

Synergies continued to be gained between work on eradication of poliomyelitis and the response to the outbreak of Ebola virus disease, particularly in respect of surveillance in West Africa. Strong ring-fencing with heightened surveillance and improvement of immunization coverage in regions surrounding Ebola-affected countries were priorities to minimize the risk of reintroduction of poliovirus; the polio eradication assets continued to support the response to Ebola across the region. Persistent circulating vaccine-derived type 2 polioviruses were still a concern in Nigeria and Pakistan, and both countries intended to optimize the mix of vaccines, including those containing the type 2 component to bring an urgent stop to the circulation of those persistent strains. Concern had been expressed about the supply of inactivated poliovirus vaccine in both the immediate and longer term; with careful planning, there was sufficient vaccine for 2015 and 2016. An aggressive programme of technology transfer of manufacturing processes was under way which would help to ensure long-term supply and bring down the cost of inactivated poliovirus vaccine. The Strategic Advisory Group of Experts on immunization had discouraged the decentralization of stockpiles of the monovalent type 2 oral polio vaccine and advised that the decision with regard to the reintroduction of the live poliovirus vaccine, should it prove necessary, be taken by the Director-General on the basis of independent, expert advice. The Regional Office for the Eastern Mediterranean would provide technical support for Libya.

The Secretariat would prepare a draft resolution, as requested, for consideration before the Health Assembly, if it were so decided.

The DIRECTOR-GENERAL, responding to the member for Japan, gave assurance that she personally oversaw the poliomyelitis eradication programme and worked closely with partners and countries providing support. She was grateful to Pakistan for its commitment to the eradication of poliomyelitis and in particular for the implementation of its low-season plan, to which WHO would lend every support.

The CHAIRMAN took it that the Board noted the report and agreed that the Secretariat would draft a resolution, taking into account the draft decision in document EB136/21 and comments made by Board members, and arrange for informal consultations on the text before its submission to the Health Assembly.

It was so decided.

The meeting rose at 12:30.

EIGHTH MEETING

Thursday, 29 January 2015, at 14:30

Chairman: Mr M.H. SHAREEF (Maldives)

1. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 8 of the Agenda (continued)

Implementation of the International Health Regulations (2005): Item 8.3 of the Agenda (Documents EB136/22 and EB136/22 Add.1)

The CHAIRMAN drew attention to the draft resolution and its financial and administrative implications for the Secretariat contained in Annex 2 and Annex 3, respectively, of document EB136/22 Add.1. Argentina had proposed numerous amendments on yellow fever risk mapping and recommended vaccination for travellers, but, given their substantive nature, the Secretariat had suggested that they be incorporated into a separate resolution.

Dr MADIES (Argentina) said that, although the report on the implementation of the International Health Regulations (2005) contained in document EB136/22 provided an overview of the international response in 2014, specific information was needed on the measures being taken on vaccination against yellow fever.

Mrs MATSOSO (South Africa), supported by Mrs VALLINI (Brazil), Ms XU Min (China), Dr GONZÁLES FERNANDEZ (Cuba), Dr GRABAUSKAS (Lithuania), Dr EERSEL (Suriname), Dr HARVEY (United Kingdom of Great Britain and Northern Ireland) and Mr KOLKER (United States of America) agreed on the need for a separate draft resolution.

Dr CORRALES HIDALGO (Panama) and Dr CANDIS IBARS (Paraguay) endorsed that proposal and said that their countries wished to be added to the list of sponsors of the second draft resolution.

The CHAIRMAN introduced the proposed draft resolution and its financial and administrative implications for the Secretariat, which read:

The Executive Board,
Having considered the report on Implementation of the International Health Regulations (2005)¹ (hereinafter “IHR (2005)” or “the Regulations”),

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

¹ See document EB136/22.

The Sixty-eighth World Health Assembly,

(PP1) Recalling the adoption by the Sixty-seventh World Health Assembly of the updated Annex 7 of the IHR (2005) recommending that a single dose of yellow fever vaccine is sufficient to confer sustained immunity and life-long protection against yellow fever disease, that a booster dose of yellow fever vaccine is not needed, and that the validity of a certificate of vaccination against yellow fever shall extend for the life of the person vaccinated;

(PP2) Highlighting the fact that States Parties may immediately apply these changes even though Annex 7 of the IHR (2005), as amended, is only expected to enter into force in June 2016, in accordance with paragraph one of Article 59 of the IHR (2005);

(PP3) Noting that, for the purposes of the Annex 7 of the IHR (2005), vaccination against yellow fever may be required of any traveller leaving an area where the Organization has determined that a risk of yellow fever transmission is present,

(OP1)1. URGES Members States:

- (1) during the interim period until June 2016, to inform WHO if they voluntarily accept to extend the validity of a certificate of vaccination against Yellow Fever for the life of the person;
- (2) to comply with the WHO recommendation for the definition of the areas at risk of Yellow Fever and of the Yellow Fever vaccination recommendations for travellers;

(OP2) 2. REQUESTS the Director-General:

- (1) to publish, in real time, an online updated list of countries accepting a certificate of vaccination against yellow fever for the life of the person vaccinated;
- (2) to establish a formal “scientific and technical advisory group on Geographical Yellow fever risk mapping”, with the participation of countries with areas at risk of yellow fever, to: (i) maintain up-to-date the Yellow Fever risk mapping; and (ii) provide guidance on Yellow Fever vaccination for travellers in ways that facilitate international travel.

1. Resolution: Yellow fever risk mapping and recommended vaccination for travellers

2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)

Category: 5. Preparedness, surveillance and response

Programme area: Alert and response capacities

Programme area: Epidemic-prone and pandemic-prone diseases

Outcome:

5.1. All countries have the minimum core capacities required by the International Health Regulations (2005) for all-hazard alert and response

Output:

5.1.1. Countries enabled to develop core capacities required under International Health Regulations (2005).

How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?

It would facilitate and reinforce guidance for international travel vaccination.

Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget**(a) Total cost**

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) The resolution is not time-bound, with implementation involving a yearly meeting of a scientific and technical advisory group on geographical yellow fever risk mapping.

(ii) Total: US\$ 100 000 per year (cost of yearly meeting of the advisory group).

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 100 000 (cost of first meeting of the advisory group)

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

Headquarters

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

No.

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

US\$ 100 000.

(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)

No.

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

US\$ 100 000. It will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

The DIRECTOR-GENERAL and the CHAIRMAN noted the extensive support for the draft resolution.

The draft resolution was adopted.¹

The CHAIRMAN invited more general discussion of the reports and the draft resolution in document EB136/22 Add.1.

¹ Resolution EB136.R5.

Dr GONZÁLES FERNANDEZ (Cuba) said that the Ebola virus disease outbreak had highlighted the need to strengthen application of the International Health Regulations (2005). Although it was reported that 81 States Parties had requested an additional two-year extension to meet the minimum core capacity requirements, he observed that implementation of the Regulations was an ongoing process and drew attention to the link between the Regulations, health care systems and the need for sustained investment.

Dr ASADI-LARI (Islamic Republic of Iran) said that the Ebola virus disease outbreak had shown that many aspects of epidemic response, such as rapid investigation and contact-tracing, were beyond the capability of many countries. It had also served to demonstrate the vulnerability of all countries and the need to improve surveillance, hospital structures, infection prevention and control and the training of health care workers. Enhancing implementation of the Regulations, especially across borders, required a multi-step approach given that many countries still lacked the necessary capacity. Coordination between, for instance, the veterinary, human health and pharmaceutical sectors needed strengthening at national and regional levels.

Mr KOLKER (United States of America) fully endorsed the statements of the previous two speakers; the Regulations were a tool for detecting and responding to global health threats and, if they had been fully implemented, many deaths in the Ebola virus disease outbreak could have been averted. As part of the response to that emergency and through the Global Health Security Agenda, his Government was accelerating work to strengthen the surveillance, laboratory and emergency response capacity of several countries. The Secretariat should engage Member States in prioritizing and filling gaps in implementation of the Regulations through technical capacity-building, and to prepare a summary report for each region of existing point-of-entry assessments.

The Board should consider establishing independent, external assessment mechanisms to help countries to identify gaps and exercise core capabilities to prevent, detect and respond to infectious disease threats, and encourage collaboration to correct shortcomings. He called on the Secretariat to set a three-year timeline for vulnerable countries to acquire the capacity needed to implement the Regulations.

Mr DE RAEDT (Belgium), speaking on behalf of the European Union and its Member States, said that Turkey, the former Yugoslav Republic of Macedonia, Montenegro, Serbia, Albania, Bosnia and Herzegovina, Georgia, Ukraine, Republic of Moldova, and Georgia aligned themselves with his statement. The European Union's decision on serious cross-border threats to health was one step to meeting the Regulations' core capacity requirements in terms of preparedness, surveillance and response. He agreed with the Review Committee that the perspective should focus on the close relationship between the Regulations and health system strengthening. For fragile countries or those with weak health systems, a step-wise approach to full implementation should be initiated immediately and sound monitoring instruments developed. Given the steady rise in the number of public health emergencies, the chronic shortage of core funding was a concern, and WHO must strengthen its own capacity to respond to several crises simultaneously. International cooperation and coordination, with a road map and time frame, were needed to ensure that core capabilities were in place by June 2016.

Dr AMMAR (Lebanon) said that poor intersectoral communication in many countries could be improved by expanding access to national electronic platforms and involving civil society, including social media, in raising public awareness. Recent events had exposed weaknesses in infection control practices and health care facilities and personnel. In Lebanon, many health and medical schools included the Regulations in their curriculums. The Secretariat should increase support to countries experiencing armed conflict and political instability, and ensure compliance with the Regulations.

Mr BOWLES (Australia) endorsed the draft resolution and the 10 recommendations contained in document EB136/22 Add.1. The recommendations would ensure that the Regulations were strengthened and remained a priority in countries still lacking the required minimum core capacities.

He agreed that their implementation should advance beyond checklists to a more action-oriented approach. The timely implementation of the Regulations by Nigeria and Senegal had facilitated the swift containment of Ebola virus disease in those countries. The same core competencies could be used to enhance preparedness for other global health security threats.

Ms MEL'NIKOVA (Russian Federation) observed that the Review Committee's report showed that many countries lacked the organizational, technical and staff capacity needed to implement the Regulations. Extensions should only be granted, however, on the basis of a clear plan that included a monitoring mechanism and regular evaluation. She called on Member States that had implemented the Regulations to provide assistance to countries experiencing difficulties in building their core capacities. Her country was assisting some eastern European and Central Asian countries and had made a contribution to WHO for building national capacities. She supported the draft resolution.

Dr HARVEY (United Kingdom of Great Britain and Northern Ireland), calling for urgent action to achieve compliance with the Regulations, welcomed WHO's work to identify risks to and gaps in global capacity. New communications and point-of-care diagnostic technologies should be built into surveillance networks. More timely sharing of information and analysis, clear decision-making pathways based on information, and a "one health" approach to improve links to animal health monitoring were needed for early identification of potential emerging human health threats. The United Kingdom was sharing its own experiences through, for example, the Global Health Security Agenda.

Mrs MATSOSO (South Africa) noted that some of the recommendations contained in the Review Committee's report were reflected in resolution EBSS3.R1 on Ebola. Referring to specific recommendations, she made the following remarks: in response to recommendation 1, South Africa would provide technical support for laboratory services; under recommendation 4, emphasis should be placed on the occupational health of front-line workers; under recommendation 6, the proposed measures for the technical working group should evolve from implementation checklists into periodic evaluations; under recommendation 7, clarification was needed on the timing and structure of the formal evaluations and consultative regional mechanisms; and under recommendation 9, with regard to the private sector, the support of companies listed in the stock exchange could be engaged, as her country had tried in response to the Ebola outbreak.

Dr OMI (Japan) pointed out that core capacity-building in line with the Regulations' minimum requirements was often not included in country cooperation strategies, which meant that in some Member States the Regulations were not accorded the highest priority, although they were recognized as the highest priority by the international community. He therefore urged the Director-General to prevail upon the Member States concerned to take steps to ensure that the Regulations were given priority on national agendas as a matter of urgency.

Professor KIM So-yoon (Republic of Korea) welcomed the draft resolution and agreed with the Review Committee that, in formulating its advice to the Director-General, it had to consider the implementation status of all States Parties, not just those that had requested a second extension.

Dr DAHN (Liberia), speaking on behalf of the Member States of the African Region, endorsed the draft resolution. Although no African country had met the minimum requirements of the Regulations by the June 2012 deadline, the outbreaks of Ebola virus disease and other epidemics throughout the world, with their economic and health impacts, had provided new opportunities to strengthen health systems. The lessons learnt should be used to accelerate assistance to help countries to achieve minimum core capacity standards within the following two years.

Mrs VALLINI (Brazil) said that the Ebola virus disease outbreak had demonstrated the importance of the Regulations as a coordination mechanism for transparency and solidarity in tackling

public health emergencies of international concern. It was important to reinforce technical and political commitments and efforts to assess and implement core capacities in response to public health emergencies, and for WHO to promote the exchange of best practices and technical assistance among countries.

Given the floor by the CHAIRMAN in response to a request by Dr EERSEL (Suriname), Mrs BERGARA (Uruguay),¹ speaking on behalf of the Union of South American Nations, underlined the exchange of experiences between countries, regions and subregions as an important way of boosting technical cooperation. She supported the draft resolution.

Mr CASALS ALÍS (Andorra) said that two suspected cases of the Ebola virus disease in Andorra served as a reminder that even small countries could be affected by epidemics. He asked the Secretariat to provide specific assistance to help small countries to adapt the Regulations, or at least provide them with an assessment of whether they were compliant with them.

Ms XU Min (China) said that the important role of the Regulations was reflected by the number of Emergency Committee meetings over the previous year. The Secretariat should continue to provide technical and financial assistance to those Member States struggling to implement the Regulations and ensure that the efforts of those that had managed to do so did not stall or suffer a reversal.

Ms ROA RODRIGUEZ (Panama) underlined the importance of control at points of entry through strengthening national and international capacities. In addition, effective means of communication should also be available.

Dr EERSEL (Suriname) said that member countries of the Caribbean Community had been prompted by the outbreak of Ebola virus disease to strengthen core capacities and improve regional security. Those efforts had resulted in a regional health security plan that would allow the countries concerned to improve their core capacities. Those countries had in the past lagged behind in chemical and radiation protection, but a new plan and guidelines on chemical incidents and emergencies were soon to be piloted in some countries, including Suriname. The plan could then be shared with other regions and countries.

Dr MADIES (Argentina) said that the next two Health Assemblies would be milestones on the road to ensuring implementation of the Regulations, identifying how to help Member States struggling to meet their core capacity requirements, and deciding how to pursue implementation of the Regulations after 2016. Regional meetings had also proven to be useful for following up implementation status and exchanging experiences.

Dr ASSIRI (Saudi Arabia), observing that countries tended to overestimate their capacities under the Regulation in self-assessments in comparison to assessments conducted by missions visiting the countries, called for a more objective way of evaluating compliance with the Regulations and reporting core capacities.

Ms KOIVISTO (Finland),¹ speaking on behalf of the Nordic countries Denmark, Finland, Iceland, Norway and Sweden and supporting the statement by the member for Belgium, expressed concern that only 64 States Parties had acquired the minimum core capacities. With regard to recommendation 4, Member States should be encouraged to develop bilateral or multilateral joint activities in close collaboration with the Secretariat in order to accelerate the development of core capacities. The Global Health Security Agenda was committed to improving countries' core

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

capacities. Although implementation of the Regulations should be embedded in countries' health systems, it was essential not to underestimate the extensive efforts and cross-sectoral cooperation that implementation implied. Instead of simple implementation checklists, a more action-oriented approach was required with periodic evaluation of functional capacities, as proposed in recommendation 7. Five partners in the Global Health Security Agenda were piloting external assessments of national capacity.

Mrs SCHMITT (France)¹ identified the main challenges in respect of the Regulations as ensuring their continued implementation after 2016 – notably by integrating them into health systems and maintaining regular, clear exchanges of information between Member States and the Secretariat on preparedness levels – and strengthening them by drawing lessons from the past decade. She supported the recommendations of the Review Committee and proposed regional and global consultations on implementation of the Regulations post-2016 for consideration by the Sixty-ninth World Health Assembly.

Mr SAGUNI (Indonesia)¹ expressed appreciation of Member States' commitment to intensify their partnership in the regional Field Epidemiology Training Network by enhancing laboratory capacity and developing the Risk Communication Resource Centre of the Association of South-east Asian Nations. He proposed that periodic assessments should be conducted of each country's capacity, that current global frameworks should be reviewed to ascertain the need to adjust them to specific country conditions, and that WHO should develop tools to assess each country's preparedness for dealing with epidemics.

Mrs ALARCON (Colombia)¹ said that her country had implemented many of the recommendations in the report (document EB136/22 Add.1), including instituting training programmes and issuing national guidelines. The Regulations should be the primary instrument for responding to outbreaks such as that of the Ebola virus disease, which had prompted a national evaluation of its responses. All Member States must work to strengthening national capacities for fully implementing the Regulations. WHO had a vital role in fostering cooperation and exchanging good practices.

Dr MAKASA (Zambia)¹ welcomed the recommendations of the Review Committee. His country, despite two requests for extensions, still would not be able to achieve all the core capacities at once. He requested guidance from the Board as to which core capacities should be prioritized.

Dr FERNÁNDEZ DE LA HOZ ZEITLER (Spain)¹ said that Member States must meet their responsibility to continue developing their capacities through their health systems. Spain particularly appreciated the regional formal evaluations and meta-evaluations proposed in recommendation 7, as they would provide more information on the strengths and weaknesses of preparation and response systems.

Dr ATTAYA LIMWATTANAYINGYONG (Thailand)¹ asked WHO to augment its advocacy of the Regulations at national levels and the establishment of national focal centres that responded to public health emergencies of international concern in a sustainable way rather than on a provisional basis. WHO should also provide technical guidance on human resource development, improvements to laboratories and the development of legislative tools supporting the Regulations.

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

Dr FUKUDA (Assistant Director-General) acknowledged that disease outbreaks in recent years, including that of the Ebola virus disease in 2014, had highlighted the need for the Regulations and the importance of countries to have the capacity to implement them. The Review Committee's report represented a paradigm shift; it highlighted the need to invest in a dynamic process, with better monitoring activities to address discrepancies between self-assessment and mission reports. More discussion was needed at the regional level to identify the best way to monitor capacities. Core capacities had to be prioritized using a tactical approach. In addition, it was important to consider capacity to implement the Regulations as an integral part of health systems.

The intention of recommendation 7 in the Review Committee's report was to find a way to improve analysis of outbreaks and to assess capacities in the longer term; such discussions could be undertaken in one single process or in two and would likely differ between regions. The Secretariat would endeavour to provide assistance where possible. With regard to the query about strengthening points of entry, a voluntary process existed to certify capacity at airports and ports; Member States could request assistance from the Secretariat in that respect. Guidelines for the process were being produced. In terms of monitoring measures, suggestions and input from countries were important. Under the Regulations, States Parties could enact additional health measures during a public health emergency of international concern. When that occurred, WHO would request information on the measures and share the information with all States Parties and update the information. Member States should be involved in the development of all relevant tools.

Dr OMI (Japan) agreed that it was necessary to prioritize some of the core capacities for implementation of the Regulations. Surveillance was of particular importance.

The DIRECTOR-GENERAL, responding to the comment by the member for Japan about making full use of country cooperation strategies, said that Member States were learning lessons through the strategies, as evidenced by the increased requests for technical support to build core capacity in the Proposed programme budget 2016–2017. The Review Committee had identified gaps which should be filled. She welcomed the identified need for a more robust evaluation mechanism; the regional offices should take the lead in that regard, given their experiences with certification of eradication of diseases such as poliomyelitis and dracunculiasis. In terms of prioritizing core capacities, it should be noted that not all capacities, such as surveillance, required high levels of funding; increased political will and the development of partnerships were equally important. Private sector partnerships could be useful, depending on the context. In terms of the deadline, if Member States were committed to 2016 as the deadline, increased efforts would be needed. However, a proposal of 2018 had also been received and she required guidance from Member States on the matter.

The Board took note of the reports and adopted the resolution contained in document EB136/22 Add.1.¹

¹ Resolution EB136.R6.

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

Health and the environment: Item 7.2 of the Agenda

- **Addressing the health impact of air pollution (Document EB136/15)**
- **Climate and health: outcome of the WHO Conference on Health and Climate (Document EB136/16)**

The CHAIRMAN drew attention to a draft resolution proposed by Chile, Colombia, France, Monaco, Norway, Panama, Ukraine, United States of America, Uruguay and Zambia on the health impact of air pollution, and which read:

The Executive Board,

Having considered the report on air pollution and health,¹

(PP1) Noting with deep concern that air pollution is one of the main avoidable causes of disease and death globally and the world's largest single environmental health risk;

(PP2) Acknowledging that over four million deaths occur each year from exposure to household (indoor) air pollution and that a further 3.7 million deaths a year are attributable to ambient (outdoor) air pollution, at a high cost to societies;²

(PP3) Aware that exposure to air pollutants, especially fine particulate matter, is a leading risk factor for noncommunicable diseases in adults, including ischemic heart disease, stroke, chronic obstructive pulmonary disease, asthma and cancer;

(PP4) Concerned that half of the deaths due to pneumonia in children aged less than five years may be attributed to household air pollution, making it a leading risk factor for children's health;

(PP5) Further concerned that ambient air pollution, and particularly its fine particulate component, is classified as a cause of lung cancer by IARC,³ which has also classified diesel combustion and the burning of coal (the principal causes of household and ambient air pollution) as being carcinogens for humans;

(PP6) Aware that both short- and long-term exposure to air pollution has a negative impact on health, with a much greater impact resulting from long-term exposure, and also that for pollutants as particles it is not possible to identify a threshold of exposure below which there would be no health effects;

(PP7) Noting the strong significance of air pollution and its health effects to the objectives and targets contained in the WHO NCD global action plan 2013–2020;

(PP8) Noting that air pollution is a cause of global health inequities, affecting in particular women and children, and old persons, as well as low-income populations who are often exposed to high levels of ambient air pollution as a result of living near busy roads or industrial sites, or in homes that have no choice but to rely on polluting fuels and technologies for cooking, heating and lighting; and noting also that air pollution is getting worse in many cities in developing countries while it is improving in the developed world, and that the adopted

¹ Document EB136/15.

² WHO. Burden of disease from ambient air pollution for 2012.

³ Straif K, Cohen A, Samet J, eds. Air pollution and cancer. IARC Scientific Publication No. 161. Lyon, France; International Agency for Research on Cancer; <http://www.iarc.fr/en/publications/books/sp161/index.php> (accessed 2 December 2014).

means of improving air quality are amongst those that have the greatest impact on health equity;¹

(PP9) Recognizing that most air pollutants are emitted as by-products of human activity in a range of sectors, with indoor air pollution typically being a result of home use of dirty fuels (such as kerosene and coal), inefficient technologies for heating, cooking and lighting or smoking, as well as volatile organic compounds (VOCs) from home building materials, and with outdoor air pollution resulting inter alia from energy production, motorized transportation, patterns of industrial and urban development, waste disposal, agriculture and burning of biomass and other household sources of energy; and noting also that indoor air pollution also has an effect on outdoor air quality and vice-versa;

(PP10) Noting with deep concern that while there are substantial data, and many national, regional and international initiatives, to mitigate the health impacts of indoor and outdoor air pollution, there is neither a coordinated global strategy nor adequate concerted efforts to reduce air pollution of outdoor or indoor origin, so as to prevent consequent disease and ill-health;

(PP11) Recognizing that the sources of air pollution, its impacts on health, and the policy options for tackling it, are specific to context and place, and that air pollution is transported over long distances, thereby requiring cooperation across sectors at the local, regional, and global level for the identification and implementation of policies with maximal health and social benefits (“win-win actions”), and that in order to contribute to policy choices that protect health and reduce health inequities, the health sector will need to engage in cross-sectorial approaches to health, including health-in-all policies;

(PP12) Noting that WHO’s air quality guidelines for both ambient air quality² (2005) and indoor air quality: household fuel combustion³ (2014) provide a goal for clean air that protects human health, but with a need outstanding for activities, such as the promotion of policies that provide access to clean fuels and clean and efficient home energy solutions, as well as sectorial policies in transport, energy and construction to reduce air pollution from emission sources;

(PP13) Acknowledging that while many of the most important and cost-effective actions against outdoor air pollution require the involvement and leadership of national governments as well as regional and local authorities, cities are both particularly affected by the consequences of air pollution and well-placed to reduce air pollution and its associated health impacts, and can complement national air quality measures and emission standards through policies and investments in more energy-efficient and healthy urban planning, more sustainable and healthy transport, building housing and energy systems, and that the health sector can contribute to identifying and communicating and evaluating the healthiest policy options for those communities with whom it works;

(PP14) Aware that both established and expanding clean-energy technologies and renewable energy solutions offer cost-effective opportunities to reduce energy poverty while facilitating a shift to cleaner sources, particularly at community and household level;

(PP15) Underscoring the fact that sources of air pollution also tend to contribute to climate change, through both long-lived greenhouse gases such as carbon dioxide and short-lived climate pollutants, such as methane and black carbon, and that climate change can also contribute to air pollution, for example through more frequent heatwaves that exacerbate the health consequences of air quality;

¹ http://www.who.int/phe/health_topics/outdoorair/databases/AAP_BoD_results_March2014.pdf?ua=1 (accessed 1 December 2014).

² WHO air quality guidelines for particulate matter, ozone, nitrogen dioxide and sulfur dioxide – global update 2005: summary of risk assessment. Geneva: World Health Organization; 2006 (document WHO/SDE/PHE/OEH/06.02).

³ WHO indoor air quality guidelines: household fuel combustion; 2014; ISBN 978 92 4 154887 8 (<http://www.who.int/indoorair/guidelines/hhfc/en/>).

(PP16) Noting that air pollution health impacts can be a health-relevant indicator for sustainable development policies, particularly with regard to sustainable energy, sustainable cities and transport, and that due consideration should be given to this opportunity in post-2015 Sustainable Development Goal discussions,

(OP 1) URGES Member States to:¹

- (1) redouble their efforts to identify, address and mitigate the health effects of air pollution, by developing, as appropriate, multisectorial cooperation on the national level, and through targeted, multisectorial measures in accordance with national priorities, by contributing to enhanced global data collection, monitoring, research, informing the development of normative standards, engaging in cooperation and sharing of best practices and through dissemination of good practices and lessons from implementation;
- (2) enable health systems to take a leading role in raising public awareness and all stakeholders of the impacts of air pollution on health and opportunities to reduce or avoid exposure, including by strengthening health systems capacity to provide information about the health effects of air pollution, to guide and carry out preventive measures to help reduce these health effects, and to interact effectively with the relevant sectors and other relevant public and private stakeholders to ensure that health concerns are integrated into relevant national, regional and local policy and decision making processes, including public health prevention, preparedness and response measures;
- (3) facilitate research to expand the evidence base on impacts of air pollution on health and the effectiveness of interventions to address them, including statistics on morbidity, mortality, health impact assessment, the use and costs of health care services and the societal costs associated with ill health, supporting identification of research priorities and strategies, engaging with academia to address knowledge gaps, and supporting the strengthening of national research institutions and international cooperation in research;
- (4) contribute to global and regional initiatives to address air pollution and its health effects, emphasising in particular the monitoring of health effects of air pollution, including, as appropriate, by collecting and sharing data on air pollution exposure and relevant health outcomes, and by working towards harmonization of indicators which could be used by decision makers;
- (5) increase coverage of air quality monitoring systems that monitor critical air pollutants through, as appropriate, multisectorial cooperation, and gradually integrate the measuring of specific pollutants that generate health impacts, thereby developing a better understanding of the current level of air quality in the member states;
- (6) improve and optimize the morbidity and mortality registry for all illnesses, on behalf of health services, especially those related to air contamination, obtaining information that may be related to the registries of critical contaminants and other more specific registries in the member states;
- (7) encourage and facilitate clean cooking, heating, and lighting practices, technologies and fuels that will lead to meaningful progress to reduce levels of indoor air pollution as identified in the WHO guidelines for indoor air quality, as well as measures promoting and implementing the aims of the WHO guidelines for ambient air quality, while recognizing the differing capacities and resources of member states;
- (8) take account of the WHO guidelines for ambient air pollution in the development of a multisectorial national response to air pollution;
- (9) take effective measures to mitigate air pollution specifically associated with health care activities, including by implementing the WHO guidelines for ambient air quality and for indoor air quality in health care facilities;

¹ And, where applicable, regional economic integration organizations.

- (10) develop policy dialogue and information sharing between different sectors to facilitate a coordinated, multisectorial basis for participation in future regional and global processes to address the health effects of air pollution;
- (11) ensure that WHO has adequate capacities to support member states and actively develop the global response to the health effects of air pollution;
- (12) meet the commitments made at the 2011 UN High level meeting on non-communicable diseases and to use, as appropriate, the road map and policy options contained in the WHO global action plan for noncommunicable diseases,

(OP2) REQUESTS the Director-General:

- (1) to establish a Program for Health and Air Pollution, in order to deliver;
 - (a) support and guidance for the implementation of the Guidelines for ambient air pollution and for indoor air pollution;
 - (b) enhanced technical support and guidance to member states, including through appropriate capacities in regional and country offices to support the above activities;
 - (c) the development and updating of air pollution guidelines and cost-benefit tools for relevant sectors, such as housing, transport and electricity production;
 - (d) increased technical capacity within the WHO to collect and analyse data on air quality, making full use of partnerships with other relevant international, regional and national actors;
 - (e) help Member States to communicate to the general public and stakeholders, on air pollution, its effects and actions to reduce it;
 - (f) enhanced ability of WHO to convene, guide and influence research strategies in the field of air pollution and health, in conjunction with the WHO Global Observatory;
 - (g) the development of appropriate advisory capacity and support tools to assist cities in tackling air pollution and their health effects;
- (2) to exercise global leadership for health and maximize synergies with relevant global efforts that promote air quality, pollution mitigation and health improvements, particularly in areas such as climate change, sustainable energy and sustainable transport;
- (3) to strengthen, and where applicable forge, links with existing global health initiatives that can benefit from air pollution reduction, including global efforts to reduce noncommunicable diseases (such as the WHO global action plan for noncommunicable diseases) and pneumonia in children;
- (4) to report to the Sixty-ninth World Health Assembly on the implementation of this resolution and the status of the global effort to tackle air pollution;
- (5) to propose to the Sixty-ninth World Health Assembly a road map for an enhanced global response to the health effects of air pollution in the period following decisions related to air pollution agreed in other fora.

Given the floor by the CHAIRMAN in response to a request by Mr CORRALES HIDALGO (Panama), Mr GULDVOG (Norway)¹ proposed that, as informal discussions on the draft resolution were under way, discussion of the item should be postponed until later in the session.

Ms McCARTHY (United States of America) applauded the leadership, technical assistance and scientific information provided by WHO, which helped Member States to develop smart policies, educate the public and generate the momentum needed to act. Her country was active on numerous environmental issues, and would continue to collaborate with the Secretariat and other United Nations

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

partners in particular on exposure to toxic chemicals, including efforts to ban lead paint worldwide, ensure proper use of pesticides, reduce air pollution, increase fuel efficiency and reduce the use of cook stoves in developing countries. WHO's information on air pollution and guidelines on air quality were extremely valuable and had been vital to shaping policies; WHO was the voice of sound science. Her Government was also responding vigorously to the challenge of climate change, through for example implementation of the Clean Air Act to reduce carbon pollution and which, contrary to fears, had not held back the economy. She encouraged WHO to continue its efforts to tackle air pollution and other environmental threats.

(For continuation of the discussion and adoption of a decision, see the summary record of the fifteenth meeting, section 1.)

3. HEALTH SYSTEMS: Item 10 of the Agenda

Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage: Item 10.1 of the Agenda (Document EB136/27)

The CHAIRMAN drew attention to a draft resolution proposed by Australia, Kenya, Monaco, Nigeria, Rwanda, Senegal, Ukraine, United States of America and Zambia, which read as follows:

The Executive Board,

Having considered the report on strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage,¹

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

The Sixty-eighth World Health Assembly,

(PP1) Recognizing that each year more than 234 million surgical procedures are performed globally for a wide range of common conditions requiring surgical care, affecting all age groups – including obstructed labour, birth defects, cataracts, cancer, diabetes, acute abdominal conditions, burns and injuries from domestic, and industrial and road accidents – and that conditions for which surgery is one of the primary clinical solutions are expected to become increasingly common in the coming years;

(PP2) Noting that many surgically treatable diseases are among the top 15 causes of physical disability worldwide and that 11% of the world's burden of disease stems from conditions that could be treated successfully through surgery, with low- and middle-income countries being the most affected;²

(PP3) Recognizing that each year more than 100 million people sustain injuries globally, more than 5 million people die from violence and injury, and that 90% of the global burden of violence and injury mortality occurs in low- and middle-income countries;³

¹ Document EB136/27.

² See the WHO global burden of disease website, at: http://www.who.int/topics/global_burden_of_disease/en/ (accessed 16 January 2015).

³ The injury chart book: a graphical overview of the global burden of injuries, Geneva: World Health Organization; 2002 (<http://whqlibdoc.who.int/publications/924156220X.pdf?ua=1>, accessed 16 January 2015).

(PP4) Noting that more than 289 000 women die every year in childbirth and that approximately a quarter of maternal deaths, as well as infant deaths and disabilities that result from obstructed labour, haemorrhage and infection, could be avoided if safe surgery and anaesthesia were universally available;¹

(PP5) Noting also that the sustainable provision of emergency and essential surgical care and anaesthesia is a critical part of integrated primary health care, lowers mortality and disability, reduces deaths resulting from birth defects and prevents other adverse health outcomes arising from the burden of injuries and noncommunicable diseases;²

(PP6) Noting further the relevance of emergency and essential surgical care and anaesthesia in achieving the Millennium Development Goals and for attending to the unfinished business post-2015, including universal health coverage;³

(PP7) Recognizing the importance of timely referral and the existence of standards and protocols, such as those defined in the WHO Integrated Management for Emergency and Essential Surgical Care, in the continuum of care,⁴ and recalling that resolution WHA55.18 on quality of care: patient safety urges Member States to establish and strengthen science-based systems necessary to improving patients' safety and the quality of health care, including the monitoring of drugs, medical equipment and technology;

(PP8) Recognizing also that emergency and essential surgical care and anaesthesia are a neglected but efficacious and cost-effective addition to the basic package of health services and that strengthening emergency and essential surgical capacity together with anaesthesia, particularly at the first-level referral hospitals, is a highly cost-efficient solution to the global burden of disease;

(PP9) Noting the importance of analgesia in surgery and anaesthesia, and that a large proportion of the global population has limited access to opioid analgesics for pain relief, and patients with moderate and severe pain often do not receive the treatment they need, that 5.5 billion people (83% of the world's population) live in countries with low to non-existent access, that 250 million (4%) have moderate access, that 460 million (7%) have adequate access, and that insufficient data are available for 430 million people (7%);⁵

(PP10) Recognizing that balanced policies and regulations for improving access to controlled medicines while preventing their misuse have been successfully implemented in a number of countries;

(PP11) Emphasizing the need for Member States,⁶ with the support of the Secretariat, the United Nations Office on Drugs and Crime, and the International Narcotics Control Board, to ensure that efforts to prevent diversion and abuse of narcotic drugs and psychotropic substances under international control pursuant to the United Nations international drug control conventions do not result in inappropriate regulatory barriers to medical access to such medicines (WHA67.19, pp 12);

¹ <http://www.who.int/mediacentre/factsheets/fs348/en/>.

² <http://www.who.int/entity/surgery/publications/s16378e.pdf>.

³ PLoS Medicine Editors. "A crucial role for surgery in reaching the UN Millennium Development Goals." PLoS medicine 5.8 (2008): e182.

⁴ WHO Integrated Management for Emergency and Essential Surgical Care: see <http://www.who.int/entity/surgery/publications/s16372e.pdf?ua=1> (accessed 16 January 2015).

⁵ A First Comparison Between the Consumption of and the Need for Opioid Analgesics at Country, Regional, and Global Levels. Marie-Joséphine Seya, Susanne F. A. M. Gelders, Obianuju Uzoma Achara, Barbara Milani, and Willem Karel Scholten. *Journal of Pain & Palliative Care Pharmacotherapy*. 2011;25:6–18.

⁶ And, as applicable, regional economic integration organizations.

(PP12) Recalling that resolution WHA56.24 on implementing the recommendations of the *World report on violence and health* requested the Director-General to provide technical support for strengthening trauma and care services to survivors or victims of violence, and that resolution WHA57.10 on road safety and health recommended Member States to strengthen emergency and rehabilitation services for victims of road-traffic injuries;

(PP13) Recognizing that 15% of the world's population live with a disability, and recalling that resolution WHA58.23 on disability, including prevention, management and rehabilitation urged Member States to promote early intervention and take necessary steps for the reduction of risk factors contributing to disabilities, especially during pregnancy and for children, and to put into practice the most effective actions to prevent disabilities, which include timely and effective surgery where required;

(PP14) Aware of the critical importance of health systems strengthening for providing access to quality, safe, effective, and affordable emergency and essential surgical care and anaesthesia and recalling resolution WHA60.22 on health systems: emergency care systems, which recognized that improved organization and planning for the provision of trauma and emergency care, including surgery, is an essential part of integrated health care delivery;

(PP15) Recalling also resolution WHA64.6 on health workforce strengthening, which emphasizes the importance of prioritizing public sector spending on health to ensure that sufficient financial resources are available for the implementation of policies and strategies to scale up and retain the health workforce, particularly in developing countries, and to recognize it as an investment in the health of the population that contributes to social and economic development, including access to emergency and essential surgical and anaesthesia services;

(PP16) Recalling further resolution WHA66.10 on noncommunicable diseases, which calls for action to prevent and control cardiovascular diseases, cancer, diabetes and chronic respiratory diseases, and noting the important role of surgical care for diagnosis, treatment and cure of a significant portion of these diseases;

(PP17) Aware of the critical importance of access to and responsible use of effective antimicrobial agents for safe surgery, and recalling resolution WHA67.25, which calls for urgent action to combat antimicrobial resistance;

(PP18) Recalling resolution WHA67.19 on strengthening of palliative care as a component of comprehensive care throughout the life course, which urges Member States¹ to promote collaborative action to ensure adequate supply of essential medicines in palliative care, and requests the Director-General to explore ways to increase the availability and accessibility of medicines used in palliative care through consultation with Member States¹ and relevant networks and civil society, as well as other international stakeholders, as appropriate;

(PP19) Acknowledging the work already done by the WHO Global Initiative for Emergency and Essential Surgical Care in the WHO programme for Emergency and Essential Surgical Care, the World Alliance for Patient Safety, and the Safe Surgery Saves Lives programme;

(PP20) Concerned that inadequate investment in the infrastructure of health systems, inadequate training of the surgical care health workforce and the absence of a stable supply of surgical equipment and necessities in many countries impedes progress in improving delivery of emergency and essential surgical care and anaesthesia;

¹ And, as applicable, regional economic integration organizations.

(PP21) Recognizing that relevant, meaningful and reliable measures of safe emergency and essential surgery and anaesthesia are needed for assessment and monitoring, and to foster political and public support;

(PP22) Acknowledging that many countries are unable to meet the threshold of 2.28 skilled health professionals per 1000, and many surgical procedures, including basic suturing, episiotomies, and draining of abscesses, can be successfully completed by other trained health care workers through task-sharing at the district and sub-district levels;¹

(PP23) Considering that additional efforts are required globally to strengthen the provision of emergency and essential surgical care and anaesthesia so as to ensure timely and effective delivery to those who need such care in the overall context of the health system, and related health and health-promotion initiatives,

(OP) 1. URGES Member States:²

- (1) to identify and prioritize a core set of emergency and essential surgery and anaesthesia services at the primary health care and first referral hospital level, and to develop methods and financing systems for making quality, safe, effective and affordable emergency and essential surgical care and anaesthesia services accessible to all who need it, including promoting timely referral and more effective use of the health care workforce through task-sharing, as appropriate, as part of an integrated surgical care network in order to achieve universal health coverage;³
- (2) to integrate emergency and essential surgical care and anaesthesia in primary health care facilities and first referral hospitals, and to promote emergency and essential surgery and anaesthesia capacity as components integral to achieving universal health coverage;
- (3) to promote the provision of emergency and essential surgical care and anaesthesia and ensure that ministries of health take a lead role in, and intersectoral coordination mechanisms, including among all health care providers, are in place for, reviewing and strengthening the provision of such care;
- (4) to promote access to essential medicines, including controlled medicines, antibiotics, medical devices and diagnostics used in anaesthesiology and surgery that are of quality, safe, efficacious, affordable, and are used responsibly and appropriately and in line with WHO guidelines;
- (5) to carry out regular monitoring and evaluation of the emergency and essential surgical care and anaesthesia capacity of health care facilities to identify unmet infrastructural needs, human resource needs, training and supply needs;
- (6) to collect and compile data on number, type, and indications of surgical procedures performed, referrals, and perioperative mortality in their respective countries, and to share such data as appropriate;
- (7) to strengthen infection prevention and control as a critical element of ensuring quality and safety of emergency and essential surgical care and anaesthesia;
- (8) to develop and implement surgical care and anaesthesia policies to assure minimum standards for a skilled workforce, adequate equipment, infrastructure and supplies, and documenting, monitoring, and evaluation of access to and quality of services, to be embedded in programmes and legislation based on current

¹ Working Together for Health, World Health Organization 2006 <http://www.who.int/surgery/publications/imeesc/en/>.

² And, as applicable, regional economic integration organizations.

³ <http://www.who.int/surgery/publications/imeesc/en/>.

knowledge and considerations promoting the right to the enjoyment of the highest attainable standard of health;

(9) to ensure that appropriate core competencies are part of relevant health curricula, training, and education of students from various relevant disciplines such as medical, nursing, midwifery, and other surgical care providers, as well as continuing education for professionals involved in provision of surgical care and anaesthesia;

(OP) 2. REQUESTS the Director-General:

(1) to foster multisectoral networks and partnerships, multidisciplinary policies and action plans, and support national, regional and global efforts to develop science-based approaches to prevention, screening, and implementation of emergency and essential surgical care and anaesthesia and to enhance teaching and training programmes;

(2) to facilitate collaboration among Member States¹ to share and exchange information, skills and technology essential to strengthening surgery and anaesthesia services;

(3) to raise awareness of cost-effective options to reduce morbidity, mortality and prevent or treat disability and deformity through improved organization and planning of provision of anaesthesia and surgical care that is appropriate for resource-constrained settings, and continue to organize regular expert meetings to further technical exchange and build capacity in this area;

(4) to establish mechanisms to collect emergency and essential surgical and anaesthesia case log data in order to increase understanding of unmet needs and improve the global capacity for surgery and anaesthesia in the context of universal health coverage;

(5) to devise relevant, meaningful and reliable measures of access to and safety of emergency and essential surgery and anaesthesia, and make available means of performing risk-adjustment of indicators such as the perioperative mortality rate, and reporting and benchmarking of these measures;

(6) to collect, assess and report related cost data on the delivery of emergency and essential surgical care and anaesthesia, as well as the economic impact of their availability;

(7) to support Member States¹ in the development and implementation of policies and regulations for ensuring access to quality, safe, efficacious and affordable-essential medicines, including controlled medicines for pain management, medical devices and diagnostics that are used in emergency and essential surgical care and anaesthesia;

(8) to continue, through WHO's Access to Controlled Medicines Programme, to support Member States in reviewing and improving national legislation and policies with the objective of ensuring a balance between the prevention of misuse, diversion and trafficking of controlled substances and appropriate access to controlled medicines, in line with the United Nations international drug control conventions;

(9) to work with the International Narcotics Control Board, the United Nations Office on Drugs and Crime, health ministries and other relevant authorities at global, regional and national levels in order to promote the availability and balanced control of controlled medicines for essential and emergency surgical care and anaesthesia;

¹ And, as applicable, regional economic integration organizations.

- (10) to further cooperate with the International Narcotics Control Board to support Member States¹ in establishing accurate estimates in order to enable the availability of medicines for emergency and essential and surgical care and anaesthesia, including through better implementation of the guidance on estimating requirements for substances under international control;
- (11) to support Member States¹ to devise policies and strategies that enhance the skills of the appropriate health workforce for emergency and essential surgical care and anaesthesia, especially at primary health care and first referral hospital level;
- (12) to set aside adequate resources for the Secretariat, in line with the proposed Programme Budget 2016–2017 and the Twelfth General Programme of Work, 2014–2019 for strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage;
- (13) to work with Member States and other relevant partners to design strategies that provide support to Member States for mobilizing adequate resources to achieve the objectives of strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage;
- (14) to report back to the Seventieth World Health Assembly in 2017 on progress in the implementation of this resolution.

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

1. Resolution: Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage	
2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf) Category: 4. Health systems	
Programme area(s): Integrated people-centred health services	Outcome: 4.2. Policies, financing and human resources are in place to increase access to integrated people-centred health services Outputs: 4.2.1. Policy options, tools and technical support to countries for equitable people-centred integrated service delivery and strengthening of public health approaches 4.2.2. Countries enabled to plan and implement strategies that are in line with WHO's global strategy on human resources for health and the WHO Global Code of Practice on the International Recruitment of Health Personnel 4.2.3. Guidelines, tools and technical support to countries for improved patient safety and quality of services, and for patient empowerment
How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)? The resolution would support the achievement of timely, safe access to emergency and essential surgical care and anaesthesia in primary health care facilities and first referral hospitals as an integral component of universal health coverage. It would foster multisectoral networks and partnerships, multidisciplinary policies and action plans, and support national, regional and global efforts to scale up a skilled health workforce and measures for access to, and safety of, emergency and essential surgery and anaesthesia services.	

¹ And, as applicable, regional economic integration organizations.

Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)
Yes.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) Five years (covering the period 2014–2018).

(ii) Total: US\$ 22.98 million (staff: US\$ 10.48 million; activities: US\$ 12.50 million).

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 9.20 million (staff: US\$ 4.20 million; activities: US\$ 5.00 million).

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

Headquarters and all six regional offices.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

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

(c) Staffing implications

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

No.

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

During the biennium 2016–2017, at least one additional staff member at grade P.4 at headquarters and one at grade P.4 in each of the six regional offices would be required.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3(b) fully funded? (Yes/no)

No.

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

The funding gap is US\$ 2.98 million for the period from May to December 2015 inclusive (eight months). It will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland), noting the centrality of the subject to universal health coverage, highlighted the references to making available comprehensive surgical and anaesthesia services (including post-operative care and infection control), improving quality and safety of surgery, and strengthening the health workforce. In connection with the fostering of global collaboration mentioned in the report, she drew attention to the work of the Lancet Commission on Global Surgery, whose findings on investment in surgery and anaesthesia in lower- and middle-income countries would be published later in 2015.

Mr CHEN Hu (China), endorsing the draft resolution, emphasized the need for investment in strengthening and training the health workforce, including the prevention of medical accidents. Infection control was vital to strengthening emergency and essential surgical care and anaesthesia.

Developing countries, however, needed a transition period to prepare national technical guidance and strengthen the training of the health workforce.

Dr KAMWI (Namibia), speaking on behalf of the Member States of the African Region, recognized the primacy of primary prevention, including reduced alcohol consumption and other lifestyle changes. Surgery, anaesthesia, blood transfusion and infection prevention and control had to go hand in hand, especially in medical emergencies. The wide gaps in surgical services in the Region need urgent attention, including investment in health systems, notably in human resources and surgical training, and provision of essential equipment and technology. He called for the Secretariat's support to ensure access to quality-assured and safe essential medicines, in particular ketamine whose provision would facilitate surgical operations at district and subdistrict levels. Similarly vital was the integration of improved surgery into wider health system strengthening through the provision of technical support. The aim must be to uphold such proven principles as appropriate and timely medical intervention within the first hour, standardization and quality assurance, and prompt and reliable referral procedures. By definition, universal health coverage implied a minimum package of essential emergency and surgical care services at the community level as part of the primary care system. He supported the draft resolution.

Dr NIK JASMIN NIK MAHIR (Malaysia) said that his country would work to improve standards of care, even in emergencies and disasters, in response to the deficiencies in human resources, availability of equipment, and capacity in the delivery of anaesthesia and surgical services identified in the assessment conducted using the WHO Integrated Management for Emergency and Essential Surgical Care toolkit. Its hospitals cluster initiative would be expanded. He expressed concern about the potential implications of the recommendations in the draft resolution, which were relevant to first-referral hospitals, for resource-limited primary health care settings. Member States should be allowed flexibility on that score and benefit from WHO's support. Nevertheless, she supported the draft resolution.

Dr AMMAR (Lebanon) said that the need for surgical care was growing in view of the rising incidence of noncommunicable diseases in countries undergoing an epidemiological transition. Essential operations and anaesthesia must be an intrinsic part of both universal health coverage and the continuum of care within the framework of integrated and people-centred health services, which called for effective case management across the different levels of those services. Front-line secondary hospitals needed skilled personnel and safe blood transfusion capabilities. Attention must also be directed to strengthening capacities for the delivery of emergency and essential surgical care and anaesthesia in countries experiencing armed conflict. He too endorsed the draft resolution.

Dr SHIMIZU (Japan) supported the development and promotion of surgical and anaesthetic services as essential components of universal health coverage, which implied strengthening referral systems and the health workforce. Country-specific priorities and needs must be taken into consideration. He wondered, however, why the topic had merited inclusion on the Board's agenda.

Mr MAMACOS (United States of America), endorsing the statement by the member for Namibia, underlined his country's commitment to improving access to surgical care and anaesthesia, particularly in low- and middle-income countries, which was not only a key component of primary health care, but crucial to the achievement of global health targets and a highly cost-effective step in pursuit of universal health coverage. Safe surgical care could be facilitated through access to the anaesthetics featured in the WHO Model List of Essential Medicines, such as ketamine, and infection prevention and control. The latter measures would also contribute to curbing antimicrobial resistance, and their strengthening, together with the disinfection and sterilization of medical devices, was to be encouraged, as was judicious use of antimicrobial prophylaxis.

Ms BAĬBARINA (Russian Federation), expressing support for the draft resolution, said that, in addition to the proposed action on monitoring and evaluation, attention must focus on infection control. It would be also important to assess patients' access not only to basic surgical care but also to essential high-technology procedures in central hospitals.

Ms MOURAD (Egypt), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that many countries did not have national policies related to surgical care or adequately trained health professionals. The Secretariat should support countries in making use of standardized tools for assessment and monitoring, such as the WHO Integrated Management for Emergency and Essential Surgical Care toolkit. It should also facilitate the establishment of regional and global networks and partnerships in order to increase surgical capacities, especially in countries experiencing conflict or emergency situations. Furthermore, Member States should integrate surgical care initiatives into their national health plans.

Ms MNISI (South Africa), Mr DE RAEDT (Belgium) and Dr GNASSINGBE (Togo)¹ said that their countries wished to sponsor the draft resolution.

Given the floor by the CHAIRMAN in response to a request by Mr BOWLES (Australia), Dr MAKASA (Zambia),¹ speaking in his capacity as chairman of the drafting group on the draft resolution, explained that the text aimed to help Member States to provide safe and timely access to emergency and essential surgical care in primary health care facilities and first-referral hospitals as an integral component of universal health coverage. It also intended to foster multisectoral networks and partnerships, multidisciplinary policies and action plans, bolstering national, regional and global efforts to expand the skilled health workforce and increase access to surgical care. He urged the Board to adopt the draft resolution.

Dr KUPA (Democratic Republic of the Congo) stressed the value of assessments on the ground and the need for support of such evaluations. Surgical care, particularly emergency surgery, required tools and equipment, and it was important to know whether conditions in the field were such that they could be used. For example, in some cases there was no electricity to operate scanners.

Mrs VALLINI (Brazil) said that a broad approach that included access to antibiotics and measures to address antimicrobial resistance was critical to prevent injuries related to surgical and anaesthetic procedures. Adequate and specialized training for health care professionals was also needed and would improve access to better surgical services. The rational use of caesarean sections would have a positive impact on maternal and child morbidity and mortality. She recognized the value of the draft resolution for improving access to health services.

Professor KIM So-yoon (Republic of Korea), expressing support for the draft resolution, said that efforts were needed to close the gaps in access to essential surgical care between urban and rural areas and to enhance its quality and safety. Professional training, through global networks and partnerships, would be particularly useful in that regard, especially in low-income countries.

Ms SAMIYA (Maldives) supported the draft resolution, but reiterated the concerns expressed by the member for Malaysia and the call for flexibility in the draft resolution's implementation in low-resource settings.

Dr GONZÁLEZ FERNANDEZ (Cuba) affirmed the urgent need to guarantee access to trained surgeons and anaesthetists and surgical supplies. Political commitment was required to integrate

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

surgical care and anaesthetics into national health plans, particularly within primary health care but with support from other levels of the health system. He endorsed the draft resolution and emphasized the need for its implementation in every country.

Ms ROA RODRIGUEZ (Panama) recognized that national health coverage in her country was not universal, with long waiting lists for operations. Access to surgical services was often limited to urban centres, but mobile primary health care facilities had been created to meet the growing need for minor surgery in hard-to-reach areas. Surgical procedures had to comply with biosafety standards, regulations and best practice, and should be monitored and evaluated. Development of a cadre of trained health care professionals was essential, and access to biomedical technology and supplies would help to avoid surgical complications. It was important to ensure access to appropriate medication, including anaesthetics and post-surgery analgesics. She supported the draft resolution, and asked that her country be added to the list of sponsors.

Ms PENEVEYRE (Switzerland)¹ welcomed the draft resolution, which would enable progress towards universal health coverage in underserved regions and populations, and requested that her country be added to the list of sponsors. The draft resolution would also contribute significantly to tackling numerous communicable and noncommunicable diseases and improving maternal and reproductive health, particularly through increased access to caesarean delivery.

Dr CHAND (Nepal) observed that quality health care had to cover emergency and essential surgical care, whose delivery depended on stronger infrastructure, better logistics and larger workforce capacity as well as partnership with educational and private institutions to institute district-level surgical care. The unequal distribution of skilled health care personnel needed to be redressed. Surgical care should also be available at strategic locations, for example near major roads. Developing countries would require technical and financial support.

Dr IHMAIDAT (Libya), taking note of the report, outlined the methodology and steps taken to try to improve health care provision in his country, which faced considerable difficulties in terms of primary health care and limited access to emergency services.

Dr KAFWAMFWA (Zambia)¹ outlined the burden of surgically treatable conditions in his country, which lacked surgical services at first-referral health facilities, health care workers trained for surgery, adequate infrastructure and essential surgical equipment and supplies, and the steps being taken. He expressed concern at the proposed inclusion of ketamine in Schedule I of the 1961 Single Convention on Narcotic Drugs, as that would have a negative impact on the production, availability and cost of that essential medicine. He called for financial and logistical resources to be allocated to the training of surgeons, obstetricians and gynaecologists and to strengthening the surgical infrastructure at all levels, encouraging skills transfer, and monitoring quality of services. He urged the Board to adopt the draft resolution and encouraged its full implementation.

Ms REITENBACH (Germany)¹ stressed disease prevention and health promotion in order to avoid surgical interventions where possible. The development of financial protection and health financing systems was a priority. The report could have included references to existing networks and global partnerships that provide knowledge transfer and joint learning.

Mr DIALLO (Senegal)¹ said that, in Africa, surgical interventions were required primarily as a result of pathologies relating to demographic growth, urban development, and socioeconomic conditions; the situation was compounded by infectious diseases and inadequate national health

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

infrastructures. Consideration of emergency anaesthesia services had to take into account the context. The lack of analgesics, particularly outside large urban centres, remained a barrier to emergency care. It was essential to strengthen legislation and infrastructure, train health care professionals, and establish partnerships within and between regions. He recommended adoption of the draft resolution, whose implementation would contribute to the attainment of universal health coverage.

Dr ANGKANA SOMMANUSTWEECHAI (Thailand),¹ noting that resource constraints prevented many countries from integrating surgical care and anaesthesia into health systems, encouraged the development of health infrastructures and workforces to ensure equitable access to services. It was essential not only to train the health workforce but to enhance their equitable geographical distribution. Strengthening the primary health care system would facilitate the integration of essential and emergency surgical services, and she supported the need to identify and prioritize a core set of services at the primary health care and first-referral levels, as urged in the draft resolution.

Dr GWINJI (Zimbabwe),¹ requesting that his country be added to the list of sponsors of the draft resolution, emphasized the importance of ketamine as an essential and accessible anaesthetic, particularly at district levels in low- and middle-income countries, and encouraged further discussions in that regard before the next session of the Commission on Narcotic Drugs.

Dr WILKINSON (World Federation of Societies of Anaesthesiologists), speaking at the invitation of the CHAIRMAN, emphasized the need for accurate data, universal access to surgery and safe anaesthesia. Despite the progress made, including the improved use of the WHO Safe Surgery Checklist, governments had to strengthen health systems and ensure they included essential surgery and anaesthesia. He expressed deep concern about the proposed inclusion of ketamine in Schedule I of the 1961 Single Convention on Narcotic Drugs, as it was often the most appropriate anaesthetic in low- and middle-income countries. His organization would work to implement recommendations adopted by the Board.

Professor GUNN (International Federation of Surgical Colleges), speaking at the invitation of the CHAIRMAN, supported the draft resolution, recalling his organization's long-standing calls to WHO to strengthen the surgical component of primary health care and that many of the millions of surgical procedures performed annually did not meet acceptable standards. His organization would continue to support WHO's efforts to strengthen emergency and essential surgical care.

Ms MORTON DOHERTY (Union for International Cancer Control), speaking at the invitation of the CHAIRMAN, underlined that surgery was a key component of curative and palliative care for cancer. As human and financial resource limitations led to unequal access to surgical services, she supported the aims of the draft resolution, even though she considered that the data on which it was based were underestimates. The Secretariat should improve its internal links and its cooperation with other international organizations and civil society in order to strengthen surgical services at the district and sub-district levels.

Mr DOWNHAM (International College of Surgeons), speaking at the invitation of the CHAIRMAN, recalled his organization's collaboration with WHO's Programme for Emergency and Essential Surgical Care since its inception. It would continue to work with WHO country offices and representatives of health ministries to provide surgical training in all countries, as surgery was often a cost-effective treatment option.

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

Ms BOLCHINI (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, emphasized the need to strengthen surgical and anaesthetic capacities by creating a decentralized and networked health system, at first-referral facilities and as appropriate to the needs at each level. That implied adequate training and workforce retention strategies. Criteria should be developed to ensure the rational use of safe and effective surgical procedures. Access to essential and emergency surgical care should be prioritized, and she warned against over-specialization and irrational use of high-cost procedures.

Mr DE MIRANDA (International Federation of Medical Students Associations), speaking at the invitation of the CHAIRMAN, said that the solution to the global disparity in access to surgical care lay in stronger health systems. He urged Member States and the Secretariat to define essential surgery and anaesthesia, integrate surgical care into national health policies and universal health coverage frameworks, recognize the value of surgical training in policies on human resources for health, involve all stakeholders in reviewing and formulating guidelines, and strengthen higher education facilities in low- and middle-income countries.

Dr KIENY (Assistant Director-General) expressed gratitude for the Board's support, as the issue was a critical element of universal health care. The Secretariat would continue to strengthen Member States' capacities in health system strengthening, health workforce training, and access to safe and affordable essential medicines and technologies for surgery and anaesthesia, including ketamine. She noted the changes to the report proposed by the representative of Germany.

The draft resolution was adopted.¹

WHO Global Code of Practice on the International Recruitment of Health Personnel: Item 10.2 of the Agenda (Document EB136/28)

Mr DE RAEDT (Belgium), speaking on behalf of the European Union and its Member States, said that Turkey, the former Yugoslav Republic of Macedonia, Montenegro, Serbia, Albania, Bosnia and Herzegovina, Ukraine, and the Republic of Moldova aligned themselves with his statement. Recalling the Recife Political Agenda on Human Resources for Health, he urged Member States to follow the example of the European Union and its Member States in using the provisions of the WHO Global Code of Practice to strengthen health systems at regional and national levels.

He requested further information on the progress made to finalize the global human resources for health strategy, which would be considered by the Sixty-ninth World Health Assembly, and on how the findings of the expert advisory group on the Code's relevance and effectiveness would be used to inform the global strategy development process. He also asked for more information on the process for defining and measuring critical health workforce shortages.

Dr ASSIRI (Saudi Arabia), speaking on behalf of the Member States of the Eastern Mediterranean Region, acknowledged the challenges in the Region to the Code's implementation and its slow reporting, and welcomed the forthcoming review of its relevance and effectiveness. He supported the designation of national authorities to fulfil national reporting requirements, encouraged all Member States to establish comprehensive migration databases as part of their overall health workforce information systems, and requested the Secretariat to provide support and promote the exchange of information between countries.

¹ Resolution EB136.R7.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) said that her country had been one of the first to implement policies that explicitly prevent the targeting of countries with critical shortages of health workers when recruiting internationally, and it continued to work closely with the Global Health Workforce Alliance and the Secretariat to develop a global strategy on human resources for health. She endorsed the proposals to facilitate review of the Code; the United Kingdom was ready to engage constructively in that process.

Dr DAHN (Liberia), speaking on behalf of the Member States of the African Region, said that their health systems continued to be destabilized as qualified health care workers were recruited for positions overseas. The outbreak of Ebola virus disease had highlighted the need for strong health systems; adequate training, retention and remuneration of health workers were determinants of preparedness and responses to public health emergencies. He endorsed the establishment of the expert advisory group to assess the Code's relevance and effectiveness as proposed in the report. The group should postpone its consideration of the Code's effectiveness until data had been collated from the second round of reporting in June 2015. The group's mandate should be extended to August 2015, so that it could fully assess the results of the second round of reporting due in June 2015. It would transmit its findings and recommendations on the Code's effectiveness to the Sixty-ninth World Health Assembly.

Mr KOLKER (United States of America) called on the Secretariat to ensure that the work of the Global Health Workforce Alliance and WHO's own programme were aligned and complementary. He welcomed the decision to establish the expert advisory group to consider the Code's relevance and effectiveness but expressed concern about the low number of countries that had provided data during the first reporting period. He supported other members' comments for the expert advisory group's work to be carefully defined. He urged WHO to provide guidance and assistance to Member States in an effort to increase the number of countries that provided data during the second reporting period and called for the development of more focused national reporting instruments for future reporting periods.

Ms WANG Qianyun (China) welcomed the first review of the Code's relevance and effectiveness and called for the subsequent review to include the views of both origin and destination countries for health professionals.

Mrs VALLINI (Brazil) said that her country had implemented the Code's provisions when conducting its recent large-scale national programme for temporary recruitment of health workers and was ready to share its national experiences during the first review of the Code's relevance and effectiveness.

Dr GONZÁLEZ FERNANDEZ (Cuba) supported the review of its relevance and effectiveness by the expert advisory group. The results of that review should be made available to Member States in a timely fashion to allow for study of its findings and recommendations in advance of the Sixty-eighth World Health Assembly.

Mr MAGALLANES (Argentina) stressed that Member States should offer technical assistance and guidance to support the international health care workforce wherever possible and recommended the introduction of an information mechanism that could facilitate data-sharing among Member States on the migratory flow of health workers and recruitment best practices. He also urged Member States to provide better training for health professionals as a key step towards national health care self-sufficiency.

Ms PENEVEYRE (Switzerland)¹ welcomed the review of the Code's relevance and effectiveness, but questioned whether the expert advisory group would be able to fulfil its mandate without data from the second round of reporting. She asked what steps would be taken to involve civil society in the questionnaire exercise and to improve the overall country reporting rate, particularly in countries of origin, to ensure that variations in health worker migration were duly recorded.

Mr SANNE (Norway)¹ stressed the importance of accurate, reliable, standardized and timely data on the migration flows of health workers at national and subnational levels and urged WHO regional offices to ensure that Member States in their respective regions contributed to the second round of reporting.

Dr ANGKANA SOMMANUSTWEECHAI (Thailand)¹ acknowledged the work of destination countries to implement the Code but recognized that implementation of the Code by source countries was far from satisfactory. She called for greater investment in health personnel information systems, particularly in low- and middle-income countries, and recommended further consultations on how to promote and implement the Code.

Mr DE RAEDT (Belgium), in response to the member for Liberia, said that it would be prudent to wait until the expert advisory group was fully operational before considering an extension of its mandate and the corresponding financial implications.

Dr ASADI-LARI (Islamic Republic of Iran) said that, despite inter-ministerial cooperation, his country faced serious shortages of nurses and the challenges of emigration of health professionals. He welcomed the establishment of the expert advisory group and fully endorsed the proposal to submit the group's findings and recommendations to the Sixty-eighth World Health Assembly.

Ms MANS (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, welcomed the review of the Code by the expert advisory group, but encouraged appropriate representation of civil society. She recommended postponing its report until the Sixty-ninth World Health Assembly so that it could take into account the data resulting from the second round of reporting in June 2015. She urged Member States to make their national reporting data publically available and called on WHO's regional and country offices to do more to promote implementation of the Code.

Mr MOREIRA DE SOUSA (International Federation of Medical Students' Association), speaking at the invitation of the CHAIRMAN, welcomed the establishment of the expert advisory group but recommended consideration of the views of educational institutions for health professionals. For the past two years his organization had been trying to provide information to show that the Code was not being implemented or followed up by member States. The group should work closely with other organizations, such as the European Union, and with WHO's regional offices to maximize resources and take into account a broader range of data.

Ms KUSYNOVÁ (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, stressed that the review of the Code's relevance and effectiveness should cover the widest possible range of health care personnel, including pharmacists, and should involve broad consultations with all relevant stakeholders.

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

Dr KIENY (Assistant Director-General) said that the Global Health Workforce Alliance had led a one-year consultation on the global strategy on human resources for health. Eight evidence-based papers had been consolidated into a synthesis paper for consideration by the Global Health Workforce Alliance Board in February 2015. That Board would, in turn, forward the recommended evidence-based synthesis to the Secretariat, which would transform it into a draft comprehensive health workforce strategy for consultation by Member States in the regional committees. The finalized draft strategy would subsequently be submitted for consideration by the Executive Board and the Health Assembly in 2016. The issues raised on measuring critical shortages in the health workforce and the national reporting instrument would be taken up with the members for Belgium and the United States of America, respectively. The review of the Code's relevance and effectiveness would inform the draft strategy. The expert advisory group would undertake its work on the Code's relevance and effectiveness as scheduled. It would report to the Sixty-eighth World Health Assembly using the available evidence. It would take account of the second round of national reporting and advise the Health Assembly if it needed more time to review national reports and bring that information into a supplementary report with costing information.

The CHAIRMAN said that he took it that the Board wished to proceed on that basis and take note of the report.

The Board agreed and noted the report.

The meeting rose at 18:05.

NINTH MEETING

Friday, 30 January 2015, at 09:05

Chairman: Mr M.H SHAREEF (Maldives)

HEALTH SYSTEMS: Item 10 of the Agenda (continued)

Substandard/spurious/falsely-labelled/falsified/counterfeit medical products: Item 10.3 of the Agenda (Document EB136/29)

Mr MCIFF (United States of America), speaking on behalf of the Member States of the Region of the Americas, welcomed the agreement on the recommendations for health authorities to detect and deal with actions, activities and behaviours that result in substandard/spurious/falsely-labelled/falsified/counterfeit medical products (SSFFC) (Annex 1 of the report) reached at the third meeting of the Member State mechanism on SSFFC medical products. Such technical documents were useful to Member States, and the Director-General, in coordination with the regional offices, should ensure their distribution and encourage their use. He also welcomed the agreement by the Member State mechanism on the revised list of prioritized activities for 2014–2015 (Annex 3), and the commitments from Member States to coordinate and support the implementation of specific prioritized activities. As gaps remained in the mechanism's funding and given the importance of financial sustainability to the functioning of the mechanism, the Director-General should make efforts to finance the prioritized activities, preferably from contributions to the Organization. The list of actions, activities and behaviours that fell outside the mandate of the Member State mechanism (Annex 2) required further debate, as no consensus had been reached on it. Taking into account the extensive list of approved activities and the achievements yet to be reached, he considered it appropriate to request the Health Assembly to postpone the review of the Member State mechanism to 2017.

Mr ARAKI (Japan) recognized that measures to counter SSFFC medical products were essential to achieving universal health coverage in every country. He expressed deep concern about the widespread use of informal supply chains, such as online pharmacies, to access medical products. Member States should enhance the capacity of regulatory authorities to manage the supply of appropriate medical products and should consider international collaboration through the Member States mechanism. Among the mechanism's prioritized activities, he urged study of the public health and socioeconomic impact of SSFFC medical products.

Mr MAGALLANES (Argentina), noting the consensus reached in the work of controlling SSFFC medical products, called on the Secretariat to disseminate the recommendations for health authorities to relevant stakeholders. The Secretariat should strengthen the links between WHO's project for the surveillance and monitoring of SSFFC medical products and the Member State mechanism. Despite pending issues for discussion, the mechanism should reach the necessary agreements at its forthcoming meeting in March 2015, in order to begin work on its prioritized activities thereafter.

Ms SAMIYA (Malaysia) welcomed the initiatives taken to achieve the recommendations of the Member State mechanism and agreed the list of actions, activities and behaviours that fell outside the mandate of the mechanism, the list of prioritized activities and the mechanism's work plan. Her

country offered support in political advocacy, communication, knowledge-sharing, education and raising awareness among consumer groups, including health professionals and industry.

Mr QIN Xiaoling (China) welcomed the revised list of prioritized activities and noted WHO's important activities in improving the affordability, quality, safety and efficacy of medicines and in strengthening medical product regulatory authorities, particularly in developing and less developed countries. As SSFFC medical products were an issue of global concern, cooperation between regulatory authorities was needed, which called for further consultation and study. He supported postponement of the review of the Member State mechanism to 2017. The proposed study on the public health and socioeconomic impact of SSFFC medical products was of particular interest to his country, which would consider participating in it and related studies.

Mr GHILAGABER (Eritrea), speaking on behalf of the Member States of the African Region, endorsed the outcome of the third meeting of the Member State mechanism, contained in the annexes to document EB136/29. The strengthening of national and regional regulatory authorities would require significant investment and coordination in the Region, entailing the continuous support and guidance of WHO and other international organizations. Any unauthorized action, activity or behaviour related to medical products should be subject to regulatory actions. The informal technical group's discussions should continue in order to establish an exhaustive list of the actions, activities and behaviours that fell outside the mandate of the Member State mechanism.

Dr ALQATTAN (Kuwait), speaking on behalf of the Member States of the Eastern Mediterranean Region, drew attention to the catastrophic consequences and large numbers of deaths reported in the Region due to the consumption of SSFFC medical products. Many countries lacked the technical capacity and financial resources to implement the mechanism's planned activities; an assessment of the prevailing situation was needed urgently. As Member States with significant free-trade zone facilities were particularly exposed to counterfeit products, she requested the Secretariat to provide them with guidance and support in investigating suspect SSFFC products and called on Member States to report counterfeit pharmaceutical products to WHO's surveillance and monitoring project.

Mr ADHIKARI (Nepal) pointed out that, despite the mechanism being Member State-driven and the fact that it did not collaborate with the pharmaceutical industry, the topic of SSFFC medical products remained highly contested, owing to the efforts of certain Member States and multinational pharmaceutical companies to combine the issues of quality of medicines and intellectual property. The mechanism's work plan encouraged voluntary contributions to fund its implementation, but that approach could distort implementation in favour of donors' preferences. The work plan should instead be funded from WHO's regular budget. Voluntary funding could be accepted on condition that it would finance the implementation of the work plan in its entirety.

Dr AMMAR (Lebanon) welcomed the recommendations for health authorities and supported the decision to study the links between accessibility and affordability and the emergence of SSFFC medical products. Better regulation, through legislation and enforcement, and control of the pharmaceutical market should be considered an integral part of strengthening health systems. He encouraged Member States to report incidents of SSFFC products to the Secretariat using rapid alert forms.

Mrs VALLINI (Brazil) emphasized the need for further discussion of the proposal concerning actions, activities and behaviours that fell outside the mandate of the Member State mechanism, in particular with regard to medical products in transit (Annex 2, paragraph 7), especially as the seizure of generic drugs in transit had led to the establishment of the Member State mechanism. Arguments for the seizure of certain goods in transit on grounds of public health and "quality" could create obstacles to the trading of legitimate medical products. A working group should be established to draft

recommendations and training materials for strengthening regulatory authorities' capacity to prevent, detect and respond to SSFFC medical products. Her country was committed to contributing to the Member State mechanism. WHO's surveillance and monitoring project should work in coordination with the Member State mechanism and embrace the same principles. The focus of discussions, including those outside WHO, should be on the health aspects of medical products, rather than on the protection of intellectual property or criminalization.

Dr AKSEL'ROD (Russian Federation) welcomed the work being done at the global level as well as WHO's project for the surveillance and monitoring of SSFFC medical products, which provided a means of informing Member States; she supported the proposed publication of a monthly bulletin in addition to WHO's drug alerts. Furthermore, her country was preparing to ratify the Council of Europe Convention on the counterfeiting of medical products and similar crimes involving threats to public health. She agreed to the postponement by one year of the review of the Member State mechanism.

Ms MATSOSO (South Africa) agreed with the revised list of prioritized activities, whose implementation should begin in March 2015. Informal discussions should continue, as should activities related to strengthening regulatory systems for medical products. The Secretariat should consider the cost implications of supporting the mechanism's activities. The review of the Member State mechanism should be postponed by one year.

Dr ASADI-LARI (Islamic Republic of Iran) pointed out that shortages of medicines at affordable prices might incentivize the production of SSFFC medicines and that policies of accessibility and affordability imposed substantial financial burdens on countries such as his with large numbers of refugees. He encouraged Member States: to take bold steps to solve the problem of high prices of medicines; to strengthen national drug regulatory systems; and to agree on the definition of "counterfeit". Informal discussions should continue and the review of the Member State mechanism should be postponed.

Mr JEON Man-bok (Republic of Korea) said that it was important to ensure that a closely coordinated global system, such as the Member State mechanism, did not regulate in a manner that undermined market principles. International consensus was needed on a clear definition of SSFFC medical products and how they should be regulated.

Dr BEJTJA (Albania) endorsed the recommendations for health authorities. Regulatory systems with clear and accepted rules were needed to act as platforms for coordinated action. He called for the establishment of "track and trace" systems for medical products and encouraged the holding of joint workshops for national regulatory agencies on the surveillance and monitoring systems for reporting SSFFC medical products to WHO.

Dr REYNDERS (Belgium), speaking on behalf of the European Union and its Member States, said that the European Union supported the mechanism's work plan, acknowledged the efforts being made by all partners to reach consensus, and reiterated the commitment to work with them in a positive, constructive and results-oriented manner.

Ms GONZÁLEZ (Uruguay),¹ speaking on behalf of the Union of South American Nations, said that the guidelines and recommendations for technical procedures elaborated by the Member State mechanism in 2014 were valuable for controlling SSFFC medical products. However, there were persistent gaps in funding some activities, and she urged the Director-General to take the necessary

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

steps to bridge them, preferably with funds from assessed contributions to ensure the sustainability of the mechanism. Health ministers of countries in the Union considered that measures to prevent and control falsification should not block access to safe and efficacious generic medicines. Medical products that met the health standards of the country of origin and the destination country and did not pose a threat to public health must not have their legitimacy questioned by a third country through which the products transited. Ensuring the efficacy, safety and quality of medical products was the responsibility of a country's sovereign health authorities. She agreed that the review of the Member State mechanism should be postponed by one year.

Mr REDDY (India)¹ recalled that the mandate of the Member State mechanism, defined in resolution WHA65.19, clearly excluded any intellectual property or trademark considerations. In the absence of a common understanding of the term "SSFFC medical products", a real danger existed of alleged intellectual property infringements being equated with such products, thereby undermining the basic objective of the mechanism. In order to advance the work of the mechanism, it was important to define its scope, and his country's proposal to list a set of actions, activities and behaviours that did not result in SSFFC medical products had been an attempt to do that. He expressed disappointment that the Member State mechanism had not reached consensus on the proposal at its third meeting. He expressed particular concern that certain countries were determined to justify their assumed rights to intercept genuine and affordable medicines on the pretext that they were SSFFC medical products, and at the attempts by certain Member States to advance their agenda in other United Nations forums and thereby undermine the progress made by the Member States mechanism. Early agreement on his country's proposed list would define the scope of the mechanism and help WHO to retain its leadership on the issue. Within that context, priority should be given to objective 9 of the Member State mechanism, concerning work on the definitions of SSFFC medical products.

Strengthening regulatory mechanisms was paramount. International cooperation among regulatory authorities and law enforcement agencies had to be improved in order to eliminate the criminal networks behind the trade in SSFFC medicines. Excessive emphasis on regulation alone, however, would not solve the problem unless simultaneous efforts were made to strengthen access to affordable medicines. The Member State mechanism's work plan should reinforce those two pillars. It should also reflect the shared priorities of strengthening regulatory authorities, building laboratory capacities, sharing best practices, promoting local manufacturing of quality medical products and facilitating technology transfer and access to affordable medicines.

Mrs SITANUN POONPOLSUP (Thailand)¹ said that WHO's project on surveillance and monitoring would ensure the availability and reliability of the evidence on supply chain weaknesses and the public health impact of SSFFC medical products that was essential for policy-making and resource allocation. She appreciated the proposal for a study of the links between accessibility and affordability and their impact on the emergence of SSFFC medical products. WHO should ensure that adequate funding was available to secure the continuous functioning of the mechanism.

Mr ALAKHDER (Libya)¹ said that countering the circulation of SSFFC medical products required multisectoral action that went beyond the efforts of WHO and the commitment of its Member States. The trade in such products was a crime of similar scale to narcotics trafficking. Those products entered countries through many channels and would always reach consumers, particularly as they could be purchased online. A concerted international effort was therefore essential.

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

Ms RUIZ VARGAS (Mexico)¹ said that, in order to guarantee quality, safe, efficacious and affordable medical products, the link between their accessibility and SSFFC medical products needed to be better understood. The Secretariat must ensure that the Member State mechanism had sufficient resources to undertake the activities entrusted to it.

Ms KUSYNOVÁ (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN and on behalf of the International Council of Nurses and the World Confederation for Physical Therapy, supported WHO's role in ensuring the availability of quality, safe, efficacious and affordable medicinal products, and welcomed progress made on the work plan. With regard to the recommendations for health authorities, decisions on corrective actions, such as batch withdrawal, should take into consideration the potential consequences on health; for quality control testing, laboratory staff might require additional training on forensic tests, as some SSFFC products contained substances for which tests were not usually conducted; health care professionals had an important role to play in relaying safety messages and should therefore be involved in decision-making and communication; and regulatory authorities and health professionals associations should be included in the organization of awareness-raising campaigns.

Ms TOWNSEND (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, warned that the continued use of the word “counterfeit” carried the risk that the work of the Member State mechanism would be used to further the agenda of intellectual property enforcement, which was counter to the mechanism's ethos. Although the mechanism had successfully identified actions, activities and behaviours that resulted in SSFFC medical products, it had not reached consensus on the identification of actions, activities and behaviours that did not result in such products. She noted sorrowfully that the proposed text in Annex 2 on “preserving the integrity of the medical product in transit” was still subject to discussion. Medicines in transit should not be intercepted without a request from either the exporting or importing country. Member States must take action to shed the trade and intellectual property considerations connected with SSFFC medical products and ensure access to affordable, good quality medicines.

Dr KIENY (Assistant Director-General) welcomed the constructive comments and expressed her commitment to working with the Member States mechanism.

The CHAIRMAN took it that the Board took note of the report and decided to request the Health Assembly to postpone the review of the Member State mechanism, and that the Secretariat would take the appropriate action.

The Board noted the report and decided to request that the Health Assembly postpone the review of the Member State mechanism by one year to 2017.²

Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination: Item 10.4 of the Agenda (Documents EB136/30 and EB136/30 Add.1)

Mr SEY (Gambia), speaking on behalf of the Member States of the African Region, said that they had carefully examined the proposals for the establishment of a pooled fund for voluntary contributions towards research and development for type II and type III diseases and the specific research and development needs of developing countries in relation to type I diseases, as well as the identification of research and development demonstration projects. He sought further information on

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

² Decision EB136(1).

the status of the demonstration projects and observed that no proposed project led by African institutions had been approved as a demonstration project. The process could be successful only if sustainable funding for the projects were secured.

Dr GRABAUSKAS (Lithuania), speaking on behalf of the Member States of the European Region, said that health research and development largely neglected the needs of poor people in developing countries. He welcomed the progress made thus far with regard to the demonstration projects and development of the concept of a pooled fund, and acknowledged the importance of the global health research and development observatory, which to be independent and sustainable should be funded through WHO's programme budget. He urged the Secretariat to ensure that the three proposed structures (the scientific review group, the fund secretariat and the coordination mechanism) were as lean and cost-effective as possible. He welcomed the information provided on the demonstration projects already under way and the selection of two further demonstration projects. The progress, challenges faced and experiences of the demonstration projects should be systematically documented and submitted to the Health Assembly to inform the discussions on the proposed pooled fund. Member States should contribute new resources to the fund, rather than repurposing existing research funding contributions.

Ms HARB (Lebanon), speaking on behalf of the Member States of the Eastern Mediterranean Region, supported the establishment of a pooled fund and requested the Secretariat to accelerate the process while finalizing the mechanism for fund management. She commended the progress made on the demonstration projects under way, and supported the proposal to establish a fund secretariat within the Special Programme for Research and Training in Tropical Diseases to manage calls for project proposals, focusing on priority needs. The Secretariat should continue to facilitate exchanges of experience and best practices on health research.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) welcomed the Secretariat's efforts to encourage Member States to agree on innovative mechanisms to fund and coordinate public health research and development, and noted the progress made. In light of the recent outbreak of Ebola virus disease and the efforts required to fast track the introduction of vaccines, treatments and diagnostics, she encouraged collaborative research and development on diseases with pandemic potential for which limited health technologies were available. Member States that were not already supporting product development should be encouraged to contribute. The pooled fund must be given new rather than repurposed funding. The coordination mechanism should be independent and evidence-based, and the fund must not be unduly influenced by any vested interests.

Mr WU Peixin (China) endorsed the proposal to establish a pooled fund and said that the Secretariat should accelerate work to develop classification criteria for health research and development and establish the coordination mechanism as soon as possible. The new scientific review group should include all stakeholders, including epidemiologists and specialists in evidence-based medicine. China supported the identification of new funds for research and development projects. The use of the pooled fund should be well coordinated with existing projects, in order to avoid duplication of effort. Use of the fund and its investment activity should be subject to scrutiny by the Joint Coordinating Board of the Special Programme and the Health Assembly. The progress of demonstration projects should be carefully monitored. Licensing agreements and other instruments should be used to promote technology transfers so that the project results would increase capacity in developing and disease-endemic countries.

Ms MATSOSO (South Africa) said that she had noted the proposal that countries should consider implementing innovative funding mechanisms at national or regional levels for research and development; options for African countries would be explored at a forthcoming regional meeting. With regard to the financial management of the fund account, two options had been presented, and she requested information on the respective advantages and disadvantages. The European & Developing

Countries Clinical Trials Partnership required African countries to match European Union funds; to avoid duplication of mechanisms she sought clarification about its relationship with the global initiative. Clinical trials would be conducted in connection with the outbreak of Ebola virus disease. Given that incidence rates were declining, she asked what could be done to ensure that such research would continue.

Ms VALLINI (Brazil) emphasized that the demonstration projects, which had been subject to a rigorous selection process, must be implemented fully. She requested further details on the possible options for the financial management of the pooled fund. Regarding the establishment of the observatory, she underscored the importance of having a mechanism to identify gaps in, and opportunities for, health research and development, and to monitor the availability of funding. More details on the status of the establishment of the observatory would be appreciated, and transparency in that process was particularly important. She urged all Member States to take innovative action to promote new ways of thinking with regard to access to medicines, in line with the provisions of the global strategy and plan of action on public health, innovation and intellectual property.

Mr FORSTER (Namibia) appreciated that a further two projects had qualified as demonstration projects, and that one from Africa was being considered. He was satisfied that the indicators for analysing the innovative components of proposed demonstration projects were appropriate and rigorous. More funds were needed for innovation in health technologies.

Mr MAMACOS (United States of America) endorsed comments on the need to attract new donors and the independence of the funding mechanism. He welcomed the progress made in implementing the demonstration projects. The success of the pooled fund would require innovative thinking and approaches to engagement. He sought further discussion and information on the new scientific review group, in particular its relationship with the Joint Coordinating Board, which should provide high-level guidance, while maintaining a strict policy of separation from the group's decision-making process. The scientific review group should work on the basis of rigorous and independent scientific criteria, and should be shielded from particular interests. The Special Programme for Research and Training in Tropical Diseases should draft a paper on management options, recognizing that the needs of the demonstration projects would likely differ, and elucidating how it would promote innovation, attract funding and achieve success. Further discussion should ensure that the Special Programme is fit for purpose.

Mr ADHIKARI (Nepal), speaking on behalf of the Member States of the South-East Asia Region, urged rigorous evaluation of the demonstration projects. Future endeavours with regard to research and development must be aligned with Member States' needs, rather than with the institutional interests of some funding agencies, and must be of particular benefit to developing countries. The need for a sustainable financial mechanism for health research and development had been further evidenced by the recent outbreak of Ebola virus disease.

Mr ASADI-LARI (Islamic Republic of Iran) said that sustainable financing for research and development was needed urgently. To enhance countries' engagement, a regional coordination committee could be established to review project proposals before submission. Given the socioeconomic diversity between Member States, a regional fund could also be established to mobilize the financial resources required for activities in areas of concern.

Mr ESIN (Russian Federation) said that the results of the demonstration projects would facilitate the establishment of a pooled fund for research and development. The fund should be under the direct authority of the Special Programme, and the research priorities set by the global health research and development observatory and the coordinating mechanism, managed by the WHO Secretariat and in line with the General Programme of Work. The work of the fund should enable specific health needs to be met.

Mr RASHEED (Maldives) said that experience gained from the current outbreak of Ebola virus disease highlighted the need to accelerate progress in implementing the recommendations of the Consultative Expert Working Group and to follow up the pertinent Health Assembly resolutions. In view of globalization and cross-border transmission, teamwork was needed to combat diseases in developing countries and ensure global health security.

Mr MAGALLANES (Argentina) said that coordination of research and development projects had proven to be an efficient tool. Given the importance of securing new contributions to the pooled fund, and bearing in mind the facts that mechanisms for collecting voluntary funds had proven to be sustainable only when there was a broad base of donors and that major voluntary donors preferred to have some level of control over the destination of their contributions, alternative funding strategies would be required to guarantee a predictable flow of resources. Voluntary contributions should not be earmarked for specific purposes.

The demonstration projects should be assessed in terms of their ability to promote free access to the knowledge needed to replicate quality, safe and affordable health technology, delinking the price of the final product from the research and development costs. To that end, greater use should be made of effective technology transfer mechanisms. The Secretariat should consult with the proponents of the projects and report on the matter to the Health Assembly. The term “preferential pricing” was ambiguous, but he did not support the use of “differential pricing”, which was controversial in terms of access to medicines. With regard to the proposed indicators of innovative components of the projects, the financing component should distinguish between resource collection and administration, on the one hand, and cost management, on the other, in order to create research and development incentives.

Ms PENEVEYRE (Switzerland)¹ announced that, as a sign of its commitment to the implementation of a global research and development support system, Switzerland would contribute US\$ 4.2 million in non-earmarked funds towards the demonstration projects, US\$ 2.1 million towards the design of a potential global research and development fund and US\$ 42 000 as start-up funding for the global observatory. Switzerland would also complement by 50% contributions made by low- and middle-income countries, up to US\$ 2 million. Political and financial support from Member States was essential to ensure the establishment of a sustainable global funding mechanism, and shared responsibility should be assumed in order to attain the ambitious post-2015 sustainable development goals. The Swiss model would, it was to be hoped, encourage other Member States to act similarly.

Dr BASHEIR (Sudan)¹ said that, because of his country’s serious public health problem with leishmaniasis, the Government was closely involved with the Visceral Leishmaniasis Global R&D and Access Initiative. She welcomed the framework and selected indicators to measure success, particularly capacity building and technology transfer.

Mr PUSP (India)¹ supported the demonstration projects already selected and encouraged reappraisal of the project from Africa. The norms and standards for classification of health research and development proposed by Member States of the South-East Asia Region during a regional consultation in July 2013 could be valuable for the global observatory and should be adopted. The recent outbreak of Ebola virus disease had underlined the urgency of implementing the recommendations of the Consultative Expert Working Group, for which a sustained funding mechanism with greater clarity and transparency was imperative.

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

Mr ROSALES LOZADA (Plurinational State of Bolivia)¹ noted with satisfaction the selection of two new demonstration projects and encouraged the selection of the project from Africa. On the financial management of the fund, he expressed preference for the Special Programme for Research and Training in Tropical Diseases holding the account. In line with the provisions of resolution WHA66.22, analysis of the contributions should focus on sustainable funding for research and development, and not be limited to voluntary contributions. The outbreak of Ebola virus disease had shown the importance of ensuring that research and development for diseases primarily affecting developing countries should not rely on market-oriented mechanisms such as those involving intellectual property. He welcomed the innovation indicators selected to measure success, although other criteria such as those suggested by the member from Argentina would be needed to secure funding.

Ms STIRØ (Norway)¹ appreciated the outline of the pooled fund. Broad mobilization of funding, including that from non-traditional donors, should be one of the outcome indicators of the demonstration project process. Norway, like Switzerland, had chosen a model to finance the projects that combined a direct contribution of five million Norwegian krone with a matching fund that would be used to increase contributions from low- and middle-income countries by 50% up to five million Norwegian krone. Double counting of matching funds should be avoided: a contribution from a low- or middle-income country could only be matched once, and information on the funding situation should continually be made available to Member States. She expressed the hope that Norway's contribution would set the example for other countries.

Dr ANGKANA SOMMANUSTWEECHAI (Thailand),¹ affirming that funding for research and development was a shared responsibility for all relevant partners, said that, with regard to resource mobilization, she welcomed the pooled funding mechanism, particularly for type II and III diseases, but had concerns that it would lose its appeal over time if poorly managed. Regarding the financial management of the fund, she preferred the option of a trust fund account held by a third party, which could promote engagement among relevant stakeholders. The foundation of that management should be to ensure the optimum proportion of administrative costs, with most of the money spent on key research and development activities.

Ms ATHERSUCH (MSF International), speaking at the invitation of the CHAIRMAN, said that the outbreak of Ebola virus disease, the looming crisis of antimicrobial resistance and inadequacies in available treatment for tuberculosis all testified to multiple market failures in the existing research and development model. Member States should view those issues holistically in order to generate tangible long-term solutions. It was doubtful that the proposed voluntary contribution model could provide a sustainable financial mechanism for health research and development, although much would depend on governance arrangements and funding structures. Financing models that ensured long-term and sustainable funding should be developed; the Secretariat and Member States should agree on a sustainable framework to address the persistent research and development challenges of diseases that primarily affected developing countries.

Mrs TOWNSEND (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, said that contributions to the pooled fund should be mandatory to ensure sustainability. It was important not to lose sight of the original purpose of the demonstration projects: to create and demonstrate innovative funding mechanisms based on delinking the price of research from the costs of essential health products. The purpose of the Consultative Expert Working Group initiative should be broadened to include, for instance, the development of new antibiotics, better low-cost diagnostics and the funding of independent clinical

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

trials. Barriers to treatment arising from trade agreements should be confronted more directly, and WHO should take a more active stance on making full use of the flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights. The open-ended meeting requested by the Health Assembly in resolution WHA66.22 should be convened as soon possible.

Dr KIENY (Assistant Director-General) said, with regard to the status of the global observatory, that two existing databases were being linked, one on funding flows and the other on research and development projects. Information was being compiled on such projects relating to antimicrobial resistance, and preparations were being made to collect information on projects concerning diseases of epidemic potential. Progress was also being made in the WHO regions. On funding the observatory, she recalled that assessed contributions could barely finance WHO's programme budget and therefore, without voluntary funding or the possibility to use the pooled fund, the observatory would not exist.

Turning to financial management, she noted the general agreement of Member States that the pooled fund should be held by the Special Programme for Research and Training in Tropical Diseases. The Secretariat considered that the option of managing the finances within WHO's overall management system, rather than requesting a third party to take on that task, was preferable from an accountability perspective. With regard to sustainable financing, Member States should consider the two options outlined in the report and make their preferences known. She welcomed the generous contributions from Switzerland and Norway.

On the demonstration projects, she noted the support of Member States for the two new projects and the one from the Council of Scientific and Industrial Research, South Africa, as well as for the proposed indicators. The total funding required for the first three projects and the observatory amounted to US\$ 50 million, and a further US\$ 23 million would be needed for the two new projects, in addition to funding for the project proposed by the Council of Scientific and Industrial Research. The current funding gap therefore stood at around US\$ 50 million. In accordance with the Strategic Work Plan, a final report on the demonstration projects would be provided in 2016. The Secretariat would continue to report regularly on progress in general and on the technical and financial challenges encountered.

Mrs VALLINI (Brazil) said that progress should be made with the five demonstration projects already selected, before support was provided for the project from Africa. Although it could not match the amounts pledged by the developed countries, Brazil would like to make a contribution of US\$ 1 million.

Dr KIENY (Assistant Director-General for Health Systems and Innovation) thanked Brazil for its contribution and said that discussions needed to be held on further refinements to the demonstration projects.

Ms MATSOSO (South Africa) said that the project from the Council of Scientific and Industrial Research, South Africa, was more a regional project that covered for instance malaria; it could include a component on Ebola virus disease research, to ensure that, after the crisis had abated, the disease did not disappear from the research "radar".

The Board noted the report.

Global strategy and plan of action on public health, innovation and intellectual property:
Item 10.5 of the Agenda (Document EB136/31)

The CHAIRMAN drew attention to a draft decision on the global strategy and plan of action on public health, innovation and intellectual property proposed by Argentina, Brazil, India and South Africa, which read:

The Executive Board,

Having considered document EB136/31 on Evaluation of the global strategy and plan of action on public health, innovation and intellectual property,

RECOMMENDS to the Sixty-eighth World Health Assembly the adoption of the following decision:

The Sixty-eighth World Health Assembly,

(PP1) Reaffirming resolutions WHA61.21 and WHA62.16 on the Global strategy and plan of action on public health, innovation and intellectual property, which established a medium-term framework to secure an enhanced and sustainable basis for needs-driven, essential health, research and development;

(PP2) Recognizing the central role the Global strategy and plan of action on public health, innovation and intellectual property plays in directing and coordinating WHO policies and programme of work on public health, innovation and intellectual property;

(PP3) Taking note that the resolution on “Ebola: Ending the current outbreak, strengthening global preparedness and ensuring WHO capacity to prepare for and respond to future large-scale outbreaks and emergencies with health consequences” reaffirmed the Global strategy and plan of action on public health, innovation and intellectual property;

(PP4) Taking note that the international community including the WHO, intergovernmental organizations, governments, nongovernmental organizations, academic institutions and all other relevant stakeholders have yet to fully implement the Global strategy and plan of action on public health, innovation and intellectual property,

(OP) 1 DECIDES:

- (1) extend the time frame of the plan of action on public health, innovation and intellectual property until 2022;
- (2) the Evaluation Management Group will be composed of 4 Member States from each region, in a transparent manner.

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

1. Decision: Global strategy and plan of action on public health, innovation and intellectual property	
2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)	
Category: 4. Health systems	
Programme area(s): Access to medicines and health technologies and strengthening regulatory capacity	Outcome: 4.3. Improved access to and rational use of safe, efficacious and quality medicines and health technologies Output: 4.3.2. Implementation of the global strategy and plan of action on public health, innovation and intellectual property

How would this decision contribute to the achievement of the outcome(s) of the above programme area(s)?

The global strategy and plan of action on public health, innovation and intellectual property aims to increase research and development needed for products for diseases that disproportionately affect developing countries, where access to needed medical technologies is hindered by market failures. By extending the time frame of the global strategy and plan of action, WHO will be able to keep its momentum and continue to advocate the implementation of policies and activities that increase availability of the most needed products. The results of the evaluation exercise will help the Health Assembly to determine new policies to improve the current strategy and ensure the effectiveness of WHO's actions.

Does the Programme budget already include the outputs and deliverables requested in this decision? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the decision during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) The global strategy and plan of action will be extended by seven years, covering the period from 2015 to 2022; the evaluation of the global strategy and plan of action will be for two years, covering the period from 2015 to 2017.

(ii) Extension of the global strategy and plan of action: US\$ 100 million (staff: US\$ 60 million; activities: US\$ 40 million).

Evaluation of the global strategy and plan of action: US\$ 670 000 (staff: US\$ 70 000; activities: US\$ 600 000).

Total: US\$ 100.67 million.

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Extension of the global strategy and plan of action: US\$ 7.0 million (staff: US\$ 4.2 million; activities: US\$ 2.8 million).

Evaluation of the global strategy and plan of action: US\$ 400 000 (staff: US\$ 30 000; activities: US\$ 370 000).

Total: US\$ 7.4 million.

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

The majority of the activities will take place at headquarters and in the regional offices.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

If "no", indicate how much is not included.

(c) Staffing implications

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

No.

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

For the implementation of the strategy from 2015 to 2022, nine additional full-time equivalent staff members in the professional and higher categories and three full-time equivalent staff members in the general service category will be required at headquarters, and two full-time equivalent staff members in the professional and higher categories and one full-time equivalent staff member in the general service category will be required in each regional office.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3(b) fully funded? (Yes/no)

No.

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

The funding gap is US\$ 2.5 million. It will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

Mrs VALLINI (Brazil) said that, because the plan of action had been established for the period 2008–2015, it was important to extend that time frame. With regard to evaluation, the proposed time line showed that the governing bodies would review the global strategy in 2017, as decided by the Board at its 133rd session.¹ However, in resolution WHA62.16 the Director-General had been requested to conduct an overall programme review of the global strategy and plan of action in 2014. She asked for clarification about how to move forward, given the provisions of that resolution, and why the Secretariat was unable to provide the progress report to the Sixty-eighth World Health Assembly. It was essential that Member States were involved in the evaluation process, not only by means of an external review. The Secretariat should present the methodology and terms of reference of the review process to the Sixty-eighth World Health Assembly, as Member States would not be able to approve the evaluation schedule without that information.

Mr SEY (Gambia), speaking on behalf of the Member States of the African Region, said that, as stringent intellectual property protection in the pharmaceutical market hindered access to affordable health products, it was a priority to secure resources for needs-driven, public health-oriented research and development relevant to diseases that disproportionately affected developing countries. The Regional Committee for Africa had endorsed a document outlining the challenges and proposed actions to enhance implementation of the global strategy. The West African Health Organisation had developed guidelines to help Member States to incorporate the public health safeguards under Agreement on Trade-Related Aspects of Intellectual Property Rights into national policies. Nonetheless, implementation of the global strategy was slow in many of the least developed countries; inadequate national coordination mechanisms and limited capacity and financing prevented them from undertaking research. He urged WHO to intensify technical support in that area. He supported the draft decision, extending the time frame of the plan of action until 2022.

¹ See document EB133/2013/REC/1, summary record of the fourth meeting, section 1.

Dr ASSIRI (Saudi Arabia), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that lessons learned from regional exercises to assess the status of implementation of the global strategy in the South-East Asia Region and the Region of the Americas should be taken into account. The composition of the evaluation team would be important, and should be limited to the officers of the Executive Board. The Secretariat was requested to provide support to countries in order to ensure that the evaluation was comprehensive, independent, focused and impartial and that all relevant stakeholders were identified and involved. Countries should do their best to minimize financial constraints through virtual consultations and polls. The Secretariat should explore the feasibility of preparing a progress report by January 2016, in addition to the proposed report on the progress of the evaluation that was expected by the end of 2016.

Dr TAKIAN (Islamic Republic of Iran) said that WHO should take the lead on establishing more appropriate mechanisms for the production, management and distribution of public health documents. No valid web portal or databank had been approved by WHO to record best public health practices from all six regions, thus making systematic searches difficult. Such databanks were useful when defining health strategies and plans; they could ensure the visibility of many projects that were commissioned by WHO or other international agencies, and access to them could be a fundamental step in health system innovation.

Mr MCIFF (United States of America) supported the time line for review of the global strategy and plan of action set out in the report and looked forward to the evaluation management group's report. He supported the aims of the draft decision, namely to add clarity on the time frame and status of the plan of action, and the evaluation policy adopted by the Board in May 2012 and further elaborated in the *WHO Evaluation Practice Handbook* issued in 2013. Part of WHO reform meant adhering to agreements reached, including those relating to sensitive and important issues such as the global strategy. Nevertheless, he understood the need for transparency and for the inclusion of Member States in the evaluation process. In that spirit, he would submit some amendments to the draft decision, including the participation of officers of the Board in the evaluation management group, as proposed by the member for Saudi Arabia.

Dr AKSEL'ROD (Russian Federation) supported the remarks by the member for Brazil concerning the evaluation of the global strategy. She welcomed the time line proposed by the Secretariat but noted the need for equitable geographical representation in the evaluation management group. She asked whether the overall programme review would be included in the terms of reference of the evaluation management group.

Ms MATSOSO (South Africa) said that, at the 133rd session of the Executive Board,¹ the Director-General had stated that the evaluation should be "conducted by experts in order to ensure that the correct methodology was used" and that "terms of reference must not be affected by conflicts of interest or vested interest". The Director-General had also asked "whether Member States would consider postponing the date of reporting to permit a more comprehensive evaluation to be achieved". She recalled that she herself had asked "whether other members of the Board could become involved in the Evaluation Monitoring Group in order to strengthen its work". She had no objection to officers of the Board being included in the evaluation management group but, in the interests of good practice, she requested that membership of the group should be extended. The reporting requirements were provided for in various resolutions; in particular, in resolution WHA62.16 the Health Assembly had specifically requested the Director-General, "in addition to continued monitoring, to conduct an overall programme review of the global strategy and plan of action".

¹ See document EB133/2013/REC/1, summary record of the fourth meeting, section 1.

Mr RASHEED (Maldives), speaking on behalf of the Member States of the South-East Asia Region, expanded the quotation of the same paragraph of resolution WHA62.16; the Director-General had been requested "... to conduct an overall programme review of the global strategy and plan of action in 2014 on its achievements, remaining challenges and recommendations on the way forward to the Health Assembly in 2015 through the Executive Board". In the present report, the Secretariat said that the evaluation report would be submitted in 2017. The Member States of the Region had played an active role in respect of the global strategy, and the Regional Committee had adopted a resolution relating to it. National and regional assessments had been undertaken; indeed, Sri Lanka was the only country within WHO that had conducted a national assessment using the assessment tool elaborated for that purpose, which had facilitated the identification of clear and implementable policy recommendations for the Government. The evaluation mechanism should involve a Member State-driven process, rather than a tender- and contract-driven one, and the time line for the evaluation should be adhered to, with reporting in 2015 as stipulated in resolution WHA62.16. The content of the evaluation should include delinking the costs of research and development from the price of health products. The outcomes of the evaluation should be taken up for decision.

Mr KIM Chang Min (Democratic People's Republic of Korea) favoured accelerated action on the evaluation report; it was regrettable that it would not be completed until 2017. The content of the evaluation should include in-depth consideration of: the implications of intellectual property; the potential to improve the current global health status; current pharmaceutical market prices versus their affordability; and progress made in delinking the cost of research and development from the price of medical products, in order to promote access to them. Intellectual property enhanced innovation, but it could also be a barrier to essential medicines for those who could least afford to pay. As a philanthropic organization, WHO could advocate the sound and balanced development of intellectual property and innovation with WIPO and WTO in order to assist the millions of people who were in dire need of access to existing medicines.

Mr MAGALLANES (Argentina) indicated his country's willingness to join the evaluation management group in accordance with the draft decision that it had cosponsored. The functions and tasks of the evaluation management group and the mandate of its members of it should be defined to allow the work to be revised and amended up to the time of publication of the definitive report. The evaluation should include consultations with Member States and relevant stakeholders through the regional offices on how the strategy was being implemented and what actions would be needed in the context of the post-2015 sustainable development agenda.

Dr GONZÁLEZ FERNANDEZ (Cuba), referring to the draft decision, said that he could accept the proposal to extend the time frame of the plan of action until 2022 but that the text should include reference to a deadline of 2017 for completion of the work of the evaluation management group composed of Member States. The Secretariat should also draw up a suggested list of items on which the group should focus.

Mr WU Peixin (China) supported the proposed time frame set out in the draft decision, the related financial implications and the proposal that the evaluation management group should be composed of Member States from each region. He also supported the proposal to extend the deadline for completion of the report until 2017 and agreed that the Secretariat should report on the remaining challenges and the way forward to the Sixty-eighth World Health Assembly.

Mrs GONZÁLEZ (Uruguay),¹ speaking on behalf of the Union of South American Nations, stressed the importance of the global strategy and plan of action in improving access to medicines and for improving coordination of research and development of medical products for illnesses that disproportionately affected developing countries. The revised plan of action should be drafted in consultation solely with Member States, and the terms of reference of the evaluation management group and agreed methodologies for the evaluation should be drawn up with their input. She supported the proposal to extend the time frame of the plan of action in order to allow more time for its objectives to be achieved.

Mr REDDY (India)¹ echoed the concerns expressed by the members for Brazil and South Africa with regard to reporting. The global strategy and plan of action were critical instruments in securing enhanced and sustainable partnerships for needs-driven research and development for developing countries. He supported the proposed extension of the time frame of the plan of action, and underscored the importance of Member States' participation in evaluating the implementation of the strategy and plan of action; the terms of reference of the evaluation group should be endorsed by the Executive Board.

Mr TYSSE (Norway)¹ supported the view expressed by the member for the United States of America regarding establishing an evaluation process that was consistent with WHO's evaluation policy and the *WHO Evaluation Practice Handbook*. It was not advisable to create ad hoc solutions where relevant policies already existed, in order to avoid duplication and contribute to more efficient governance.

Mr MIRANDA (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, supported the proposed time line for evaluation of the global strategy and plan of action, including the recognition of stakeholder participation in the evaluation process. However, he asked for further information on: the type of experts who would be involved in the process; the role of stakeholders; the specific opportunities for stakeholder involvement; how the process would be made transparent; and how conflicts of interest would be addressed. It was not clear that an external consultant would have the necessary experience and expertise, and he urged the consideration of alternative solutions.

He strongly supported the proposal in the draft decision to extend the mandate of the global strategy and plan of action until 2022, in view of the fact that its goals had not yet been fully realized. He highlighted the role of WHO in ensuring policy coherence between trade and health at regional and global levels, and its engagement in ensuring that international trade agreements promoted rather than undermined access to medicines and health.

Mrs BERGER (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, said that the global strategy was a pioneering attempt to undo a global governance mistake by reclaiming terrain from the trade agenda and restoring it to the field of human rights. The relevance of the strategy to the human right to health had been illustrated by the recent outbreak of Ebola virus disease. However, implementation of the strategy had not been successful and almost no efforts had been made to develop country ownership. Lack of financial support and a piecemeal approach had been highlighted as reasons for inaction yet, given its importance. WHO should have funded it as a substantive activity through the core budget. She welcomed the proposed extension of the time frame of the plan of action which must be tied to a thorough qualitative and quantitative evaluation conducted by experts.

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

Ms KUSYNOVÁ (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN and also on behalf of the International Council of Nurses and the World Confederation for Physical Therapy, recommended that the Secretariat consult all interested stakeholders, including those involved in research and development, during the evaluation process. The global plan of action had an impact on how research was conducted and on the competencies of researchers; those aspects should be covered in the evaluation. Innovation should not be limited to translating scientific advances into new medicines but should also apply to their safe and practical delivery and responsible use.

Ms ATHERSUCH (MSF International), speaking at the invitation of the CHAIRMAN, supported the proposal to extend the mandate of the global strategy and plan of action which, if properly implemented, could play an important role in ensuring innovation and access to medicines. The current system of research and development had demonstrated increasing failures, whether with respect to antibiotic resistance, Ebola virus disease or other neglected diseases. The Secretariat should be able to counter the attempts by multinational pharmaceutical companies to increase intellectual property protection by taking bold and decisive action, with Member States, that would increase access to medicines and introduce new models of innovation.

Dr KIENY (Assistant Director-General), responding to comments, said that the Secretariat had been due to give a progress report every second year; the last had been provided in 2014 and the next one would be due in 2016. The Board had taken a decision at its 133rd session with respect to the timing of the evaluation based on options presented by the Secretariat in May 2013. Therefore, since 2013, the Secretariat had operated on the assumption that the implementation period up to 2015 would be evaluated and presented at a later date. The evaluation management group would be set up as soon as possible and its composition would be guided by the Board with the final decision being taken by the Director-General. The methodology to be used had been endorsed by the Board and could be found in document EB133/7.

Ms MATSOSO (South Africa) reiterated her view, based on the remarks of the Director-General as set out in the summary records of the Board's 133rd session, that the evaluation management group would be expanded to include other members of the Board. She believed that all found acceptable the time line for the evaluation (to be completed by 2017).

Dr KIENY (Assistant Director-General) explained that details of the composition of the evaluation management group and the terms of reference would be presented to the Health Assembly in May 2015.

Mr BURCI (Legal Counsel), responding to a question by Mrs VALLINI (Brazil), expressed the view that the proposal to extend the time frame, set out in paragraph 1(1) of the draft decision, was a matter for the Health Assembly to decide as it would extend the application of a normative instrument adopted by the Health Assembly. The Board could recommend to the Health Assembly to extend the time frame until 2022. As explained by the member for South Africa, the proposed composition of the evaluation management group set out in paragraph 1(2) and the timing of the review could be legitimately decided by the Board.

Ms MATSOSO (South Africa) said that it was important to establish how decisions were taken by the Board and how the views of Member States were reflected in the summing up by the Chairman, as it was her understanding that the proposal to extend the time line for the evaluation had been agreed during the fourth meeting of the Board at its 133rd session and entered in the record.

(For adoption of a decision, see the summary record of the fifteenth meeting, section 3.)

The meeting rose at 12:40.

TENTH MEETING

Friday, 30 January 2015, at 14:35

Chairman: Mr M.H. SHAREEF (Maldives)

1. HEALTH SYSTEMS: Item 10 of the Agenda (continued)

Blood and other medical products of human origin: Item 10.6 of the Agenda (Document EB136/32)

The CHAIRMAN drew attention to a draft decision on principles for global consensus on the donation and management of blood and other medical products of human origin proposed by Italy, Lithuania, Malta, Slovenia and Spain:

The Executive Board,

Having considered the report of the Secretariat on blood and other medical products of human origin;

(PP1) Recalled the guiding principles on the safety, quality and availability of blood and blood products supported by the World Health Assembly, through resolutions WHA28.72, WHA58.13 and WHA63.12, as well as the WHO Guiding Principles on Human organ and tissue transplantation endorsed in resolution WHA63.22;

(PP2) Noted that several medical products of human origin (MPHO), which are intended for human clinical application, have significant commonalities as to sharing some characteristics inherent to their human origin;

(PP3) Recognized that protection of the donor is a prerequisite in order to meet the needs of patients for access to safe MPHO, which is of high importance in the context of universal health coverage;

(PP4) Acknowledged that MPHO may raise safety issues for donors and recipients;

(PP5) Recognized that global consensus on the donation and management of MPHO intended for human clinical application, based on good governance mechanisms, is needed in order to protect the fundamental human rights of donors;

(PP6) Recognized that common standards to guarantee quality and safety of MPHO and to ensure traceability, vigilance, surveillance and equitable access to these products are essential for the well-being of recipients;

(PP7) Request the Director-General to convene consultations with Member States and international partners, to support the development of global consensus on guiding ethical principles for the donation and management of the mentioned MPHO; good governance mechanisms; and common tools to ensure quality, safety and traceability, as well as equitable access and availability as applicable, to result in a document to be submitted, when appropriate, to the World Health Assembly for consideration.

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

<p>1. Decision: Principles for global consensus on the donation and management of blood and other medical products of human origin</p>		
<p>2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)</p> <p>Category: 4. Health systems</p> <table border="0"> <tr> <td>Programme area(s): Integrated people-centred health services</td> <td> <p>Outcome: 4.2. Policies, financing and human resources are in place to increase access to integrated people-centred health services</p> <p>Output: 4.2.3. Guidelines, tools and technical support to countries for improved patient safety and quality of services, and for patient empowerment</p> </td> </tr> </table> <p>How would this decision contribute to the achievement of the outcome(s) of the above programme area(s)?</p> <p>The decision would support and facilitate the development of global consensus and harmonized procedures for the implementation of the WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation endorsed by the Health Assembly in 2010, regarding the donation and use of medical products of human origin. Good governance mechanisms, common tools to ensure quality, safety and traceability, and equitable access to and availability of medical products of human origin are needed, where appropriate, to protect donors and recipients.</p> <p>Does the Programme budget already include the outputs and deliverables requested in this decision? (Yes/no)</p> <p>Yes.</p>	Programme area(s): Integrated people-centred health services	<p>Outcome: 4.2. Policies, financing and human resources are in place to increase access to integrated people-centred health services</p> <p>Output: 4.2.3. Guidelines, tools and technical support to countries for improved patient safety and quality of services, and for patient empowerment</p>
Programme area(s): Integrated people-centred health services	<p>Outcome: 4.2. Policies, financing and human resources are in place to increase access to integrated people-centred health services</p> <p>Output: 4.2.3. Guidelines, tools and technical support to countries for improved patient safety and quality of services, and for patient empowerment</p>	
<p>3. Estimated cost and staffing implications in relation to the Programme budget</p> <p>(a) Total cost</p> <p>Indicate (i) the lifespan of the decision during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).</p> <p>(i) Four years (covering the period 2015–2018).</p> <p>(ii) Total: US\$ 5.6 million (staff: US\$ 4.6 million; activities: US\$ 1.0 million).</p> <p>(b) Cost for the biennium 2014–2015</p> <p>Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).</p> <p>Total: US\$ 1.40 million (staff: US\$ 1.15 million; activities: US\$ 250 000).</p> <p>Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.</p> <p>Headquarters.</p> <p>Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)</p> <p>Yes.</p> <p>If “no”, indicate how much is not included.</p> <p>(c) Staffing implications</p> <p>Could the decision be implemented by existing staff? (Yes/no)</p> <p>Yes.</p> <p>If “no”, indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.</p>		
<p>4. Funding</p> <p>Is the estimated cost for the biennium 2014–2015 indicated in 3(b) fully funded? (Yes/no)</p> <p>No.</p> <p>If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).</p> <p>The funding gap is US\$ 250 000 (activities). It is expected to be funded by WHO collaborating centres and scientific societies in official relations with WHO.</p>		

Dr KUPA (Democratic Republic of the Congo), speaking on behalf of the Member States of the African Region, said that the safety, quality and availability of blood and blood products were of great concern to them: numbers of registered donors were low and testing was not always conducted for HIV and other bloodborne infections or fully carried out in all countries. He outlined some of the efforts underway in the Region to improve access to uncontaminated blood and blood products. Countries often had no technical capacity for transfusion and few, if any, had blood banks. The outbreak of Ebola virus disease revealed the weak capacity to provide whole blood for transfusion or convalescent plasma. Governments must do everything possible, with support of WHO and partners, and in a coordinated manner, to mobilize the resources necessary to ensure the safety and availability of blood and blood products and their transport up to the point of transfusion.

Dr NIK JASMIN NIK MAHIR (Malaysia) said that, given the growth of emerging therapies in regenerative medicine, stem cells should also be considered as medical products of human origin. Countries should incorporate the three principles – respect for human dignity, availability and safety, and good governance – in their policies and legislative frameworks on the donation and use of medical products of human origin. Intersectoral collaboration should be strengthened at the national and international levels for the sharing of information and raising public awareness of shared responsibility, and highlighted the importance of equitable access. She supported the draft decision.

Dr AKSEL'ROD (Russian Federation) said that countries had a responsibility to address the scarcity of, and unequal access to, blood and blood products. It was important to prevent such products being used for financial gain, and she therefore welcomed the development of WHO's policy on promoting access to life-saving products of human origin. Member States should strengthen regulatory oversight of such products, promote the sharing of information and coordinate relevant media campaigns. She supported the draft decision.

Dr REYNDERS (Belgium) said that the same ethical considerations should apply globally concerning medical products of human origin, from donation to the follow-up of the recipient. Belgium would welcome the development of a global consensus on guiding principles and wished to cosponsor the draft decision.

Given the floor by the CHAIRMAN in response to a request by Dr GRABAUSKAS (Lithuania), Mr REDONDO BALDRICH (Spain)¹ said that, although blood and other products of human origin were essential components of health care provision, there were ethical and physical risks from donation to the follow-up of recipients. Recalling relevant Health Assembly resolutions and various international initiatives, including the Declaration of Istanbul on Organ Trafficking and Transplant Tourism and the Council of Europe Convention against Trafficking in Human Organs, he said that the draft decision should be considered as a firm commitment to achieving consensus on principles such as respect for human dignity, availability, quality and safety, and good governance. Following comments from Member States, he proposed that the draft decision be amended as follows: paragraph 3 to read "... in the context of access to health and universal health coverage"; in paragraph 6 "common standards" should replace "appropriate standards"; paragraph 7 to read: "... to result in a document to be submitted to the Seventieth World Health Assembly for consideration."

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

Mr WOLFE (United States of America) supported the way forward proposed in the report and encouraged continuing evaluation of the guiding principles to take account of changing technology and Member States' experiences. The Secretariat should assist Member States in strengthening legal frameworks for regulation of blood components as biological therapeutic products and in developing regulatory and monitoring frameworks that supported principles including ethics and safety. The United States would be pleased to share its experience in that regard.

Dr GONZÁLEZ FERNANDEZ (Cuba) said that voluntary non-remunerated donation among low-risk populations was essential to ensure the safety, quality, availability and accessibility of supply. He welcomed the development of a structured global framework on guiding principles and standards of good governance for the safe donation and use of medical products of human origin, the implementation of which should be controlled by Member States.

Mr COTTERELL (Australia) said that self-sufficiency, good governance and voluntary non-remunerated donation formed the cornerstones of good national systems for the supply of medical products of human origin. Quality issues that led to large volumes of blood products being wasted were a concern and he supported collaboration to strengthen regulatory capacity, ensure safety and quality, and prevent wastage. He supported the amendments to the draft decision proposed by the representative of Spain.

Ms SHI Ying (China) said that China's non-remunerated blood donations were sufficient for clinical use, and the national system for organ allocation functioned well. Member States should work with the Secretariat to establish national management and regulatory systems, encourage voluntary donations and monitor safety. There should be cooperation between Member States and among regions to combat illegal trade in products of human origin and transplant tourism. The Secretariat should provide technical assistance to Member States, in particular in developing advanced systems to ensure the safety of medical products of human origin.

Dr KREMER (Argentina), supported the comments of the representative of Spain. With regard to the report, paragraph 5 should have made mention of stem cells as a treatment, although there was no conclusive scientific evidence justifying that use. He was pleased to note that WHO would discourage the cryopreservation of cord blood by private banks, as some States did not yet have appropriate regulatory frameworks. The principles should be implemented gradually, with assistance from WHO, and timelines agreed with Member States. Argentina wished to cosponsor the draft decision, as amended.

Dr TAKIAN (Islamic Republic of Iran) said that his country, in which all blood donation was non-remunerated, had robust ethical rules for blood and organ donation, and had founded a regional cooperation network in the field of transfusion. To address challenges associated with plasma fractionation described in the report (paragraph 9), Member States were encouraged to enter into plasma fractionation contracts or establish regional fractionation centres in cooperation with WHO. Member States were also encouraged to install vein-to-vein monitoring software with technical assistance from WHO and to develop national guidelines on rational and ethical blood use. He supported the draft decision.

Ms ROA RODRIGUEZ (Panama) said that efforts should be made to encourage voluntary donation and screening, as blood and blood products were essential components of health care provision. Other medical products of human origin should be regulated and controlled to prevent their sale and ensure equitable access, with due regard for bioethical principles, and follow-up systems should also be established. Panama wished to cosponsor the draft decision, as amended.

Mr ARAKI (Japan) said that, in developing a global consensus on the donation and management of medical products of human origin, it was important to take into consideration the specific issues related to the particularities of each medical product of human origin. He supported WHO's approach, as indicated in the report (paragraph 16).

Mr BEJTJA (Albania) said that compliance with the guiding principles could prove difficult in areas of conflict or civil unrest. Technical support, legal advice and coordination would facilitate regulatory oversight of medical products of human origin, and small countries could pool funds and resources to establish regional centres of reference and excellence, especially on organ transplantation and assisted reproduction. He supported the draft decision.

Mr PLAVČAN (Slovakia),¹ recognizing the principle of voluntary non-remunerated donation ensuring the safety of blood products, agreed that financial incentives and lack of information put donors at risk. He supported the request for global consultations in the draft decision; they should lead to a clearer and distinct definition of terms that built on existing international definitions. He proposed that the title of the draft decision should be amended to read "Principles for global consensus on the donation and management of blood, blood components and medical products of human origin".

Mrs VALLINI (Brazil) emphasized the importance of voluntary non-remunerated donation and equitable access to safe medical products of human origin. The current challenge lay in building effective processes for monitoring such products, from donors to recipients, and countries should, with support from the Secretariat, consider developing and implementing policies to regulate all aspects of blood and other medical products of human origin. Key elements to be considered included training and the strengthening of health systems, traceability, data confidentiality and surveillance. Brazil wished to cosponsor the draft decision.

Ms PENEVEYRE (Switzerland)¹ said that the report might usefully have referred to the Council of Europe's work on medical products of human origin, which, although undertaken in a regional framework, could be useful at the global level. As such products were very varied and some were already governed by international standards, the issue of how they should be grouped was important and deserved particular attention.

Ms RUIZ VARGAS (Mexico)¹ called for a global consensus on ethical guiding principles concerning the donation and use of stem cells, bone marrow and placental blood, taking into consideration aspects including differences in health regulations and cultures. Furthermore, in view of the diversity of legislation in Member States, guidance should be developed to prevent the wastage of plasma, ensure the availability of sufficient high quality plasma derivatives, and prevent unjustified transfusions. Mexico supported the draft decision.

Dr THANAPHAN SUKSA-ARD (Thailand),¹ although supportive of the draft decision, said that neither it nor the report had adequately addressed the issues of the human rights and human dignity of both donors and recipients. Management of medical products of human origin, and monitoring systems, needed strengthening to avoid shortages and health complications. In addition, demand and supply management, guidelines for rational use, and the competence of health workers required further consideration.

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

Ms DANIAULT (France)¹ said that her country supported the three principles set out in the report and was particularly attached to voluntary non-remunerated donation. France wished to cosponsor the draft decision.

Monsignor VITILLO (Holy See), speaking at the invitation of the CHAIRMAN, referring to the WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation, said that the Holy See had long promoted properly regulated and monitored provisions for voluntary donation of organs after death. Respect for the life of the donor must always prevail and any procedure commercializing human organs or considering them as items of exchange or trade was morally unacceptable. He proposed three additional principles to be considered in the proposed way forward, namely: free and full consent of the donor; proportionality of the risks to the donor to the benefit for the recipient; and respect for the sacredness of human life, from conception to natural death.

Dr KIENY (Assistant Director-General) thanked speakers for their comments and said that the Secretariat had noted the requested changes to the report.

The Board noted the report and adopted the decision, as amended.²

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

Monitoring of the achievement of the health-related Millennium Development Goals: Item 7.1 of the Agenda (Document EB136/14)

Dr ABDOU SHEBL (Egypt), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that greater understanding was required of the specific factors hampering progress in countries unable to meet their Millennium Development Goal targets. She welcomed steps to recognize maternal and child health as a strategic priority under the sustainable development goals, and called on stakeholders to build on existing successful models, such as the maternal and child health acceleration plans in the Eastern Mediterranean Region. Concerted efforts should be made to address cross-cutting issues, such as universal health coverage, health system strengthening, equitable access to quality health care, ensuring a functional infrastructure and social determinants of health. She called on the Secretariat to promote closer coordination among organizations in the United Nations system and development partners in order to sustain political commitment, financial support and investment, particularly in situations of instability and unrest.

Dr REYNDERS (Belgium), speaking on behalf of the European Union and its Member States, said that Turkey, the former Yugoslav Republic of Macedonia, Montenegro, Serbia, Albania, Bosnia and Herzegovina, Ukraine, the Republic of Moldova and Georgia aligned themselves with his statement. WHO and its partners had made a fundamental contribution to the realization of the health-related Millennium Development Goal targets by informing, encouraging and monitoring actions at country level. Given the uneven progress, substantial effort was needed to reduce mortality rates, notably in the areas of maternal and newborn health. Noting the importance of completing the unfinished work in the post-2015 sustainable development era, he called for country-level leadership, governance and investment for stronger health systems, taking into account a cross-cutting, human rights-based approach within the context of universal health coverage. Special attention should be

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

² Decision EB136(2).

given to programmes that tackle inequalities, gender imbalances and discrimination. He requested the Director-General to report to the Health Assembly on WHO's work towards and beyond 2015, paying particular attention to the development of a framework for monitoring the health-related sustainable development goals.

Ms OKADA (Japan) listed three matters of unfinished business in the health-related Millennium Development Goal agenda: strengthening health systems and human capacities; using human security as a guiding principle for people-centred, sustainable development which took into account the globalized development agenda and diverse stakeholders; and the need to strengthen international cooperation to promote inclusiveness and resilience in order to achieve universal health coverage.

Dr EERSEL (Suriname) said that central to the successes in reducing the burden of malaria, tuberculosis and HIV/AIDS had been the additional financial resources that had become available and integration of programmes into primary health care. Despite the progress made, Suriname continued to face numerous challenges, particularly concerning the management of HIV infection, owing to the complexity and duration of the treatment and the prevailing stigmatization. She called on WHO for capacity-building assistance. There was also a need for further investment and capacity building to improve early neonatal critical care, and she encouraged WHO to support and promote interventions such as Kangaroo Mother Care. Noting the negative impact of noncommunicable diseases on maternal and infant health outcomes, she said that WHO should provide support in the development of guidelines and protocols.

Dr MAKUBALU (South Africa) speaking on behalf of the Member States of the African Region, gave an overview of the achievements and challenges concerning the health-related Millennium Development Goals. More must be done to reduce neonatal and maternal mortality and consider social determinants of health. The Millennium Development Goals monitoring framework had been an invaluable tool for monitoring, reporting and adjusting implementation rates and approaches. Sufficient financial and human resources were also needed in the context of strong and resilient health systems. Universal health coverage would be the most appropriate vehicle for delivery of results, alongside the provision of point-of-care diagnostics and affordable, safe and high-quality medicines. The Region counted on continued assistance and support from the Secretariat, development partners and the international community in achieving the Millennium Development Goals and in the transition to the post-2015 sustainable development goals.

Ms GIBB (United States of America) said that WHO's leadership and Member States' continued engagement were critical to ensuring that ambitious targets for maternal and newborn mortality and reducing the burden of infectious diseases were reflected in the post-2015 agenda. Her country, which considered HIV/AIDS a continuing international public health priority, welcomed the progress made in the HIV response and the guidance in the global health sector strategy on HIV/AIDS 2011–2015.

Dr TAKIAN (Islamic Republic of Iran) enumerated some of the obstacles blocking countries' progress towards the Millennium Development Goals, drawing particular attention to the importance of actions to prevent neonatal mortality. He requested stakeholders to include easy and convenient pregnancy as a basic human right within the post-2015 agenda, and highlighted the need for further research on how to improve social determinants of health.

Mr LA Ki-tae (Republic of Korea) expressed concern about the lack of progress on certain health-related Millennium Development Goals, notably maternal mortality, and the fact that some gains had been eroded by the Ebola virus disease outbreak. WHO should continue to promote strategies and targets that Member States could incorporate into their national plans. He called for continued focus on universal health coverage in the post-2015 health agenda.

Dr GONZÁLEZ FERNANDEZ (Cuba) said that the Millennium Development Goals served as a powerful stimulus for keeping health on the international agenda, and noted that Cuba had attained practically all the Goals. Although the post-2015 sustainable development goals were still under discussion, maternal and infant mortality and universal health coverage must be addressed. Moreover, indicators measuring global progress towards sustainable development should cover the social, environmental and economic pillars of sustainability.

Mr COTTERELL (Australia) praised the strategic objectives of WHO's post-2015 vision for ending preventable maternal mortality and welcomed actions by Member States in response to the newborn health action plan.¹ Australia had hosted the international AIDS 2014 conference and looked forward to sharing lessons learned in addressing the HIV epidemic.

Ms ZHANG Lingli (China) said that the Ebola virus disease outbreak had set development in Africa back by several years. Some developing countries were struggling to maintain progress because they no longer qualified for financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria or the GAVI Alliance. Further South–South and North–South cooperation between governments and pharmaceutical companies was essential to meet the target of providing access to affordable essential medicines in developing countries.

Dr AKSEL'ROD (Russian Federation) said that further efforts were needed to reduce neonatal mortality. A key factor in lowering maternal and child mortality was the training of doctors and health professionals. Her country, which had achieved Goals 4 and 5, provided training for doctors from other countries, and encouraged other Member States to do likewise. The post-2015 sustainable development goals should cover the protection of maternal and child health, noncommunicable diseases and prevention of disease throughout the life course.

Mr RASHEED (Maldives) said that adequate denominators must be identified if progress were to be monitored on the basis of objectively quantifiable indicators and if the real magnitude of crucial health issues were to be understood. Accordingly, in formulating the sustainable development goals, Member States should prioritize the development of reliable national health information systems and civil registration systems. The resulting data would facilitate the equitable allocation of resources and the management of inherent problems among vulnerable populations.

Mrs VALLINI (Brazil), welcoming the work of the Open Working Group of the General Assembly on Sustainable Development Goals, emphasized the importance of focusing on universal access strategies and health systems strengthening in order to ensure that the sustainable development goals remained broad. A consolidated global strategy on reproductive health was essential, as the improvement of women's health had direct consequences on neonatal health. She urged the reinforcing of WHO's mandate in building strategies and actions on prevention and treatment of sexually transmitted infections, HIV and viral hepatitis. Brazil looked forward to the development of a post-2015 HIV strategy and urged the Secretariat to consolidate the global action plan on prevention and control of viral hepatitis. She thanked WHO and PAHO for their efforts to help countries in the difficult task of attaining the Millennium Development Goals.

Dr KREMER (Argentina) said that, although the report focused on certain health-related goals, all the Millennium Development Goals were connected to health and should be considered with a view to strengthening intersectoral policies. Argentina would welcome inclusion in the new post-2015 sustainable development agenda of the concept of universal access to health from the perspective of the social determinants of health and reduction in inequalities. The Secretariat should make a final

¹ Resolution WHA67.10.

comprehensive assessment of the Millennium Development Goal initiative and its health impact from that perspective, identifying the main achievements and challenges.

Dr KUPA (Democratic Republic of the Congo), recalled a recent study undertaken in his country with international partners and all relevant sectors to determine how to deliver essential medicines to treatment centres and promote achievement of Millennium Development Goals 4 and 5.

Dr ABDOU SHEBL (Egypt) said that, although her country had achieved Millennium Development Goal 4, Target 4.A, and was implementing a maternal and child health acceleration plan, neonatal mortality remained a concern. Egypt had made significant progress with regard to Goal 5, but challenges remained, including unequal access to quality services and a shortage of health professionals.

Ms ROA RODRIGUEZ (Panama) said that health inequalities remained a challenge and efforts should be redoubled to guarantee the full development of all people throughout the life course. Achieving universal health coverage and tackling the determinants of noncommunicable diseases were key priorities; implementation of the WHO Framework Convention on Tobacco Control would be crucial in that regard.

Ms CORLUKA (Canada)¹ reiterated her country's commitment to assisting partner countries in achieving the health-related Millennium Development Goals and stressed the need for a robust monitoring and evaluation framework to ensure accountability. The post-2015 sustainable development agenda should be ambitious and have maternal, newborn and child health at its centre. Technical experts should be involved in the development of the relevant indicators.

Mr KIM Chang Min (Democratic People's Republic of Korea), drawing attention to challenges faced by his country and welcoming the support received from WHO and other United Nations agencies, said that it was essential that the unachieved elements of the Millennium Development Goals featured strongly in the post-2015 sustainable development agenda.

Mr PRAKASH (India)¹ outlined his country's achievements in terms of the health-related Millennium Development Goals, including certification as being polio-free, drawing attention to measures taken to improve maternal, newborn, child and adolescent health, including a flagship strategy and newborn action plan. India looked forward to working with the international community on the United Nations Secretary-General's Global Strategy for Women's and Children's Health for the post-2015 era.

Ms PENEVEYRE (Switzerland)¹ said that implementing and monitoring progress towards the Millennium Development Goals had generated important lessons, including poor data quality and analysis, insufficient or absent data, and disaggregation. Precise targets and specific indicators were needed for the health-related sustainable development goals in order to facilitate the monitoring of progress and adjustment of strategies, where necessary. Particular attention should be given to equitable access to health services. She welcomed WHO's efforts to ensure inclusion of health indicators as a cross-cutting measure to monitor progress achieved across all of the future sustainable development goals.

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

Mr SAMAR (Algeria)¹ said that, given the people-centred approach to development that suffused its socioeconomic and investment programmes, Algeria attached particular importance to the health-related Millennium Development Goals, notably Goal 1, which it had attained several years in advance of the target date. The quest for food security in Africa was a major focus; the Africa Food Security Conference, held in September 2014, had underscored the right to development, the need for equity, and the promotion of international cooperation. In Algeria, maternal and child health had improved, having been given priority in the health system, with special emphasis on access to affordable medicines, health supplies and wastewater collection and treatment. International cooperation and the efforts of United Nations organizations, including WHO, must be further harnessed towards exceeding the Millennium Development Goals and supporting national development endeavours.

Mrs GONZÁLEZ (Uruguay),¹ speaking on behalf of the Union of South American Nations, encouraged strengthened commitment to achieving the Millennium Development Goals. The health perspective must be included in the sustainable development goals, with a focus on universal access, health systems strengthening and intersectoral collaboration to ensure a health-in-all-policies approach. The report to be submitted to the forthcoming Health Assembly might also address the sustainable development goals and the post-2015 development agenda.

Mr SCHMITZ-GUINOTE (Germany)¹ stressed that the unfinished Millennium Development Goals should not be forgotten when agreeing on the future development agenda. Much of the under-five mortality was preventable, and he was pleased to report that the record amount pledged at the recent GAVI Alliance pledging conference in Germany would enable the vaccination of an additional 300 million children by 2020. He requested further information on the process for developing a new global strategy on HIV/AIDS for the post-2015 period.

Mrs SITANUN POONPOLSUP (Thailand)¹ encouraged the Secretariat and Member States to continue working on the health-related Millennium Development Goals and to ensure their full integration into the post-2015 development agenda. It was essential to take into account lessons learnt from implementation successes and failures in developing future goals. She called on the Secretariat to undertake a comprehensive, systematic review of the Millennium Development Goals and to make the results publically available.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) suggested that a discussion on the matter issue be held during the Sixty-eighth World Health Assembly, depending on the information provided by the Secretariat on WHO's leadership in relation to the health-related aspects of the post-2015 sustainable development agenda.

Dr IMHAIDAT (Libya)¹ highlighted the particularly difficult situation faced by his country in terms of the provision of health care services and the lack of capacity for monitoring and reporting. He requested assistance from WHO in redressing those problems.

Mr MATUTE HERNANDEZ (Colombia)¹ reiterated that health should be both a principle and cross-cutting element of the sustainable development goals and welcomed WHO's efforts to that end. He also drew attention to health-related actions in his country, which took into account the social determinants of health and focused on reducing gaps in health services.

Mr DE MIRANDA (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, expressed concern about the unequal progress both between

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

countries and disadvantaged socioeconomic groups within countries. He was surprised at the absence of reporting under Goal 7 on ensuring environmental sustainability given the strong links between environment and health, and encouraged the development of robust and effective monitoring strategies for future goals.

Ms MATZKE (Union for International Cancer Control), speaking at the invitation of the CHAIRMAN, said that Member States should, in their deliberations on the post-2015 sustainable development agenda, agree on an ambitious, technically sound target to reduce mortality from noncommunicable diseases; propose indicators related to health and noncommunicable diseases across the sustainable development goal framework; and support strong means of implementation for health.

Ms BAY (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, requested that an item on the sustainable development goals be included on the provisional agenda of the Sixty-eighth World Health Assembly. Lessons learnt from the implementation of the Millennium Development Goals should be taken into account during the design of the post-2015 agenda. Universal health coverage must provide the framework for fair and equitable health-related goals and targets. She called for stronger national target-setting.

Dr KIENY (Assistant Director-General) observed that, in light of progress achieved in many areas, the Millennium Development Goals were regarded as a success. However, infectious diseases and maternal, newborn and child health and nutrition continued to be major public health issues that should be prominent in the post-2015 sustainable development agenda. Significant inequality in health care provision persisted and health systems remained weak in many countries, while health care needs continued to increase. Intergovernmental negotiations on the outcome document on the post-2015 sustainable development agenda would be held in the coming months. The Secretariat was working closely with other United Nations agencies on the monitoring framework for that agenda, which should include a concise set of indicators to track global progress and also clarify national, regional and global responsibilities for monitoring and reviewing progress and galvanizing action. Member States should provide input on that framework, for example through discussions on the matter at the Sixty-eighth World Health Assembly, as suggested by several speakers.

Dr BUSTREO (Assistant Director-General), welcoming the comments made, reminded Member States that more than 300 days remained before the target date for the Millennium Development Goals; although it was likely that the world would fall short of reaching the targets, much progress could be made in that period. She was encouraged that some Member States had implemented the action plan Every Newborn: an action plan to end preventable deaths. The Secretariat would strive to ensure that women's and children's health remained at the centre of the sustainable development goals.

The DIRECTOR-GENERAL suggested that, if Member States wished to consider an item on the post-2015 sustainable development agenda for the provisional agenda of the Sixty-eighth World Health Assembly, they could raise the matter during the Board's consideration of item 13.4.

Dr NAKATANI (Assistant Director-General), responding to the representative of Germany, said that the Secretariat was considering the development of a new strategy on HIV/AIDS and would work closely with UNAIDS to ensure that any new strategy was compatible with the multisectoral national plans developed by countries. When a new strategy was developed, the Secretariat would consult closely with the regional committees before submitting a draft to the Board for review.

The Board noted the report.

Adolescent health: Item 7.3 of the Agenda (Document EB136/17)

Mr COTTERELL (Australia), recognizing the need to integrate approaches across numerous areas of health, asked how WHO would work with other United Nations partners, exploiting the relative strengths of each, and about linkages with other strategies. He supported the proposed approach and consultative process on a framework for accelerated action for adolescent health.

Dr ALKHAWARI (Kuwait), speaking on behalf of the Member States of the Eastern Mediterranean Region, recognized the need for the proposed framework and for multisectoral collaboration led by health ministries and including adolescents. The framework had to be flexible, and take into account the diverse cultural, social and religious contexts, particularly regarding sexual and reproductive health and substance use (including alcohol). Appropriate and friendly health services for adolescents needed financial and human resources. She enjoined the Director-General to support the involvement of Member States and adolescents in the consultation process.

Dr PAVIĆ ŠIMETIN (Croatia) welcomed the development of the framework as an opportunity to bring together a set of holistic and evidence-based actions, for minimum input and maximum output, especially with its focus on harmonizing adolescent health services within the context of universal health coverage, and on health education. Particular attention should be given to vulnerable young people, including those not in education, with developmental difficulties or inadequate parental care. She supported the proposed approach, which was commendably inclusive.

Dr NCHABI KAMWI (Namibia), speaking on behalf of the Member States of the African Region, where HIV/AIDS, road traffic injuries and alcohol misuse were major causes of adolescent mortality, supported the development of a framework based on the proposed domains and common determinants. The framework should build on the positive aspects of the adolescent period of development. The consultations should be as inclusive as possible, and he had noted with satisfaction the reference to the crucial role of families and communities in the development of the framework as well as the fact that the Regional Office for Africa was planning to develop a regional strategy on adolescent health.

Dr NIK JASMIN NIK MAHIR (Malaysia), welcoming the consideration of adolescent health as part of commitments such as the Millennium Development Goals and the post-2015 sustainable development agenda, supported the proposed approach. She affirmed the importance of broader social determinants of health, country-specific contexts, and use of new communication technologies.

Dr GRABAUSKAS (Lithuania), speaking on behalf of the Nordic and Baltic countries Denmark, Estonia, Finland, Iceland, Latvia, Lithuania and Norway, said that any framework must be based on the social determinants of health and have a clear gender perspective, with a requirement for gender-disaggregated data. It should reflect more strongly than the report did, the values of a stable upbringing, safe environment, education, healthy lifestyle and access to health services. As the challenges facing adolescents were changing, policies and measures must be based on up-to-date evidence. WHO's action should be based on the principles of the United Nations Convention on the Rights of the Child. The framework should aim to reduce the toll of HIV/AIDS on adolescents and contribute to the cessation of female genital mutilation. He agreed with the proposed process and elements.

Ms ZHANG Lingli (China), commenting on the vulnerability of adolescents as they developed physically and mentally, drew attention to some of her country's initiatives aimed at providing specific attention and protection, such as legislation on the protection of minors. She supported the development of a framework, which should guide Member States' actions on adolescent health in areas such as sexual violence, unwanted pregnancy and protection against HIV infection.

Mrs HAMAMOTO (United States of America) applauded WHO's leadership in developing a framework for accelerated action for adolescent health, particularly in ensuring girls' access to essential health services. The framework should include strategies appropriate to the various developmental stages of adolescents, and promote an inclusive, multisectoral approach encompassing areas such as mental health, sexual and reproductive health, the prevention of human trafficking and injury prevention. Data collection and measurable objectives and indicators to evaluate progress were important, as was the identification of new data sources to address knowledge gaps.

Ms BAĬBARINA (Russian Federation) emphasized the importance of preventing smoking and the excessive use of alcohol, and promoting exercise, healthy nutrition and reproductive health among adolescents. The Russian Federation had introduced programmes and legislation that had reduced tobacco and alcohol use and the incidence of abortion among adolescent girls. She welcomed the proposed consultative process on the extremely important work.

Mr LA Ki-tae (Republic of Korea) said that his country had already prioritized several areas for promotion of adolescent health that were consistent with the five areas described in the report. Regional variations in risks to health meant that action plans should be drafted at regional, national and community levels with specific, locally-tailored health measures for adolescents. He supported the development of the proposed framework and the consultative process.

Dr KREMER (Argentina) commended the development of a framework for adolescent health, which should focus on common social determinants of health and the promotion of positive adolescent behaviours, but recommended that it should take into account existing regional strategies and action plans on adolescent health, such as PAHO's Adolescent and Youth Regional Strategy and Plan of Action 2010–2018. The framework should also seek to reduce morbidity and mortality resulting from external causes, such as road traffic injuries, homicide and suicide.

Mrs VALLINI (Brazil) said that her country, which was committed to universal and equitable access to health services, was developing a comprehensive health care policy for adolescents. She welcomed the consultative process on the proposed framework and concurred that existing regional plans should be taken into consideration in the framework's development.

Dr TAKIAN (Islamic Republic of Iran) emphasized the need for an integrated approach towards adolescent health within the context of universal health coverage and taking into account different social and cultural contexts. He suggested several components of the framework for consideration, including: measurable indicators; engagement with multiple stakeholders; annual student health screening programmes; adolescent health service packages; surveillance and prevention of high-risk behaviour; and education on healthy lifestyles and parenting.

Dr AHMED BASHEIR (Sudan)¹ supported WHO's approach which would guide the development and implementation of national programmes for adolescent health. She supported four of the five proposed domains but expressed concern about references to an age- and culturally-appropriate debut of safe alcohol consumption and to sexual debut. She proposed the addition of a common determinant on partnership, which would facilitate a multisectoral and multidisciplinary approach. She commended the proposed three-stage development process, emphasizing that cultural variations must be taken into account in the first phase.

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

Mr SAGUNI (Indonesia),¹ noting the complexity of the issues, said that adolescent health programmes should be introduced into schools, as had been done in his country. He supported the proposal to develop a framework, and called for a comprehensive approach encompassing individuals, families and schools, including religious boarding schools, where appropriate to the country context.

Dr SAIPIN CHOTIVICHIE (Thailand)¹ emphasized the increase in teenage pregnancy in many developing countries, and its associated long-term health consequences for mother and child, as well as the rising trend of mental illness and noncommunicable diseases in young people. Greater public investment in adolescent health and action to make health care services adolescent-friendly were needed. She expressed concern that the report under-rated the impact of alcohol on adolescent health and challenged the implication in the fourth proposed domain (paragraph 9(iv)) that alcohol consumption was healthy, which was not based on scientific evidence; it was the main risk factor to adolescent health. Delaying the onset of drinking should be a target.

Ms GONZÁLEZ (Uruguay),¹ speaking on behalf of the Union of South American Nations, agreed with the proposed development of a framework for adolescent health and recognized the importance of youth participation in the consultations. The framework should take into account: the need for intersectoral action to ensure universal access, particularly among vulnerable populations including indigenous communities; the consequences of anaemia on the health and development of adolescents, especially young women; and the urgent need for attention to mental illness and care of adolescents with a disability in integrated adolescent health services.

Mr PUSP (India)¹ observed that India had more than 250 million adolescents and had been one of the first to adopt a strategic approach to adolescent health. Its recently-launched national adolescent health programme encompassed not only sexual and reproductive health but other issues such as nutrition, violence, noncommunicable diseases, mental health and substance abuse. He supported the proposed three-stage consultation process on the framework, including engagement with youth organizations worldwide.

The meeting rose at 17:30.

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

ELEVENTH MEETING

Friday, 30 January 2015, at 18:05

Chairman: Mr M.H. SHAREEF (Maldives)

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

Adolescent health: Item 7.3 of the Agenda (Document EB136/17) (continued)

Mr MATUTE HERNANDEZ (Colombia)¹ endorsed the proposal to create a framework for accelerated action for adolescent health. It should include social, economic and environmental policies and encourage physical activity. Adolescents should be given information about health topics such as the dangers of psychotropic drugs. Other sectors than health that had responsibilities for the economic and social determinants of health should be involved in setting strategic health objectives for adolescents. Such a coordinated approach would avoid duplication of policies.

Ms ARMITAGE (United Nations Population Fund) said that discriminatory laws, practices and attitudes continued to keep women and young people, particularly adolescent girls, from accessing sexual and reproductive health services, including family planning. The Beyond 2014 Review of the commitments undertaken at the International Conference on Population and Development in 1994 had prompted the inclusion of adolescent health in the renewed global strategy for women's, children's and adolescents' health. Her organization was working with WHO and other partners to ensure that countries paid more attention to the sexual and reproductive health of young women and men. With more than 1200 million adolescents coming of age in the near future, of whom 88% lived in the developing world, more investment was needed in girls' education, comprehensive sexuality education for young people and free access to sexual, reproductive and maternal health services.

Mr MWANGI (World Heart Federation), speaking at the invitation of the CHAIRMAN, said that, although rheumatic heart disease was curable, it continued to kill and disable adolescents among the world's poorest populations. As a noncommunicable disease caused by a communicable pathogen, it defied easy categorization; proven and cost-effective approaches to prevention and control had been neglected. He called on countries and regions in which rheumatic heart disease was endemic to include early detection of the disease in educational curricula for health workers. He supported the proposed framework and its domains, in particular the emphasis of the context of universal health coverage.

Dr HOMB (International Association for Child and Adolescent Psychiatry, and Allied Professions), speaking at the invitation of the CHAIRMAN, observed that the risk of contracting mental health problems was highest in adolescence; that aspect should be taken into account in any action plan. The development of new and modified, multi-culturally based intervention strategies specifically for adolescents was essential, and she welcomed the proposed approach encompassing consultation with countries and stakeholders in the development of a draft framework for accelerated action for adolescent health.

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

Dr BUSTREO (Assistant Director-General) welcomed the suggestions for the proposed framework, including those on social and environmental determinants of health; gender; the need to show a clear linkage and articulation with the global strategy for women's, children's and adolescents' health, with an emphasis on possible gains over the life course; and alcohol, tobacco and early sexual debut. The work would be guided by other WHO strategies and action plans, including the comprehensive mental health action plan 2013–2020 and the global strategy to reduce the harmful use of alcohol. The cross-cutting aspects of adolescent health required the involvement of several departments within WHO and other organizations in the United Nations system, including UNAIDS, UNESCO, UNFPA and UNICEF. The consultation process would include Member States, stakeholders and youth organizations.

The Board noted the report.

Women and health: 20 years of the Beijing Declaration and Platform for Action: Item 7.4 of the Agenda (Document EB136/18)

Mrs VALLINI (Brazil), speaking on behalf of the Member States of the Region of the Americas, said that since 1990 the prevalence of noncommunicable diseases among women had risen, making it essential to control risk factors, including tobacco use and physical inactivity, and to promote healthy lifestyles. Despite overall gains in sexual and reproductive health, persistent inequalities continued to exist between and within countries, indicating that the current development model was inadequate and that further health systems strengthening was needed. Many countries in the Region had enacted legislation on sexual and reproductive health and launched interdisciplinary and multisectoral policies and programmes. Progress had also been made in improving access to reproductive health, maternity and contraception services, leading to a drop in maternal and infant mortality rates. The current discussion was timely in view of the imminent 20-year review of the Beijing Declaration and Platform for Action, work on the renewed global strategy on women's, children's and adolescents' health, and the post-2015 sustainable development agenda.

Dr DAHN (Liberia), speaking on behalf of the Member States of the African Region, said that the African Union had declared 2015 the Year of Women's Empowerment. Several countries had been collecting sex- and age-disaggregated data for integration in health information systems. A continental-level campaign had been launched to end child marriage, empower women, strengthen girls' education and promote women's rights. The Member States called on the Secretariat to improve screening and early detection of breast cancer in low- and middle-income countries and to reflect the need for education and economic empowerment of women in the ongoing global discussion on the post-2015 sustainable development agenda and the renewed global strategy on women's, children's and adolescents' health.

The data provided by WHO on various programmes were inconsistent, and there was a mismatch between the data and decisions in the Proposed programme budget 2016–2017. For example, the report recognized that girls and young women living with HIV were the most affected section of the population, but they were not included among the key populations. In paragraph 14, it was stated that girls and young women were less physically active than men; however, she expressed doubts that that was the case in Africa. WHO should harmonize data provided by different units and programmes and review the sources of the data in the report.

Ms BAĬBARINA (Russian Federation) supported the renewal of the global strategy for women's, children's and adolescents' health and described some of the actions being taken in her country to improve the reproductive health of women and adolescent girls and to reduce maternal mortality, including better infrastructure, distance learning and continuing medical education for health professionals, school programmes and use of social media to raise awareness of the benefits of healthy lifestyles. The renewed strategy should address equal access to health and social services for women, public information and everyday safety.

Ms HARB (Lebanon) said that prioritizing women's health had helped her country to achieve Millennium Development Goals 4 and 5, yet gender disparities in health care and outcomes for women persisted. A two-pronged approach should be adopted: multidisciplinary interventions to tackle the underlying causes of gender disparity, including better access to health professions and equal pay; and restoring women's control over their own bodies, particularly in respect of reproductive health. The Secretariat should support countries in generating health indicators disaggregated by gender, and by measuring progress in the context of the accountability framework for women's and children's health.

Ms ZHANG Lingli (China) noted the persistent inequalities in core areas of women's health, including reproductive and maternal health, which were linked to access to health services. In its efforts to implement the commitments made in the Beijing Declaration, her Government had introduced legislation and devised development programmes on women's and children's health, such as delivery in hospital and breast and cervical cancer screening in rural areas. The post-2015 sustainable development agenda required WHO to review successful practices, identify existing problems, set new priorities and elaborate a new global programme with strategic goals, which gave greater priority to women's, children's and adolescents' health. WHO should also strengthen its own capacity for guiding and evaluating developing countries' performance under the revised global strategy.

Mr COTTERELL (Australia) said that his country remained committed to implementing the Beijing Declaration and Programme of Action, and looked forward to the outcomes of their respective reviews.

Ms JORDAN-SULLIVAN (United States of America) welcomed the global reductions in maternal and infant mortality rates and the increases in health service uptake and school enrolment rates among girls and women. Nevertheless, she urged WHO to tackle inequalities in access to health care for women of all ages and to respond to the increase in domestic and sexual violence. It should also continue its focus on increasing access to good quality sexual and reproductive health services, cervical cancer screening and immunization, and on reducing maternal morbidity, injuries and tobacco use. Particular attention should be paid to the provision of appropriate health services for adolescent girls.

Dr NIK JASMIN NIK MAHIR (Malaysia) called on the Secretariat, as part of its efforts to reduce global disparity in women's access to health care, to support Member States in strengthening their national health systems, data collection mechanisms and research capacities. The renewed global strategy should accommodate national, cultural and religious differences relating to women's health, and the health indicators used in it should be explicitly mentioned in the post-2015 sustainable development goals.

Mr LA Ki-tae (Republic of Korea), supporting the development of a new global strategy, stressed the need to redress the slow progress made towards gender equality and structural inequities, particularly regarding access to health services, and rectifying poor quality of care and weak monitoring and surveillance. Social and economic empowerment of women was inextricably linked to improving women's health. The Secretariat and Member States must promote global awareness of gender equality and women's right to health care.

Dr GONZÁLEZ FERNANDEZ (Cuba) said that further efforts must be made to improve women's health, in particular through access to sexual and reproductive health services. Prenatal care and safe births needed properly trained health personnel and tackling cervical cancer needed much more attention, as did HIV infection, violence against girls and women, and women-focused health programmes. Women often faced discrimination at work and lacked educational opportunities. Work was needed to overcome the economic, social and cultural obstacles limiting their access to health services, and to ease their double burden of paid work and caring for their families.

Dr TAKIAN (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that it was important to consider the underlying causes and social determinants responsible for the slow and uneven progress in improving women's health. Stronger coordination between health ministries and other international organizations, partners and stakeholders would be required. Health issues such as substance abuse, road traffic injuries, domestic violence, mental health disorders and women's and girls' vulnerability in emergency situations should not be neglected. New strategies for women's health should not be developed while current strategies had not been fully implemented or evaluated: WHO should update its existing strategy rather than create a new one, and provide appropriate tools for application at country level, with allocation of suitable financial and human resources. Women's health strategies should take into account cultural and religious differences and should be adaptable to the local context of each country.

Speaking on behalf of his own country, he called on WHO to make affordable human papillomavirus vaccines available in low- and middle-income countries, tackle maternal morbidity as well as mortality, address women's health during and after the menopause, and promote happiness and positive attitudes among women.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) said that progress towards Target 5.B on universal access to reproductive health, which had been a late addition to the Millennium Development Goal framework, lagged seriously behind progress towards other targets. Women and adolescent girls had to be empowered to have sexual and reproductive choices, rights, the ability to make informed decisions about child-bearing, and access to services. She urged WHO, as the leading coordinating body on global health, to promote those health rights and called on Member States to support the inclusion of universal access to sexual and reproductive health and rights in the post-2015 sustainable development agenda.

Dr BEJTJA (Albania) welcomed the attention being paid to reducing domestic violence against women. Closer links must be established with other international organizations, such as UNFPA and the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women), in order to achieve synergies and efficiencies in interventions to improve women's health. He called for greater action to ensure the availability and affordability of human papillomavirus vaccine.

Mr MAGALLANES (Argentina), also speaking on behalf of the Member States of the Region of the Americas, added that the Secretariat should provide a more comprehensive analysis for consideration by the Sixty-eighth World Health Assembly.

Ms RUIZ VARGAS (Mexico)¹ noted the unequal and unbalanced progress towards the commitments made in the Platform for Action on women's health, in particular regarding violence and sexual and reproductive health. More systematic efforts must be made to include a gender perspective in epidemiological analyses of risk factors and in the design of health services and health promotion programmes. It should also be an indicator used in the evaluation of health programmes. Policies were needed to encourage women and girls to increase their levels of physical activity, as in community-based projects in her country, and to tackle mental health problems.

Ms GONZÁLEZ (Uruguay)¹ described the action taken by her country to improve women's rights in sexual and reproductive health, including free contraception, safe termination of pregnancy, in-vitro fertilization irrespective of the woman's sexual orientation, and appropriate legislation. Her country's progress had shown that a rights-based approach to removing inequities in women's health and expanding access to services was vital. She too called for a more detailed report for consideration by the Health Assembly.

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

Mr RIETVELD (Netherlands)¹ endorsed the priorities set by the Secretariat and the call for a new global strategy, which should draw on the outcomes of recent meetings of the International Conference on Population and Development and the provisions of resolution WHA67.15 on strengthening the role of the health system in addressing violence, in particular against women and girls. Besides the unfinished business of the Millennium Development Goals, in particular reaching Target 5.B on universal access to reproductive health, the strategy should also address infertility, maternal morbidity, and women's health in humanitarian emergencies, and contain concrete action points on gender inequality. It should emphasize prevention, especially comprehensive sexuality education, with access to information being as important as access to services. He endorsed the inclusion of investment in universal access to integrated sexual and reproductive health and human rights.

Dr FONES (Chile),¹ recognizing that women still faced inequities and obstacles in access to health services, care and treatment, endorsed the calls for a more thorough analysis of the challenges to women's health and to investigate the link between women, health and sustainable development in the context of the proposed new global strategy. The recent outbreak of Ebola virus disease illustrated how inequities in access to health care rendered women extremely vulnerable in emergencies. Member States must pay particular attention to reducing maternal mortality from preventable causes, providing comprehensive sexual and reproductive health services and supporting women in humanitarian emergencies. They must also take steps to mainstream gender in local, regional and global health agendas and introduce gender-specific prevention, treatment, education and research programmes. That meant commitment of more resources as well as monitoring and evaluation.

Ms DAESCHLER (France)¹ described her Government's priority actions for overcoming the legal, financial and social barriers to women's access to services and care, which included a national programme to improve access to abortion, the creation of a commission to protect women against violence, and putting the right and access to care at the heart of its development aid programme. She welcomed the preparation of a renewed global strategy and supported the priorities outlined in the report. She urged WHO to continue its work to tackle gender inequality and discrimination based on gender and sexual orientation. The health problems women and girls faced were changing; health systems must evolve accordingly.

Mr PETTERSSON (Sweden),¹ speaking on behalf of the Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, said that investing in women and girls was vital to supporting inclusive and sustainable development, yet in many countries they faced inequitable access to good quality health services, and gender-related barriers prevented them exercising their sexual and reproductive rights. Gender analysis was essential in all health work, with sex-disaggregated data vital for strengthening WHO's gender responsiveness. Respect for and promotion of sexual and reproductive health rights were instrumental in securing women's active participation in society and in making decisions. Efforts to promote their sexual and reproductive health rights continued to meet strong resistance, as indicated by the prevalence of violence against women and female genital mutilation. A more holistic approach to women's health through the life course must be adopted, with a greater focus on changing male attitudes and behaviours. Future investments in the unfinished agenda of the Millennium Development Goals and the inclusion of noncommunicable diseases in the post-2015 sustainable development agenda would foster the adoption of that approach.

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

Dr THANAPHAN SUKSA-ARD (Thailand)¹ noted the increasing trend in teenage pregnancies in many countries and that many women and girls were still afflicted by preventable health conditions and excluded from health care systems. Sociocultural factors often prevented women and girls from benefitting from good quality services. Community participation strategies could lead to changes in behaviours and norms, and moves towards universal health coverage would enhance women's access to health services. Investing in women's health brought wide-ranging socioeconomic and health benefits for families, communities and indeed society at large, bearing in mind the substantial reliance on the female workforce, including in the health sector. WHO and its partners must therefore continue to advocate for the requisite fundamental change in approach.

Mr SAGUNI (Indonesia)¹ underlined that much remained to be done to improve the health status of women and girls in many countries. In Indonesia, gender mainstreaming was practised as a matter of policy and supported by a health law that included reproductive health rights and maternal health, including a Minimum Initial Service Package for reproductive health in crisis situations, which included antenatal care and the supply of contraceptives. The country's young population profile called for the adoption of a life cycle approach and a greater focus on adolescent health and early marriage. WHO, in addition to ensuring that maternal mortality reduction remained high on the post-2015 sustainable development agenda, must optimize stakeholder coordination and strengthen partnerships for accelerating, monitoring and evaluating implementation of the Beijing Declaration and Platform for Action.

Ms MARTINEZ (Ecuador)¹ expressed concern over the continuing obstacles to women's fair and equitable access to health services in general, and to good quality sexual and reproductive health services in particular. All such services must also be delivered to women irrespective of their sexual orientation. Her Government had taken steps to ensure access for women among the traditionally-excluded communities, such as sex workers. Intersectoral policies relating to women and health included culture-specific aspects, as in the case of the provision of antenatal and obstetric care to indigenous women. The emerging priorities for improving women's health should be covered in a detailed report to the forthcoming Health Assembly.

Ms MARKBREITER (World Heart Federation), speaking at the invitation of the CHAIRMAN, said that, despite some progress, societies were still failing women and compromising their right to health. Gender equality remained a distant reality in the area of cardiovascular disease, which was responsible for one third of female deaths worldwide. Although women were often more adversely affected than men, they were more likely to be under-diagnosed and under-treated, partly because their disease presentation, progression and outcomes differed; that fact was little understood in the existing male-oriented research world. Using WHO publications as guidance, her organization had identified remedies to that situation, such as the inclusion of women in clinical trials, access to sex-specific data and training in sex-specific care.

Dr BUSTREO (Assistant Director-General) welcomed the recognition afforded during the discussion to the importance of the unfinished agenda of women's health and to emerging priorities such as adolescent health and noncommunicable diseases, with an emphasis on breast and cervical cancer. The achievements of the United Nations Secretary-General's Global Strategy for Women's and Children's Health would be relayed to the Sixty-eighth World Health Assembly in the form of a progress report on implementation, an assessment of the accountability framework developed in the light of the recommendations of the Commission on Information and Accountability for Women's and Children's Health, and a review carried out by an independent expert group, all of which would likewise serve as input to the renewed global strategy on women's, children's and adolescents' health.

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

Members clearly shared WHO's concern to build systemic resilience for delivering integrated health services covering all illnesses affecting women across the life course. The strong focus on reproductive health would continue at WHO, as exemplified by its close work with UNFPA and UN Women, in which context it was advocating the incorporation of the women's health dimension in the regional progress reports being prepared for Beijing+20 and would do likewise at the 59th session of the Commission on the Status of Women (New York, 9–20 March 2015). Neither women's rights nor women's empowerment would be achieved unless women's right to health was fully realized and protected.

Mrs VALLINI (Brazil) endorsed an earlier point made about human papillomavirus vaccine, stressing the importance of universal access to and affordability of health services.

Dr BUSTREO (Assistant Director-General), responding that due note had been taken of that point, underscored the importance of financing for guaranteeing women's health and services. Many countries were afforded access to human papillomavirus vaccine through the support provided by the GAVI Alliance, with which headquarters and regional bodies were working to reduce the cost of the vaccine and improve accessibility. It was hoped that the global financing facility being developed in support of the Every Woman, Every Child movement would serve as another vehicle for funding the vaccine and provide access to curative services, such as those for cancer.

The Board noted the report.

2. WHO REFORM (continued)

Framework of engagement with non-State actors: Item 5.1 of the Agenda (Documents EB136/5 and EB136/INF./2) (continued from the fourth meeting)

The CHAIRMAN drew attention to a revised version of the draft decision, adding that a report on its financial and administrative implications for the Secretariat was in preparation. The draft decision read:

The Executive Board, having considered the report of the Secretariat on the "Framework of engagement with non-State actors" (document EB136/5) and having taken note of the Programme, Budget and Administration Committee report to the Executive Board (document EB136/3) and the "Framework of engagement with non-State actors: Information on regional committee debates" (document EB136/INF./2),

NOTES that important progress has been made in the elaboration of the Framework of engagement with non-State actors, but that further improvements are needed especially but not limited to the issues listed in the annex to this decision, with a view to its adoption by consensus at the Sixty-eighth World Health Assembly,

DECIDES to:

(OP)1. Invite Member States to submit to the Director-General specific proposals for amendments, inclusions or deletion of text from the draft overarching framework of engagement with non-State actors and the four specific policies contained in the annex of EB136/5 by 16 February 2015;

- (OP)2. Requests the Director-General to:
- (1) compile these proposals and to make them available to Member States by 9 March 2015;
 - (2) convene an open-ended intergovernmental meeting from 30 March to 1 April 2015 with a view to discussing the textual proposals submitted by Member States;
 - (3) submit, based on the outcome of the above intergovernmental meeting, a revised version of the Framework of Engagement with non-State actors to the Sixty-eighth World Health Assembly through the Programme, Budget and Administration Committee.

ANNEX

NON-EXHAUSTIVE LIST OF ISSUES WHICH SEEM TO NEED MORE WORK AMONGST MEMBER STATES

Conflict of Interest (including individual conflict of interest)

Criteria of due diligence and process of risk management

Transparency

Secondments and provision of personnel

Role of private sector (acceptance of funds, pooling mechanism, evidence generation and advocacy)

Engagement with particular industries

Criteria for attribution to type of non-State actors, including criteria applied to classify some nongovernmental organizations as international business associations

In which kind of meetings can non-State actors participate

Use of funds provided by non-State actors to support the salary of WHO staff

Official relations (some aspects)

Policy, norms and standard setting

Applicability of the Framework to all levels of the Organization and all 6 regions

General principles that guide collaboration

Definitions of terms (“arm’s length”, “resources”, etc.)

Support to policy making at national level.

Dr CARBONE (Argentina) said that the resulting text set out a demanding but feasible road map with a non-exhaustive list of issues requiring more work, the aim being to strike a balance between the collective will of the members and the need to bring about a successful conclusion. She looked forward to a constructive discussion of a revised version of the Framework at the Sixty-eighth World Health Assembly.

Dr REYNDERS (Belgium), speaking on behalf of the European Union and its Member States, expressed support for the adoption of the draft decision but requested that, for paragraphs 1, 2(1) and 2(2), the standard practice be followed of adding a footnote referring to regional economic integration organizations, where applicable.

Mr COTTERELL (Australia), observing that open-ended intergovernmental meetings were expensive, said that no costing document was yet available. Also, such meetings undermined the function of governing bodies. With reluctance, he agreed with the draft decision, in the interest of preserving the consensus.

Dr SMITH (Executive Director) informed the Board that the cost of the requested three-day open-ended intergovernmental meeting would amount to US\$ 350 000, which would be funded from existing resources. The report on the financial and administrative implications was expected to be made available the next day.

The CHAIR took it that the Board wished to adopt the draft decision as amended by the member for Belgium.

The decision, as amended, was adopted.¹

The meeting rose at 19:40.

¹ Decision EB136(3).

TWELFTH MEETING

Saturday, 31 January 2015, at 09:35

Chairman: Mr M.H. SHAREEF (Maldives)

1. PROGRAMME AND BUDGET MATTERS: Item 11 of the Agenda (continued)

Strategic budget space allocation: Item 11.3 of the Agenda (Document EB136/35) (continued from sixth meeting, section 1)

The CHAIRMAN invited the Board to consider the following draft decision prepared by the Secretariat:

The Executive Board, having considered the report on strategic budget space allocation¹ and the report by the Working Group on Strategic Budget Space Allocation,²

- (1) welcomed the report of the Working Group on the Strategic Budget Space Allocation and expressed its appreciation to the members of the Working Group for their diligence in developing a methodology in an objective and timely manner;
- (2) endorsed the guiding principles recommended by the Working Group;
- (3) requested the Director General, with respect to the Proposed programme budget 2016–2017:
 - (a) to apply the recommendations of the Working Group with regards to operational segments 2 (provision of global and regional goods), 3 (management and administration) and 4 (response to emergency events, such as outbreak and crisis response);
 - (b) to propose an allocation of budget space for operational segment 1 (technical cooperation at country level), applying the guiding principles of the new methodology, and taking into account comments made by the 136th session of the Executive Board;
- (4) requested the Working Group on Strategic Budget Space Allocation to continue its work to further develop operational segment 1 (technical cooperation at country level) taking into consideration the issues raised during the 136th session of the Executive Board with regards to the choice of appropriate indicators and availability of data, and report to the Executive Board at its 137th session in May 2015.

¹ Document EB136/35.

² Document EB136/35, Annex.

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

1. Decision: Strategic budget space allocation	
2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf) Category: 6. Corporate services/enabling functions	
Programme area(s): Strategic planning, resource coordination and reporting	Outcome: 6.3. Financing and resource allocation aligned with priorities and health needs of the Member States in a results-based management framework Output: 6.3.1. Results-based management framework in place including an accountability system for WHO’s corporate performance assessment
How would this decision contribute to the achievement of the outcome(s) of the above programme area(s)? The decision would allow the Working Group on Strategic Budget Space Allocation to continue its work to further develop operational segment 1 of the proposed methodology (Technical cooperation at country level), taking into consideration the issues raised during the 136th session of the Executive Board with regards to the choice of appropriate indicators and availability of data. The Working Group will then report to the Executive Board at its 137th session in May 2015.	
Does the Programme budget already include the outputs and deliverables requested in this decision? (Yes/no) Yes.	
3. Estimated cost and staffing implications in relation to the Programme budget	
(a) Total cost Indicate (i) the lifespan of the decision during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000). (i) Four months (covering the period February–May 2015). (ii) Total: US\$ 50 000 (staff: US\$ nil; activities: US\$ 50 000).	
(b) Cost for the biennium 2014–2015 Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000). Total: US\$ 50 000 (staff: US\$ nil; activities: US\$ 50 000). Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant. Headquarters. Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no) Yes. If “no”, indicate how much is not included.	

(c) Staffing implications

Could the decision 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)

No.

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

The funding gap is US\$ 50 000. It will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

Ms ROA RODRIGUEZ (Panama), speaking on behalf of the Member States of the Region of the Americas, suggested in subparagraph 3(b), after “to propose”, the insertion of “in consultation with the Global Policy Group (GPG)” and, after “new methodology”, of “the three pillars for the preparation of the 2016–2017 Programme budget (bottom-up approach, realistic costing of outputs and clear roles and responsibilities across the three levels of the organization) as requested in decision WHA66(9)”.

Mr KIM Chang Min (Democratic People’s Republic of Korea), speaking on behalf of the Member States of the South-East Asia Region, proposed that in paragraph 1 the words “for their diligence in developing a methodology in an objective and timely manner” should be deleted. In subparagraph 3(b) he proposed adding “the needs of various regions and” after “taking into account”. In paragraph 4, after “with regards to”, he proposed inserting the words “the proposed methodology,” and replacing “Executive Board at its 137th session” with “Programme Budget and Administration Committee at its 22nd session”. The Member States of the South-East Asia Region wished to nominate Thailand to represent the Region on the Working Group on Strategic Budget Space Allocation.

Dr ASADI-LARI (Islamic Republic of Iran) proposed that in paragraph 4 the words “continue its work to develop operational” should be replaced by the words “develop innovative measures to operationalize”.

Ms WANG Qianyun (China) recalled that her delegation had asked in the fifth meeting for further discussion. The Working Group could re-examine the methodology in light of feedback from Member States before submitting a draft decision for the Board’s consideration.

Ms MATSOSO (South Africa) said that it would not be productive to return to the question of the methodology for segment 1 after the Board had already held extensive discussions on the issue.

Dr AMMAR (Lebanon) agreed with the previous speaker. Amendments that discredited the work done so far on strategic budget space allocation would undermine the Working Group. He therefore could not support the amendment to paragraph 1 proposed by the member for the Democratic People’s Republic of Korea.

Mr COTTERELL (Australia) said that the draft decision accurately reflected the outcome of the Board's discussions. He wished to submit a proposed amendment to paragraph 4, to the effect that many Member States had commented on the detail of the methodology; it would be useful for those comments to be submitted to the Working Group in writing. He accepted the other amendments proposed, except for that to paragraph 1, as the Working Group had done its job with diligence. He strongly supported the draft decision.

Mr KIM Chang Min (Democratic People's Republic of Korea), speaking on behalf of Member States of the South-East Asia Region, withdrew the proposed amendment to paragraph 1.

Dr OMI (Japan) supported the views of the members for Lebanon and Australia, and wished to see a revised text incorporating the proposed amendments.

The CHAIRMAN said that a revised draft would be prepared in light of the comments made, to be resubmitted to the Executive Board for its consideration.

(For adoption of a decision, see the summary record of the fourteenth meeting, section 2.)

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

Outcome of the Second International Conference on Nutrition: Item 6.1 of the Agenda (Document EB136/8)

Given the floor by the CHAIRMAN at the request of Mr MCIFF (United States of America), Dr MÍČ (Czech Republic)¹ welcomed the Rome Declaration and the Framework for Action. Implementation of the pledges made needed a multisectoral approach, with engagement of the United Nations organizations, regions, countries and other stakeholders. He introduced the following draft decision on the outcome of the Second International Conference on Nutrition, proposed by Albania, Argentina, Australia, Brazil, Chile, Colombia, Czech Republic, Ecuador, Haiti, Mexico, Norway, Paraguay, Peru, South Africa, Suriname, Turkey, United States of America, Uruguay, Zimbabwe, and the Member States of the European Union:

The Executive Board, recalling relevant WHO international targets and action plans, including the WHO 2025 Global Nutrition Targets and the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020,

Having considered the report of the Secretariat on the outcome of the Second International Conference on Nutrition, decided the following:

- (1) to note the commitments of the Rome Declaration on Nutrition and the recommendations of the Framework for Action;

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

- (2) to request the Director-General:
- (a) to provide technical support to Member States¹ to implement the commitments of the Rome Declaration on Nutrition across multiple sectors, by expanding WHO's evidence-informed guidance to cover the policy areas identified in the Framework for Action in the fields covered by WHO mandate; by developing as needed policy papers informed by the best available, robust quality scientific evidence providing the rationale, operational details and necessary elements for the calculation of costs and benefits of the recommended policies, with active involvement of all relevant stakeholders;² by strengthening multilateral initiatives at global and regional levels aimed at sharing experience on implementing different policy approaches or legislative tools; and by creating, together with the Director General of FAO and in cooperation with other UN agencies, a repository of examples of country nutrition plans, including on increased investments to improve people's diet and nutrition, as well as plans that are relevant to nutrition in health, agriculture and trade, social protection, education, water, sanitation, hygiene and the environment;
 - (b) to contribute, together with the Director-General of FAO, to joint United Nations mechanisms on nutrition, such as the United Nations Standing Committee on Nutrition the Renewed Efforts Against Child Hunger and Undernutrition Partnership, the High Level Task Force on the Food Security Crisis and the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases, by improving the existing multiagency coordination mechanisms and by developing a United Nations global nutrition agenda, taking account of organizations' respective mandates;
 - (c) to facilitate and enhance coordination of activities and actions across sectors, based on existing experiences and good practice by preparing policy briefs as needed and collaborating as appropriate, with the Committee on World Food Security and the Global Coordination Mechanism on the prevention and control of noncommunicable diseases; and by maintaining engagement, including with different multistakeholder platforms such as the Scaling Up Nutrition movement, in line with the guidance to be provided by the World Health Assembly on engagement with non-State actors;
 - (d) to contribute, together with the Director General of FAO, and in close collaboration with other United Nations partners, to accountability including by inviting Member States to register their commitments in each of the areas indicated by the Framework for Action, as appropriate;
 - (e) to facilitate consideration of a Decade of Action on Nutrition from 2016 to 2025, within existing structures and available resources, by the United Nations General Assembly in 2015 by preparing a road map jointly with the Director-General of FAO and in cooperation with other United Nations agencies, including proposed milestones, and priority action for governments, international organizations and other actors, and by contributing to informal discussions among Member States,¹
 - (f) to facilitate informal discussions among Member States with a view to enabling national parliaments to address ICN2 follow-up at the 132nd Inter-Parliamentary Union Assembly in 2015;

¹ And, where applicable, regional economic integration organizations.

² In line with the guidance to be provided by the World Health Assembly on engagement with non-State actors.

- (3) to recommend to the Sixty-eighth World Health Assembly that it:
- (a) endorses the Rome Declaration on Nutrition, as well as the Framework for Action which provides a set of voluntary policy options and strategies for use by governments;
 - (b) calls on Member States¹ to implement commitments of the Rome Declaration through the Framework for Action;
 - (c) requests the Director-General, in collaboration with the Director-General of FAO and other United Nations agencies, funds and programmes and other relevant regional and international organizations, to prepare a biennial report to the World Health Assembly on the status of implementation of commitments of the Rome Declaration on Nutrition.

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

1. Decision: Outcome of the Second International Conference on Nutrition	
2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf) Category: 2. Noncommunicable diseases <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>Programme area: Nutrition</p> </div> <div style="width: 50%;"> <p>Outcome: 2.5. Reduced nutritional risk factors</p> <p>Outputs: 2.5.1 Countries enabled to develop, implement and monitor action plans based on the maternal, infant and young child nutrition comprehensive implementation plan</p> <p>2.5.2 Norms and standards on maternal, infant and young child nutrition, population dietary goals, and breastfeeding updated, and policy options for effective nutrition actions for stunting, wasting and anaemia developed</p> </div> </div> <p>How would this decision contribute to the achievement of the outcome(s) of the above programme area(s)? The decision would raise the profile of the programme area in Member States' policy-making and would highlight priorities for action for the Secretariat and partners.</p> <p>Does the Programme budget already include the outputs and deliverables requested in this decision? (Yes/no) Yes. The Proposed programme budget 2016–2017 also includes the outputs and deliverables requested.</p>	
3. Estimated cost and staffing implications in relation to the Programme budget <p>(a) Total cost</p> <p>Indicate (i) the lifespan of the decision during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).</p> <ul style="list-style-type: none"> (i) Ten years (covering the period 2015–2024). (ii) Total: US\$ 250 million (staff: US\$ 113.62 million; activities: US\$ 136.38 million). 	

¹ And, where applicable, regional economic integration organizations.

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 31 million (staff: US\$ 14.09 million; activities: US\$ 16.91 million).

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

Currently, 44% of costs would be incurred at headquarters, 25% would be incurred in the African Region, and between 4% and 6% in each of the other regions.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

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

(c) Staffing implications

Could the decision 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)

No.

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

The funding gap is estimated at US\$ 13.83 million. It will be tackled through the Organization-wide coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015.

Dr AKSEL'ROD (Russian Federation) said that the Second International Conference on Nutrition had afforded an opportunity to strengthen international efforts to correct poor nutrition and its consequences. The Russian Federation stood ready to participate in the proposed consultative process. The Board should recommend the Health Assembly to endorse the Rome Declaration. Nutrition must have a place on the post-2015 sustainable development agenda.

Dr KREMER (Argentina), speaking on behalf of the Member States of the Region of the Americas, said that the outcome documents of the Rome Conference and United Nations General Assembly resolution 69/240 on “Agriculture development, food security and nutrition” testified to governments’ recognition that malnutrition not only affected people’s health and well-being but burdened health systems and sustainable development policies. The Rome Declaration recognized the need to incorporate nutrition into national health systems and promote access to healthy diets, and the Framework for Action provided public policy guidance to achieve those aims. Significant progress had been made in tackling malnutrition and micronutrient deficiencies in the 22 years since the first Rome Conference, although coordinated action to promote healthy lifestyles would be required in order to tackle emerging problems related to overweight and obesity. Member States in the Region were committed to implementing the outcomes of the Rome Conference and recognized the need to develop national capacities to that end.

Dr REYNDERS (Belgium), speaking on behalf of the European Union and its Member States, expressed the hope that all countries would build on the energy that had been expended on the Conference in order to strive for full implementation of the Rome Declaration. The European Union's Member States were proud to sponsor the draft decision.

Dr BEJTJA (Albania) said that his country aligned itself with the comments of the previous speaker, believing that the Rome Declaration and the Framework for Action would make a significant difference to reducing malnutrition worldwide.

Dr AMMAR (Lebanon) noted that developing countries suffered the most from undernutrition, vitamin and mineral deficiencies, consumption of unhealthy food and obesity. The links between those different forms of malnutrition and current food systems demanded global solutions. Armed conflicts and displacement of populations were aggravating factors. WFP's termination of food aid to the 1.3 million displaced Syrians in Lebanon due to a lack of financing would have a catastrophic impact on vulnerable populations, particularly women and children. Lebanon could not be left by the international community to deal alone with the high burden of displaced people, who represented 25% of its total population. The Rome Declaration considered refugees, displaced persons and migrants to be among the most vulnerable groups and called upon all responsible parties to ensure the safe and timely supply of food to them. He looked forward to the implementation of that recommendation with the active participation of WHO.

Dr MOURAD (Egypt), speaking on behalf of the Member States of the Eastern Mediterranean Region, asked the directors-general of WHO and FAO to support Member States in operationalizing the commitments they had made in the Declaration, while monitoring progress towards achieving existing global nutrition targets. The two organizations should also support Member States in identifying priority actions appropriate to their context and establishing their own national targets, and support the possibility of introducing a related global goal into the post-2015 sustainable development agenda.

Dr CHANG Jile (China) said that the Second International Conference on Nutrition had provided clear guidance on how to improve nutrition. He outlined the remarkable progress China had made during the previous 20 years in tackling malnutrition, including introduction of a national plan for the period 2014–2020 governing food production and consumption, nutrient intake and nutrition-related disease control. In order to enhance implementation of the Rome Declaration and Framework for Action, developing countries should be supported in their introduction of national plans, monitoring and training.

Dr MAKUBALO (South Africa), speaking on behalf of the Member States of the African Region, commended the outcome documents, including their affirmation of the Health Assembly's adoption of global targets relating to maternal, infant and young child nutrition and the global plan to prevent noncommunicable diseases, as well as the emphasis placed in the recommendations in the Framework for Action on strong, resilient health systems and universal health coverage. She urged Member States to implement the recommendations, which also addressed social, economic, political and structural factors relating to health and nutrition. The African continent suffered from a heavy burden of malnutrition, undernutrition and, increasingly, overnutrition. She therefore fully endorsed the recommendations and welcomed the commitment to establishing national monitoring frameworks to monitor progress in implementing the outcomes of the Conference.

Mr RASHEED (Maldives) said that his country had achieved some targets under the health-related Millennium Development Goals but still faced challenges in achieving those related to nutrition, and the subject had therefore been included in the country's United Nations Development Assistance Framework. Initiatives to promote the accessibility and affordability of healthy food products required a multisectoral response. Current food systems in the South-East Asia Region were unsustainable and unhealthy: increased production had come at a high environmental cost, and a greater proportion of food had been made available with high energy, fat, sugar and salt content. New systems were required to produce food in sufficient quantities and quality. He supported the draft decision.

Mr RUOCCO (Italy),¹ speaking also on behalf of Croatia, Cyprus, Greece, Malta, Portugal and Spain, said that the Secretariat must provide assistance to Member States in order to ensure full implementation of the recommendations contained in the Framework for Action, paying particular attention to the preparation of appropriate guidelines based on high-quality scientific evidence, such as the recognized benefits of the traditional Mediterranean diet, which contributed to the prevention of chronic noncommunicable diseases. The production of guidelines must take into account the comments made at the current session of the Board and the forthcoming Health Assembly, and Member States and other stakeholders should be fully involved in the process. The participation of all stakeholders would be essential in implementing the recommendations that came out of the International Conference.

Dr HISHAM ABDULLAH (Malaysia) said that the comprehensive draft decision would be of assistance in implementing the recommendations on nutrition. However, with respect to the report on financial and administrative implications for the Secretariat, he sought clarification on whether the Proposed programme budget 2016–2017 would cover all the outputs and deliverables indicated in the Conference outcome documents.

Mrs VALLINI (Brazil) supported the endorsement of the Rome Declaration by the Health Assembly and underscored the importance of implementing all the recommendations included in the Framework for Action. She reiterated her country's position that nongovernmental initiatives should not be considered on the same basis as a multistakeholder platform or mechanism. Further, WHO must assume a leadership role, promoting research, stimulating knowledge-sharing and dissemination, and providing technical assistance to countries, as well as developing ethical political solutions in order to produce change in the global nutritional status. WHO must be part of the Advisory Group of the Committee on World Food Security in order to guarantee that the health perspective would be explored.

Mr COTTERELL (Australia) supported the recommendation to the Health Assembly to endorse the Rome Declaration and Framework for Action. WHO had an active role to play in the follow-up to the Conference, and he called for all work to be undertaken wherever possible through existing structures and mechanisms and timed accordingly. He strongly encouraged consultation and collaboration in order to implement the road map.

Ms ROA RODRIGUEZ (Panama) underscored the importance of a global monitoring system for maternal, infant and young child nutrition that would enable more effective decision-making on policy and technical issues and the incorporation of new indicators in order to ensure appropriate follow-up. Malnutrition was a growing public health problem, and she acknowledged the importance of working to meet existing global nutrition goals by 2025, strengthening intersectoral work and

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

collaborating with bodies in the United Nations system. Panama wished to be included as a sponsor of the draft decision.

Mr JEON Man-bok (Republic of Korea) said that nutrition was a fundamental pillar of human health and development across the life span; it was a matter of science, not opinion, and standards and regulations should therefore be established on the basis of scientific evidence. He endorsed the commitments of the Rome Declaration and the recommendations set out in the Framework for Action and urged all partners in health to actively implement them.

Dr USHIO (Japan) said that the outcome documents of the Conference should be swiftly implemented in accordance with the conditions prevailing in individual countries. He appreciated the emphasis on collaboration within the health sector and the importance of multisectoral coordination. There was a growing need to implement food safety measures by taking account of advances in scientific technologies, the expansion of food retailing areas and increased globalization. The importance of nutrition would continue to grow, as it served as an intervention point for tackling noncommunicable diseases.

Dr ASSIRI (Saudi Arabia) noted that, although the Conference had had a global perspective, more emphasis had been placed on the nutrition challenges in developing countries. Accordingly, he asked how the outcomes of the Conference would build on existing global and regional political processes and initiatives, and contribute to the post-2015 sustainable development agenda. How would coherence be achieved at national and global levels in with regard to economic policies and those affecting healthy diets, and how would the Conference enlarge on the United Nations Secretary-General's call to take up the Zero Hunger Challenge? He urged all Member States to commit themselves to the introduction of a nutrition-related goal in the post-2015 sustainable development agenda; to take routes appropriate to their own context to achieve existing global targets and to establish their own nutrition targets; and to monitor programme implementation and nutrition outcomes through existing monitoring and accountability mechanisms.

Mr KOLKER (United States of America), commenting on the remarks made by the representative of Italy, said that WHO's status rested on its responsibility to provide high-quality technical guidance, and it would be very dangerous to take any action to diminish the rigour and independence of the scientific process. Like non-State actors, Member States had interests, and he did not therefore favour opening up the norm-setting process to a greater role for them. A case in point was the draft guideline on free sugars issued in 2014 for public consultation. The draft new guideline had been presented in a way that was confusing and included information that it was based on "very low quality" data according to the GRADE assessment. The technical basis for the recommendation might well be sound, but it posed a potential reputational risk to WHO to present recommendations in such a manner. He recommended that further consideration be given to the matter, in order to ensure that the process and substance of that draft guideline were appropriate.

Dr ASADI-LARI (Islamic Republic of Iran) said that his country had managed to reduce malnutrition significantly in recent years. Combatting antimicrobial resistance was important, but food safety needed to be considered in a broader sense, "from farm to fork": the report should place greater emphasis on foodborne diseases and pesticide residues. As well as traditional monitoring programmes, dietary studies could be conducted to determine the impact of agrochemicals on public health. A draft global action plan to combat chemical residues in food should be developed. WHO should operationalize the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 and provide increased technical support for the implementation of country and regional action plans.

Dr CHAND (Nepal) said that, recognizing the importance of nutrition, his Government was implementing a multisectoral nutrition plan. He supported the draft decision.

Dr KUPA (Democratic Republic of the Congo) highlighted the fact that malnutrition was multifaceted. To eliminate rather than merely reduce malnutrition, it was necessary to address all its causes.

Ms MARTINEZ (Ecuador)¹ said that her Government prioritized the concept of *Buen Vivir* (“living well”), an outlook that valued people above trade, which included an integrated vision of nutrition, encompassing sustainable agricultural systems, highly nutritious crops, traditional knowledge and fair distribution chains. The United Nations General Assembly should declare the proposed Decade of Action on Nutrition, 2016–2025, and Member States should collaborate to develop an action plan for the decade ahead, in order to reinforce the post-2015 sustainable development agenda.

Ms PALMIER (Canada)¹ expressed concern that the Secretariat had proposed an accountability framework to assess Member States’ fulfilment of the Framework for Action, as Member States had negotiated the removal of such a framework from the Rome Declaration, given that suitable accountability mechanisms already existed. It was positive that WHO intended to collaborate with the Scaling Up Nutrition movement and to work with other bodies of the United Nations system to ensure that nutrition featured in the post-2015 sustainable development goals. WHO should collaborate with other organizations to evaluate countries’ progress; specifically, it should work with FAO to develop indicators to monitor the implementation of actions towards the six global nutrition targets that had been endorsed by the Health Assembly.

Dr MAKASA (Zambia)¹ said that his Government remained committed to improving nutrition for all through government-led intersectoral collaboration. Zambia wished to cosponsor the draft decision. Member States should not be involved in the development of the evidence-informed guidance in the policy areas covered by the Framework for Action: the process should be a technical one, free of political influence, as the member for the United States of America had said.

Ms PEAN MEVS (Haiti)¹ recommended that the Secretariat should support Member States in complying with the recommendations proposed in the Framework for Action. Her Government remained committed to implementing its existing nutrition and food security programme. Haiti wished to cosponsor the draft decision.

Mr PRAKASH (India),¹ seconded by Dr CHAND (Nepal) and Mr RASHEED (Maldives), supported the draft decision but proposed that subparagraph 3(b) should read: “calls on Member States to consider implementing commitments of the Rome Declaration through the Framework for Action”, to bring it into conformity with subparagraph 3(a), which mentioned voluntary policy options and strategies.

Mr SAGUNI (Indonesia)¹ said that, although his country had made progress towards eradicating hunger and malnutrition in the previous five years, significant challenges remained. His Government had elaborated several relevant policies, including a national action plan on food and nutrition, and was committed to implementing the Rome Declaration through the recommendations in the Framework for Action. The food industry must be held to account to support healthy, diversified diets; conflicts of interest arising from collaboration with corporations should be avoided.

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

Dr THANAPHAN SUKSA-ARD (Thailand)¹ supported the proposed amendment to subparagraph 3(b). The Secretariat should provide Member States with technical support to ensure that they could implement the recommendations in the Framework for Action within the designated time frames. WHO must maintain its independence and integrity, and avoid any influence from profit-driven industries that benefitted from unhealthy dietary practices.

Dr SÄRLIO-LÄÄTEENKORVA (Finland),¹ speaking on behalf of the Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, supported the draft decision. For effective implementation of commitments, evidence-informed guidance on the policy areas identified in the Framework for Action was essential, especially on healthy diets; WHO should produce and publish its revised dietary guidelines without delay. It should also provide guidelines to facilitate implementation of the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020 and the associated political declaration. Calculations of the costs and benefits of different ways to promote healthy diets should be updated and published, in a transparent process. The Nordic countries had a long-standing set of recommendations that integrated nutrition, physical activity and a sustainable diet.

Ms BERGARA (Uruguay)¹ said that her Government had begun to implement intersectoral policies to promote balanced and healthy diets, including a policy on school food. With regard to recommendation 4 in the Framework for Action, governments must avoid potential conflicts of interest when fostering private investment. Community-based management should not be the only approach to tackling acute malnutrition. In the context of environmental sustainability through the conservation of natural resources, special mention should be made of the use of agrichemicals, especially pesticides.

Ms MATZKE (Union for International Cancer Control), speaking at the invitation of the CHAIRMAN, said that WHO should participate actively in discussions on making the Committee on World Food Security the leading mechanism for follow-up to the Second International Conference on Nutrition. Biennial reporting on the implementation of the Conference commitments to the regional committees and Health Assembly would be valuable. The Secretariat and Member States should translate commitments into targets and indicators aligned with existing WHO monitoring frameworks and integrate them into national nutrition monitoring frameworks. Likewise, Member States should, with support from the Secretariat, ensure that intergovernmental negotiations on the post-2015 sustainable development agenda led to the integration of the Conference commitments into the development goals.

Ms ARENDT (International Baby Food Action Network), speaking at the invitation of the CHAIRMAN, said that the Rome Declaration and Framework for Action, while welcome, were not enough to combat global malnutrition. The report inaccurately referred to the Committee on World Food Security as a multistakeholder forum, whereas it was an intergovernmental committee in FAO and would be a key body in the follow-up to the Conference. Inclusion of WHO in the Committee's Secretariat and Advisory Group would increase its capacity to fulfil its envisaged role in nutrition.

Ms FABBRI (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, affirmed that the conclusions of the Conference negotiations were welcome but insufficient. New international instruments were needed to regulate transnational corporations in areas where their interests ran counter to public policy objectives; WHO should open negotiations with UNCTAD to explore strategies for such regulation. The barriers to food security and food sovereignty in current trade and investment agreements must be

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

clearly articulated. Conflicts of interest had to be avoided, especially in multistakeholder platforms that included private sector participation. Member States should oppose attempts to create any mechanism outside the intergovernmental system to oversee food and nutrition issues: to fulfil its nutrition-related role, WHO should join the Committee on World Food Security's Secretariat.

Ms BAY BUNDEGAARD (The Save the Children Fund), speaking at the invitation of the CHAIRMAN and also on behalf of World Vision International, stressed the need for accountability, in view of the voluntary nature of the Conference commitments. It was alarming that the world was not on track to meet any of the six global nutrition targets set by the Health Assembly, and that it had not been possible in the *Global Nutrition Report 2014* to make country-level assessments of progress towards the targets for low birth weight and breastfeeding owing to gaps in the data. WHO should work with FAO to report annually on progress on implementing the Conference's commitments and should reconvene Member States to check progress in five years' time. It should work with other bodies in the United Nations system to ensure that all Member States could report on progress towards all six nutrition targets, and put in place a global monitoring framework that took equity into consideration by means of disaggregated data. Nutrition had been relatively neglected in the Millennium Development Goals; the post-2015 sustainable development goals must include the six nutrition targets, as well as indicators of dietary diversity and national budget allocations for nutrition.

Dr CHESTNOV (Assistant Director-General) said that the world expected action on hunger and food safety after the Conference. The post-2015 sustainable development goals should include the topic of food safety, and negotiations were under way with FAO and other bodies on establishing a Decade of Action on Nutrition, 2016–2025 that, it was to be hoped, would find the support of Member States. It was important not to replace other organizations but, as a trusted specialized agency of the United Nations, WHO should strengthen and assist the work of other organizations in the field of nutrition. Crucially, WHO should retain its leading position with regard to norms and standards, which were the basic work of the Organization. Developments with regard to nutrition greatly depended on the work of politicians, who should have a clear understanding of WHO's role and of the need to balance economic interests and food safety and security; there was also a need to reconcile well-being with the development of markets. The Committee on World Food Security could assist with carrying out the necessary multisectoral work. Social engagement in the topic of nutrition was gathering pace, and the international community should capitalize on that momentum to deliver significant results.

The DIRECTOR-GENERAL welcomed the proposal that WHO should join the Committee on World Food Security. She would work with her team to ensure that the many declarations touching on the topic of nutrition could contribute to work in that area. Countries were at different stages of implementation of the various strategies and action plans, and further work was required by the Secretariat to determine which kind of technical support framework could bring coherence to work on nutrition in countries in different regions.

She thanked Member States for their recognition that there should be no tampering with the process for guidelines development, and that no political influence should be allowed with regard to the evidence on which guidelines were based. The process was one of the most robust in terms of considering scientific evidence and avoiding conflicts of interest and interference, and she intended to protect it. She would reconsider how to explain to Member States, the scientific community and the public the difference between a strong recommendation, based on strong evidence, and a conditional recommendation, based on less strong evidence. The Secretariat could not omit evidence, as past experience had shown that, even when initially weak, evidence should be brought to the attention of the public through a conditional recommendation, as in the case of mother-to-child transmission of HIV through breastfeeding, for example. When a conditional recommendation was issued, specific reference was made to the relevant evidence, and when more research became available, the guideline was updated accordingly. With regard to the draft guideline on intake of free sugars for adults and children she would personally ensure that the process was robust and would address the difference between strong and conditional recommendations in an additional document.

Dr REYNDERS (Belgium) said that he could not accept the amendment to the draft decision proposed by the representative of India and proposed that subparagraph 3(b) should read “calls on Member States¹ to implement commitments of the Rome Declaration through a set of voluntary policy options within the Framework for Action”.

Dr CHAND (Nepal), supported by Mr PRAKASH (India)² and by Mr RASHEED (Maldives), agreed with the proposal by the member for Belgium.

The Board noted the report and adopted the decision, as amended.³

Follow-up to the 2014 high-level meeting of the United Nations General Assembly to undertake a comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases: Item 6.4 of the Agenda (Documents EB136/11 and EB136/11 Add.1)

Ms MATSOSO (South Africa) asked for more information on the proposal to develop a set of process indicators.

Dr AMMAR (Lebanon) noted the difficulty in reporting on progress towards long-term objectives in the absence of short-term indicators. In resolution EM/RC61/R.3, the Regional Committee for the Eastern Mediterranean had requested the Board at its current session to invite the Director-General to develop a set of process indicators for use in assessing the progress made at national level in the implementation of the Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, for consideration by the Sixty-eighth World Health Assembly. Process indicators would allow Member States and partners to take practical steps towards long-term outcome indicators and encourage them to advance work on the indicators and targets contained in the comprehensive global monitoring framework. They would also establish a framework for accountability in the short term. Context-specific policies and a framework for action were needed. Owing to some countries' reservations, however, an alternative proposal had been developed that accommodated the views of countries from other regions and which would be presented to the Board by the member for Kuwait.

Dr ALHAMAD (Kuwait), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the lack of guidance in the outcome document of the 2014 high-level meeting (document EB136/11, Annex 1) on how progress on the implementation of the Political Declaration should be reported to the General Assembly in 2017 was a source of major concern. The nine voluntary targets in the global monitoring framework were accompanied by outcome indicators that could not be used to assess interim progress. Careful and strategic planning was needed to achieve progress before the third high-level meeting, due to be held in 2018. She therefore requested the Board to consider the following draft decision:

The Executive Board, having considered report EB136/11 on the follow-up to the 2014 high-level meeting of the United Nations General Assembly to undertake a comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases,

¹ And, where applicable, regional economic integration organizations.

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

³ Decision EB136(4).

(1) noted resolution EM/RC61/R.3 which requested the Executive Board at its 136th session to invite the Director-General to develop a set of process indicators, for consideration by the Sixty-eighth World Health Assembly, to assess the progress made at national level in the implementation of the Political Declaration, which would enable the United Nations Secretary-General and the Director-General to report in 2017 to the high-level meeting of the General Assembly in 2018 on the prevention and control of noncommunicable diseases;

(2) requested the Director-General to develop an assessment framework by which to measure progress, based on existing monitoring tools, that would allow the United Nations Secretary-General and the Director-General to submit, in 2017, an objective report on the progress countries are making.

Dr REYNDERS (Belgium), speaking on behalf of the European Union and its Member States, said that the nine voluntary targets could only be achieved if efforts were continued at the national level in all sectors, including health systems. The work of Member States should be supported by bodies of the United Nations system, in accordance with their mandates and through the United Nations Inter-agency Task Force on the Prevention and Control of Non-communicable Diseases. The European Union wanted to see intensified engagement of non-State actors through the global coordination mechanism. The comprehensive global monitoring framework and the indicators for the WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2020 had been adopted after lengthy negotiations and must remain the main instruments for collecting data on the progress made in the implementation of the Political Declaration. The data collected by the WHO's global noncommunicable disease country capacity survey and other reporting instruments could complement reports, while progress towards the targets and indicators of the global monitoring framework would be sufficient as milestones. No additional global indicators were needed.

He supported the proposed work plan for the global coordination mechanism. The first general meeting of the global coordination mechanism, planned for 2017, should be held as a working level meeting, in order to ensure efficient use of limited resources. WHO's leadership was needed to improve public health and show the world that the Organization could deliver on its agreements. Many countries lacked the capacity to apply the global monitoring framework, which appeared to have some gaps. He did not agree with the proposal made by the member for Kuwait and trusted the Secretariat to prepare a report that would allow the Director-General and the United Nations Secretary-General to report the progress made by countries to the United Nations General Assembly in 2017.

Mr GHILAGABER (Eritrea), speaking on behalf of the Member States of the African Region, acknowledged the follow-up activities to the high-level meeting in 2014. Although the Sixty-sixth World Health Assembly had adopted the comprehensive global monitoring framework, its targets and indicators were, however, outcome indicators. He supported the development of process indicators, capable of application across country settings, to assess the progress made in the implementation of the road map of commitments included in the Political Declaration and the prioritized commitments in the outcome document.

Dr GRABAUSKAS (Lithuania) said that political will to tackle noncommunicable diseases was not sufficient: society as a whole had to be involved. It was also crucial to strengthen public health capacity to implement, monitor and evaluate actions at national and international levels, and the European Region had already taken some steps in that regard, including the joint Regional Office for Europe/European Commission project on integrated surveillance of noncommunicable diseases and the CINDI Policy Academy on integrated surveillance of noncommunicable diseases, based in his country. He reiterated his country's support for the global coordination mechanism.

Dr AKSEL'ROD (Russian Federation) said that to meet national commitments for 2015–2016, her Government was giving priority to management, prevention and reduction of risk factors, health care and monitoring. With regard to the proposed work plan the following tasks should be undertaken: developing criteria for the web platform and using it to disseminate information on the work of the global coordination mechanisms and to make comparative assessments of countries' commitments on implementation; identifying target groups for information on the global monitoring mechanism; and developing a unified research protocol to determine the noncommunicable disease burden in each WHO region and to enable interregional comparisons. The nine voluntary global targets and the 25 indicators were sufficient to assess progress in implementation of the global action plan.

Dr KAMALIAH MOHAMAD NOH (Malaysia) argued that the lack of guidance on how the Director-General was to report to the United Nations General Assembly in 2017 was not a problem, as there were ample data on progress. She would support additional process indicators provided that they generated useful information at country and regional levels and did not overburden Member States. The distinction between core, extended and optional indicators for surveillance of noncommunicable diseases could be extended to process indicators, which should not be universally applied, as the member for Kuwait had suggested. Monitoring was important, but the greatest challenge was reducing exposure to risk factors. Countries should remain focused on achieving the voluntary global targets.

Mr COTTERELL (Australia) identified multisectoral approaches and the engagement of the nongovernmental sector as vital to preventing and controlling noncommunicable diseases. With regard to the proposal made by the member for Kuwait, he associated himself with the remarks made by the member for Belgium: the nine voluntary global targets and 25 outcome indicators were sufficient.

Mr McIFF (United States of America) supported most of the actions described in the draft work plan for 2016–2017 but suggested that, as the global coordination mechanism had yet to begin its work in earnest, its preliminary evaluation in 2017 at the level proposed might be premature. He questioned whether the web-based platforms would be sufficient for disseminating new knowledge and suggested that other low-cost measures should be considered. With regard to process indicators, it was likely that other regions would agree with the proposal made by the member for Kuwait and benefit from a slightly different set of milestones; the development of such process indicators was fully consistent with and included in the global mandates that WHO already possessed for implementation of the global action plan and global monitoring framework. He therefore supported the request for the Secretariat to elaborate a draft decision.

Dr CHANG Jile (China) said that noncommunicable diseases had rightly become a major global public health issue, and they had been included in his country's overall economic and social development plan. It had developed a work plan on their prevention, was expanding monitoring to include causes of death, chronic diseases and nutrition, and was conducting campaigns on tobacco control, physical activity, nutrition and health education. In the follow-up to the 2014 high-level meeting, WHO should continue to play a leading role and strengthen coordination with other international organizations to provide technical support to Member States. It should also update and disseminate technologies on the prevention and control of noncommunicable diseases based on key diseases and risk factors, and use information technologies to improve its efficiency and response capacity. With regard to monitoring, the 25 outcome indicators and nine voluntary global targets were sufficient.

Ms MATSOSO (South Africa) noted that, in paragraphs 12, 13 and 14 of document EB136/11, there was no guidance to the Director-General on reporting. The proposal made by the member for Kuwait might be workable, but she thought that the outcome indicators should be used: the reporting time frame was only two years, and additional measurements might overburden countries. The assessment framework should be studied further.

Mrs VALLINI (Brazil) maintained that no new indicators were necessary: the nine global targets and 25 indicators were sufficient. She acknowledged the positive interaction between WHO and non-State actors but reiterated the concerns that she had expressed during the discussion of the topic earlier in the session. The global coordination mechanism was an important tool for implementation of the global action plan, and she supported the proposed second work plan. WHO had to continue playing its leadership role.

Mr BLACK (United Kingdom of Great Britain and Northern Ireland) said that his country was fully committed to tackling noncommunicable diseases as the leading cause of death and was taking action to reduce tobacco use, especially to stop children taking up smoking. International cooperation and information exchange were obligations under the WHO Framework Convention on Tobacco Control and should be extended across other noncommunicable disease areas. As many of the general risk factors for noncommunicable diseases could also contribute to dementia, he welcomed the fact that WHO would be hosting the First Ministerial Conference on Global Action against Dementia in March 2015. He supported the proposed work plan for the global coordination mechanism for the period 2016–2017.

Mr CORRALES HIDALGO (Panama) supported the request by the member for Kuwait. As tobacco-related deaths were a worldwide phenomenon, he requested that advances in combatting tobacco use within the WHO Framework Convention on Tobacco Control be detailed in the progress report on the prevention and control of communicable diseases.

Dr KREMER (Argentina) said that his country had already incorporated the 25 indicators and nine voluntary global targets in its national policies. He accepted that a stronger assessment and review process could be developed, and was prepared to consider a set of indicators, in the light of the proposal made by the member for Kuwait, which could incorporate monitoring of intersectoral actions and equity of access to the strategies implemented.

Dr ASSIRI (Saudi Arabia), observing that progress had been insufficient and uneven, expressed the strongest possible support for the adoption of an assessment framework to measure progress based on existing monitoring tools. It would make a real difference to the global fight against noncommunicable diseases, by motivating Member States and partners, enabling health ministries to give higher priority to noncommunicable diseases at the national level, and allowing for monitoring of multisectoral engagement in their prevention and control. It would also generate much-needed information about the status of implementation of interventions, and allow attention to be focused on crucial process measures.

Dr GONZÁLEZ FERNANDEZ (Cuba) agreed that commitment was needed to take the necessary steps in the priority areas of governance, prevention and reduction of risk factors, health care and surveillance. In Cuba, a focal point in the health ministry was responsible for the control of the risk factors and determinants of noncommunicable diseases. With regard to the development of a set of process indicators, monitoring and evaluation using the existing 25 indicators and nine voluntary global targets was already a challenge for some countries: more indicators would only add to the burden. He had some concerns about the proposed work plan of the global coordination mechanism, which he would submit to the Secretariat in writing.

Dr KUPA (Democratic Republic of the Congo) said that the quality of results depended on the quality of work done. He was aware that developing indicators was a large task but thought it should be possible to concentrate on a few critical ones.

Dr MOURAD (Egypt) said that the development of process indicators and an assessment framework was essential for evaluating the progress made in implementing strategic and cost-effective actions.

Dr CHAND (Nepal) urged greater efforts to implement proven interventions. Even though the proposed work plan would give fresh impetus, noncommunicable diseases must be included in the post-2015 sustainable development agenda and universal health coverage. Global and regional efforts were needed to make policy-makers accountable and to stimulate urgent implementation of the work plan. With regard to the indicators, national monitoring and evaluation frameworks and their recording and reporting mechanisms had to be aligned with them. Health systems in many countries, however, urgently needed strengthening to adopt the indicators. In particular, WHO should support the strengthening of national health information systems.

Dr REYNDERS (Belgium) reiterated his view that there was no need for additional global efforts on the issue. To address some concerns, the Secretariat could add a few simple closed questions to the NCD Country Capacity Survey, to assess more specifically countries' activities and to avoid overlap with existing data collection systems. In order to set the baseline, the new Survey should be launched in 2015 and repeated unchanged in 2017. He asked for Member States to be briefed about the changes made and for his comments to be reflected in any decision.

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

The meeting rose at 12:40.

THIRTEENTH MEETING

Monday, 2 February 2015, at 09:05

Chairman: Mr M.H. SHAREEF (Maldives)

NONCOMMUNICABLE DISEASES: Item 6 of the Agenda (continued)

Maternal, infant and young child nutrition: development of the core set of indicators: Item 6.2 of the Agenda (Document EB136/9)

Dr KAMALIAH MOHAMAD NOH (Malaysia) proposed that intermediate outcome indicators IO1 and IO3 and process indicators PR2, PR3 and PR6 should not feature in the core set, as they did not reflect the global and country-level nutrition situation, but instead be incorporated into the proposed extended set of indicators. The periodic revision of the global monitoring framework should be done every 10 years, in accordance with the time frame recommended by the Second International Conference on Nutrition.

Ms WOOD (United States of America) supported the draft framework and changes to the proposed addition indicators. A new intermediate outcome indicator on the dietary diversity score of women should be introduced; intermediate outcome indicator IO1 should be amended to read: “Two-week prevalence of diarrhoea in children under 5 years of age”; and intermediate outcome indicator IO5 should read: “Proportion of school-age children and adolescents (5–18 years) with obesity”; and process indicator PR6 should make reference to appropriate complementary feeding and should use the term “caregivers” rather than “mothers”. She supported WHO’s efforts to increase coordination with other United Nations entities at the country and global levels and, in particular, WHO’s involvement in the Scaling Up Nutrition movement.

Ms ZHANG Yang (China) said that her country had introduced various programmes and initiatives on maternal, infant and child nutrition, and remained committed to WHO’s core nutrition indicators. Intermediate outcome indicators IO1, IO2 and IO3, however, should not be considered obligatory. Instead, an additional intermediate outcome indicator for the proportion of children under five years of age with a height of more than one standard deviation below the WHO Child Growth Standards median should be added, with the aim of reducing the global prevalence of stunting.

Dr NCHABI KAMWI (Namibia), speaking on behalf of the Member States of the African Region, expressed concern at the very slow decline in neonatal and infant mortality rates. A significant number of neonatal deaths could be prevented if breastfeeding started within one hour from birth. He emphasized the importance of continuously monitoring the global burden of all forms of malnutrition, but cautioned against introducing too many indicators, given the cost and feasibility implications. WHO should do further research before adding 14 additional indicators to the core set. He welcomed the establishment of a scientific and technical advisory group. The frequency of revision of the global monitoring framework should be not less than three years.

Dr MOURAD (Egypt), speaking on behalf of the Member States of the Eastern Mediterranean Region and reaffirming their commitment to global efforts to improve maternal, infant and young child nutrition, asked the Director-General to consider integrating the proposed additional indicators into the global and regional core sets of indicators in order to ensure consistency and streamline data

collection through the respective national health information systems. The Secretariat should also build capacity and provide technical support to Member States, so that they could engage with global, regional and national research centres in regular data collection and analysis activities, and consider the need for coordination of partners' data collection and analysis.

Dr EERSEL (Suriname) welcomed the proposed indicator IO4, on overweight and obese women, and called for its inclusion in the Multiple Indicator Cluster Survey. It would also contribute to the Safe Motherhood Initiative. She asked which guidelines would be used to define the minimum acceptable diet for children aged 6 to 23 months, referred to in process indicator PR1. Policy indicator PE1 (referring to the density of trained nutrition professionals) should be reworded to focus on decentralized capacity strengthening through training in nutrition for existing health workers, predominantly at the primary health care level. Short training programmes for community nutrition counsellors, similar to those in her country, could be useful.

Dr AKSEL'ROD (Russian Federation) fully supported the additional indicators. She welcomed the inclusion of intermediate outcome indicators IO4 and IO5 to monitor obesity and overweight in women, children and adolescents.

Mr COTTERELL (Australia) expressed appreciation for the efforts to harmonize the proposed indicators with existing monitoring frameworks but noted that some still differed from standard indicators; PR2 referred to safely managed drinking service" rather than "improved drinking-water sources". As the global monitoring framework should be relevant to multiple forms of malnutrition and obesity, he welcomed the flexibility offered by an extended set of indicators. He supported the global monitoring framework and the inclusion of 14 additional indicators, which would need final review before consideration by the Sixty-eighth World Health Assembly. The framework should be reviewed after a 10-year period.

Mr RASHEED (Maldives) called for a multisectoral approach to improving maternal, infant and young child nutrition, as was practised in his country with good results. The global monitoring framework should be amended to incorporate a life-course approach extending from conception to adulthood, with indicators reflecting the various age groups. Member States should allocate adequate resources to scaling up nutrition interventions, draw up guidelines prohibiting the marketing of unhealthy foods to children and adolescents, and introduce maternity protection regulations to promote breastfeeding among working mothers.

Mrs VALLINI (Brazil) noted that the comprehensive implementation plan and the indicators reinforced countries' responsibilities. She stressed the importance of implementing a broad range of culturally-sensitive, country-level policies to promote healthy eating habits in childhood. Member States should also pay particular attention to tackling childhood obesity.

Ms PALMIER (Canada)¹ proposed that a process for elaborating standardized definitions for each indicator should be submitted to the Sixty-eighth World Health Assembly. Additional indicators could be added to the framework over time, and indicators without standardized definitions could be incorporated into the extended set. She supported the timely formation of an expert group and recommended the inclusion of experts from sectors beyond health.

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

Mr GWIAZDA (Poland),¹ speaking also on behalf of Austria, Estonia and Latvia, welcomed progress on the proposed additional core indicators, but recommended additional consultations, preferably online, to establish clearly defined and measurable indicators.

Mr SAGUNI (Indonesia)¹ said that his country was experiencing difficulties in adopting all the proposed additional indicators owing to a lack of data. Several process indicators, including PR2, PR3 and PR5, needed modification so that they could be monitored at least annually. Member States needed flexibility to prepare a set of indicators relevant to their domestic context.

Mr PUSP (India)¹ agreed that the global monitoring framework should comprise a core set, reported by all countries, and an extended set of indicators, from which countries could choose according to their circumstances and conditions. Data on process indicators PR5 and PR6 would be difficult to collect in India, and he called on the Secretariat to devise alternative indicators that could be monitored by all countries.

Ms ARENDT (International Baby Food Action Network), speaking at the invitation of the CHAIRMAN, welcomed the additional indicators: process indicators PR5 and PR6 would help monitoring of breastfeeding policies. Intermediate outcome indicator IO1 should be combined with the core indicator on the prevalence of exclusive breastfeeding. Indicators on children's consumption of soft drinks and marketing regulations should be reinstated in the proposed additional indicators. In the interests of transparency, the list of participants at the consultation on development of the indicators in October 2013 should be made public.

Dr CHESTNOV (Assistant Director-General) said that WHO would continue its efforts to address maternal, infant and child nutrition, and in particular to reduce the rates of childhood malnutrition and obesity. He proposed that further consultations be held to discuss and provide clear definitions of the proposed additional indicators for the core and extended sets.

It was so agreed.

The Board noted the report.

Update on the Commission on Ending Childhood Obesity: Item 6.3 of the Agenda (Document EB136/10)

Mr SEY (Gambia), speaking on behalf of the Member States of the African Region, noted with concern the increasing global prevalence of childhood obesity and welcomed the establishment, composition and first meeting of the Commission on Ending Childhood Obesity.

Dr KAMALIAH MOHAMAD NOH (Malaysia) urged the Secretariat to be proactive and provide guidance on a range of matters, including marketing issues. The terms of reference of the two ad hoc working groups needed clarification, as publicly available documents suggested considerable overlaps in their work.

Dr ALHAMAD (Kuwait), speaking on behalf of the Member States of the Eastern Mediterranean Region, outlined the reasons for the increase in childhood obesity in the Region and its consequences later in life. The Commission should place emphasis on a life-course approach and the integration of preventive and control interventions into school health programmes and curricula. Coherent policies must be formulated that linked trade, industry and health. The Commission should

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

also devise ways to involve the private sector that avoided conflicts of interest. Its work must reflect the realities and cultural contexts of the different regions and countries.

Dr ASADI-LARI (Islamic Republic of Iran) said that in his country younger children were becoming obese more rapidly than their older counterparts, reflecting epidemiological and nutritional transitions. No single intervention was likely to have a significant overall impact on childhood obesity. Interventions must include education and personal responsibility, but be accompanied by changes to the environment and societal norms. Coherent policies linking trade, industry and health to ensure a healthy food supply, and partnerships with the private sector that avoided conflicts of interest, were important. Broad areas of society, from government and employers to the media and families had to work together. Interventions during pregnancy and early childhood were most likely to have a positive sustained effect on health. He recommended integration of interventions within school health programmes, and the inclusion of WHO's recommendations on physical activity and health.

Dr KREMER (Argentina) said that tackling childhood obesity required solutions that focused on changing the prevailing environment and avoided the influence of advertising on people's decisions. Member States had the capability to introduce measures that encouraged healthy eating, such as advertising standards and warning labels on food, and he urged the Commission to take note of the Plan of Action for the Prevention of Obesity in Children and Adolescents, approved by the 53rd Directing Council of PAHO,¹ in order that progress might be made in regulating food products and promoting a healthy diet and physical activity.

Ms ZHANG Yang (China) observed that, in response to a sharp rise in childhood obesity nationally, her Government had formulated guidelines for the prevention and control of obesity among school-age children and adolescents, and had launched several programmes in order to raise public awareness of the problem, encourage a healthy lifestyle among young people, and provide guidance to parents. China stood ready to participate in the regional consultations and looked forward to the outcome of the Commission's work.

Mrs VALLINI (Brazil) emphasized the urgency of preventing and controlling childhood obesity, not least because of the increased risk of chronic diseases in later life. The work of the Commission should be integrated in and articulated with WHO's other existing strategies, particularly at regional level, through political mobilization across sectors.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) said that, although obesity rates in England had remained stable since 2010, much remained to be done. She described approaches that appeared to be bearing success. As part of a cross-government approach, the health ministry was working with the education and business ministries and industry to reduce calories in drinks marketed primarily to children and food, and to introduce clearer labelling. Individual initiatives included a social marketing programme, which supported families to make positive changes in their diet and lifestyle, and a school food plan aimed at teaching children about good nutrition. She stood ready to share such experiences.

Dr BEJTJA (Albania) highlighted the following initiatives designed to end childhood obesity undertaken by the Regional Office for Europe: the Vienna Declaration on Nutrition and Noncommunicable Diseases (2013); the European Food and Nutrition Action Plan 2015–2020; and the Childhood Obesity Surveillance initiative, which facilitated the streamlining of information and comparability of data among countries. He supported the work of the Commission.

¹ Resolution CD53.R13.

Dr ASSIRI (Saudi Arabia) said that the available data on childhood obesity in the Eastern Mediterranean Region were limited to children under 5 years of age and those between 13 and 15 years, but nevertheless showed that it was more prevalent in urban areas and among the higher socioeconomic classes. It was expected to increase rapidly in middle-income countries and spread to lower socioeconomic groups. He called for the Commission to place emphasis on: a life-course approach to prevention; the integration of interventions in school health programmes; inclusion of WHO's recommendations on physical activity and health; development of coherent policies linking trade, industry and health; and formation of partnerships with the private sector that avoided conflicts of interest.

Ms RUIZ VARGAS (Mexico)¹ outlined her Government's health promotion and disease prevention activities aimed at tackling childhood obesity, including regulation of the sale and distribution of food and beverages in schools. She welcomed the proposed forthcoming consultations.

Dr SAIPIN CHOTIVICHIE (Thailand)¹ said that the approach being taken to tackle childhood obesity in Thailand involved 18 government ministries. Various factors contributed to the problem, including fast foods, insufficient consumption of fruit and vegetables, and lack of physical activity. Social determinants, "health in all policies", transparency and avoidance of conflicts of interest should therefore be core principles of the Commission's work. In implementing resolution WHA63.23 on infant and young child nutrition, Thailand was encountering resistance from powerful producers, which could have a detrimental effect on the process. She therefore called on the Secretariat to build the capacity of Member States to manage such a situation.

Mr KRANIAS (Greece)¹ said that restoring traditional healthy dietary habits and setting limits on the content of *trans*-fatty acids, saturated fat and sodium, combined with daily physical activity, through integrated programmes based on scientific evidence, were the best ways of preventing overweight and obesity. The data being generated through surveillance, monitoring, evaluation and research programmes were being used by the health, education and sport ministries in his country to implement targeted and effective policies for improving public health.

Ms SAMANIEGO (Ecuador)¹, drawing attention to the PAHO's Plan of Action for the Prevention of Obesity in Children and Adolescents, applauded governments that had introduced bold legislative measures, such as taxes on sugary drinks, controls on advertising and, as in her country, labelling of processed foods, with some successes: some companies were reducing the levels of saturated fats, sugar and salt in their products. She urged the Commission to give due regard to the scientific evidence and supported early consultations.

Mr SIMPSON (FDI World Dental Federation), speaking at the invitation of the CHAIRMAN and on behalf of the International Council of Nurses, the International Pharmaceutical Federation and the World Confederation for Physical Therapy, said that children with illnesses, injuries and disabilities were especially prone to obesity because of lack of access to generally available programmes and facilities for physical activity. Physical therapists could work with parents and children to design exercise and activity programmes to improve fitness, regardless of the health condition. Specific efforts were needed to reduce the daily sugar consumption of children, as it had a documented association with both obesity and dental caries. Strategies in settings such as schools, places of work and homes were an essential part of the lifelong approach to enhancing physical activity levels.

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

Ms RUNDALL (International Baby Food Action Network), speaking at the invitation of the CHAIRMAN, said that, although her organization had been invited to attend the Commission's hearing with non-State actors, she had reservations about the procedures followed: a wide range of corporations had been invited on the same basis as true nongovernmental organizations. Their presence might prevent the Commission from reaching a consensus that was in the public interest. It was doubtful whether minor concessions by powerful companies would solve the multitude of nutritional challenges being faced. Furthermore, how many Member States that would be participating in the forthcoming discussions on a European Union directive that was not aligned with the International Code on the Marketing of Breast-milk Substitutes would introduce national regulations to protect child health rather than the infant formula market? She called on the Board to ensure that the Commission avoided conflicts of interest in its work.

The DIRECTOR-GENERAL said that her intention in establishing the Commission had been to ensure that future work had a strong scientific basis and to investigate further the biology and epigenetics of childhood obesity. Duplication of effort would be avoided by ensuring that the chairmen of both working groups were fully aware of their respective remits. The need for both physical activity and the life-course approach had been understood by the Commission. Breast-feeding was of fundamental importance, and she strongly encouraged countries to take decisive action against any developments that contravened the International Code of Marketing of Breast-Milk Substitutes. She acknowledged that ending childhood obesity required political mobilization and participation at the highest level of government.

She had already received confirmation from the Regional Office for the Western Pacific that it would hold a consultation in March 2015, and other regional offices would submit the dates of their consultations in due course. The initial version of the Commission's report would be available online in March 2015 in order to allow for further refinement based on the input from the regional consultations. The target date for completion of the final report was November 2015.

The Board noted the report.

Follow-up to the 2014 high-level meeting of the United Nations General Assembly to undertake a comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases: Item 6.4 of the Agenda (Documents EB136/11 and EB136/11 Add.1) (continued from the twelfth meeting, section 2)

Dr ALHAMAD (Kuwait), speaking on behalf of the Member States of the Eastern Mediterranean Region, introduced a revised draft decision, which read:

The Executive Board, having considered the Director-General's report,¹

DECIDED to request the Director-General to develop an assessment framework by which to measure progress, based on existing monitoring tools, that would allow the UN Secretary-General and the Director-General to submit, in 2017, an objective report on the progress countries are making.

An assessment framework was needed because neither the nine indicators of the global action plan for the prevention and control of noncommunicable diseases 2013–2020 nor the 25 outcome indicators would measure progress that countries would make before the comprehensive review in 2018. The revised draft decision did not call for a mandatory set of new indicators or for the reopening of negotiations, nor would it impose any additional burden on Member States. Its goal was to facilitate

¹ Document EB136/11.

the Secretariat's preparation of the report to be submitted by the Director-General and the United Nations Secretary-General in 2017. As many Member States had commented on the insufficient and uneven progress made between 2011 and 2014, it was essential to have a framework within which to make an objective assessment of progress, in order to intensify efforts to implement the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases.

Dr AHMED BASHEIR (Sudan)¹ supported the proposed assessment framework but highlighted the challenges in data reporting faced by Sudan and other developing countries. Health information systems and national surveys often did not include data on noncommunicable diseases, but rather focused on the agendas of survey sponsors. She called on the Secretariat to develop a comprehensive and compulsory survey module on noncommunicable diseases and negotiate with survey sponsors to ensure wide-ranging data collection.

Mr LINDGREN (Norway)¹ took note of the proposed work plan for the global coordination mechanism on the prevention and control of noncommunicable diseases covering the period 2016–2017, and the proposal that the general meeting of the global coordination mechanism in 2017 be technical. He commended the initiative proposed by the member for Kuwait and agreed with the role of regional offices in providing technical assistance to Member States. Nevertheless, WHO already had sufficient tools and, through the Political Declaration, guidance on reporting on progress to the United Nations General Assembly in 2017. He supported the proposal by the member for Belgium to use the WHO global noncommunicable disease country capacity survey for data collection, amending it if, and as, necessary. He expected that work to be handled by the Secretariat was an internal technical matter.

Dr GONZÁLEZ FERNANDEZ (Cuba) supported the revised draft decision, as it was right that the Director-General should decide on the most effective framework for reporting progress.

Dr SARIWATI (Indonesia)¹ recognized the significant but insufficient and uneven progress made since 2011, and the need to improve multisectoral collaboration at the national level. Her country remained committed to the 25 outcome indicators and nine voluntary global targets approved by the Sixty-sixth World Health Assembly. Additional process indicators would place an unnecessary burden on Member States. She supported the proposed work plan for the global coordination mechanism for 2016–2017 and asked the Secretariat to strengthen technical support at country level.

Mrs VALLINI (Brazil), supported by Dr REYNDERS (Belgium), who spoke on behalf of the European Union and its Member States, welcomed the clarification provided by the member for Kuwait, and requested the Secretariat to prepare and distribute the proposed draft decision, and any corresponding financial and administrative implications for the Secretariat, to facilitate discussion by Member States.

Mr GHILAGABER (Eritrea) supported the availability of process indicators, as they had been recommended during the high-level meeting of the United Nations General Assembly in 2014 and would be instrumental in assessing progress made in implementing WHO's global action plan at national level. However, he expressed concern about how the indicators would be developed and monitored at that level, particularly in countries with limited capacity. Technical support from the Secretariat in that regard would be essential.

Dr ASADI-LARI (Islamic Republic of Iran) supported the idea of establishing process indicators and endorsed the commitments contained in the outcome document from the high-level

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

meeting in 2014. It was important to provide an accurate assessment of progress in 2017. Indicators would enable Member States to monitor and address emerging challenges, and he therefore encouraged the Board to support the proposal made by the member for Kuwait.

Ms MATSOSO (South Africa) said that it was essential to clarify how the proposed assessment framework would fit in with the other documents and policies governing the prevention and control of noncommunicable diseases, and that would require further consultations.

Mr SEGARD (Canada)¹ stated that sufficient indicators and data already existed for the Director-General to prepare a report. The limited resources of the Secretariat should be used for action, not additional reporting. He agreed with the request from the member for Brazil for the draft decision to be produced in written form.

The CHAIRMAN reminded the Board that the proposal was for a new assessment framework and not for a new set of indicators.

Dr EL BERRI (Morocco),¹ supporting the assessment framework, said that the new framework had been proposed because not all Member States had access to the necessary data.

Ms PUNZO (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, emphasized that noncommunicable diseases were one component of a wider agenda with the same underlying structural, social and economic determinants of health. He expressed disappointment that the terms of reference of the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases and the global coordination mechanism contained no action on those determinants. Member States should adopt process indicators to assess national progress on addressing those underlying determinants, before the high-level meeting in 2018. With regard to the regulation of transnational corporations and the potential implications of trade and investment agreements for noncommunicable diseases, WHO should implement resolution WHA59.26 in order to protect public policy space for health and nutrition. The global coordination mechanism should be tasked with monitoring potential conflicts of interest in the area of noncommunicable diseases.

Ms KOLAPPA (Stichting Health Action International), speaking at the invitation of the CHAIRMAN, cited three instances where campaigns to undermine measures for noncommunicable disease control had been funded by corporations and their interests. Such measures must be driven by the best public health evidence. Member States had the right to regulate the content and marketing of unhealthy foods, and should make full use of the flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights. Their efforts to implement their noncommunicable disease control plans warranted the full support of intergovernmental organizations, including WHO. A robust solution to conflicts of interest had to be found if countries were to control the epidemic of noncommunicable diseases.

Ms MATZKE (Union for International Cancer Control), speaking at the invitation of the CHAIRMAN and on behalf of Alzheimer's Disease International, the Framework Convention Alliance for Tobacco Control, the International Diabetes Federation, the International Union against Tuberculosis and Lung Disease and the Union for International Cancer Control, urged Member States to establish effective national governance for noncommunicable disease control, including the development of national targets, plans and commissions, by the end of 2015. Governments should work with national noncommunicable disease control alliances, engaging them in policy development,

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

service design and monitoring. A strong accountability and monitoring framework and regular benchmarking of progress were required to inform deliberations at future high-level review meetings. She therefore encouraged Member States to support the proposal made by the member for Kuwait.

The DIRECTOR-GENERAL noted that speakers did not want any additional reporting burden or further costly consultations on indicators. The assessment framework proposed by the member for Kuwait contained indicators for which data collection was already provided under the global action plan for 2013–2020 or through the noncommunicable disease country capacity survey. She suggested that the Secretariat organize a briefing for those Member States that sought clarity on those indicators, and encouraged the Board to consider the proposal by the member for Kuwait.

Ms MATSOSO (South Africa) welcomed the proposed briefing, which would enable Member States to better understand the assessment framework and its place in relation to other global, regional and national instruments and monitoring frameworks on noncommunicable diseases, which her country had already begun to implement.

Dr REYNDERS (Belgium), speaking on behalf of the European Union and its Member States, agreed that a briefing would be useful, and reiterated the need for the draft decision to be distributed in written form.

Dr CHESTNOV (Assistant Director-General) took note of requests to strengthen the work of the Secretariat on noncommunicable diseases and to ensure WHO's ongoing leadership in that area. The global coordination mechanism would be helpful in preparing a report and guiding the work of Member States.

Following a request for clarification from Mrs TYSON (United Kingdom of Great Britain and Northern Ireland), the CHAIRMAN confirmed that the proposed briefing would be held before the end of the current session, to enable the Executive Board to take a decision.

(For adoption of a decision, see the summary record of the fourteenth meeting, section 6.)

Global status report on violence and health: Item 6.5 of the Agenda (Documents EB136/12 and EB136/12 Corr.1)

Mr RUSH (United Kingdom of Great Britain and Northern Ireland), backing the development of the global action plan, suggested a streamlined process for its preparation, without compromising Member States' opportunities to comment. In the previous year, his country had hosted three major international summits on aspects of tackling violence against women and girls and significantly increasing funding for programmes on related humanitarian issues, including the elimination of early and forced marriage and female genital mutilation.

Ms HARB (Lebanon), noting that women and children were particularly affected by violence and abuse, called for both preventive and rehabilitative measures, with multisectoral collaboration on social and security dimensions. The Global status report set out recommendations at national level, but WHO should provide support for their implementation, in particular regarding data collection and drafting of care protocols, and for building national capacity. She welcomed the planned consultations on the draft global action plan, encouraging the full involvement of civil society, academia and other stakeholders, including ministries of justice and criminal courts.

Dr REYNDERS (Belgium) said that Global status report, which despite indicating some positive trends presented an extremely worrisome picture, formed a good basis for the draft global action plan. The report's strategies, developed by sharing best practices, agreeing on basic standards and developing guidelines, should result in a persuasive action plan and the more efficient combating of interpersonal violence in national jurisdictions. Belgium remained committed to engaging in the development of the global action plan.

Ms ZHANG Yang (China) requested WHO to increase its support in poor regions; establish coordination mechanisms with other United Nations bodies and international organizations and support countries in setting up multisectoral coordination networks; adopt integrated measures to prevent violence against women and children; create mechanisms for capacity-building at regional and global levels; encourage sharing of experience on legislation in different countries; and ensure that prevention of child maltreatment was at the centre of the early childhood development agenda. Summarizing her country's steps to reduce child abuse, she emphasized that the health sector should play a key role in promoting the collection and sharing of data on violence, offering medical support and promoting physical and mental recovery.

Dr NCHABI KAMWI (Namibia), speaking on behalf of the Member States of the African Region, noted with concern the many indirect costs related to violence, such as unemployment, absenteeism and disability. Given the variety of cultural and social factors underlying the violent crimes committed against women and children, not least those in situations of armed conflict, he agreed that more specific national and subnational data and multistakeholder involvement were required to help countries to prioritize and focus their responses. Commending the Director-General's commitment to capacity-building in Africa, he urged WHO to continue that technical support to help Member States. He agreed with the proposed steps for developing a draft global action plan.

Mr McIFF (United States of America), speaking on behalf of the Member States of the Region of the Americas, said that the current momentum towards a global action plan came at a good time, not least in the Region, which had the highest homicide rates in the world. Emphasizing the staggering social and public health costs and the need for data, he requested the Secretariat to include women, girls and boys throughout the life course in its database on the effectiveness of interventions to prevent violence. He urged Member States to participate fully in consultations on the draft global action plan, and to draw on WHO's expertise and guidance to create a set of practical options for implementation of the health sector response. The Global status report on violence was a firm base on which to develop the draft global action plan with the goal of a world free from violence, but that vision would require a societal transformation. The health sector was well positioned to champion the message that violence was preventable, through an engaged response based on sound science and evidence.

Dr GRABAUSKAS (Lithuania) spoke on behalf of the five Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, the three Baltic countries, Estonia, Latvia and Lithuania, and the Netherlands. The Global status report and resolution WHA67.15 provided a sound basis for the draft action plan. The resolution, which represented a successful compromise on difficult issues, provided the necessary guidance on the action plan's approach and scope, which must be retained. That political mandate meant that the development of a draft plan ought to be a technical process based on evidence. The proposed process for developing the draft action plan was overly elaborate, particularly as it would be inefficient and inappropriate to submit it to the regional committees. He suggested using a more evidence-based, technical and resource-efficient process, such as that for the antimicrobial resistance action plan in 2014 which allowed input from the regional committees. He supported the proposal by the previous speaker for a menu of options of policies that could be refined or adapted at regional or national level.

Dr ASADI-LARI (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, stressed the need to strengthen the health sector within the wider multisectoral context, as it was frequently the first point of professional contact for victims of violence. He urged the Director-General, during development of the draft global action plan, to intensify consultations with Member States, so that their different social and cultural concerns and contexts were taken into consideration and reflected in the plan, and to engage with other bodies in order to ensure coordination across the United Nations system. Given the diverse factors contributing to violence, the best preventive approach might be to concentrate on biopsychosocial aspects, particularly the elimination of poverty and discrimination. He proposed establishing a regional common platform on violence and health, so that socioculturally homogenous countries could exchange their best practices.

He also outlined the steps taken in his country to integrating activities to reduce violence into the national primary health care network.

Mr COTTERELL (Australia) welcomed WHO's work on the links between alcohol, gender-based violence and HIV infection, but noted with concern that some parts of the programme budget for the current biennium for the violence and injuries programme area remained unfunded. He supported the timeline for regional consultations on the draft global action plan, supported its collaboration within the United Nations system, and urged greater involvement of smaller Member States.

Dr ALKHAWARI (Kuwait) said that the extent of violence against children in her country could not be quantified owing to lack of statistical data. Although hospital admission figures existed, many cases went unreported. As governmental and nongovernmental efforts to combat the growing problem had not achieved their objectives, a higher national committee had been established. Its achievements included: the development of a national programme to combat violence; the introduction of multidisciplinary child protection teams in all hospitals; the institution of mechanisms, including a hotline, for reporting suspected cases; information and data collection; the conduct of national surveys; promotion of research; organization of a community awareness campaign; and a review of legislation on children's rights currently being considered by the National Assembly.

Mrs VALLINI (Brazil), stressing the importance of political commitment to addressing violence, said that the role of the health sector should be strengthened through prevention, control and advocacy activities. Her Government had been improving surveillance systems, training professionals, producing operational guides and protocols, and developing and enhancing intersectoral policies. Documents such as the Global status report should include only validated data. The coverage, definitions, sources and methods of data collection used by local information systems must be taken into account, to ensure that they did not lead to inappropriate conclusions in international comparisons.

Ms ROA RODRIGUEZ (Panama) said that violence should be tackled in a comprehensive manner throughout the life course. More research was needed at country level on gender issues and the capacity of health systems; that would require an information system with indicators for monitoring risk factors and their control in order to enable informed decision-making. She outlined steps taken in her country, including reform of the penal code, development of a national plan against domestic violence, and coordinated multisectoral activities. She welcomed the development of a draft global action plan, which must be flexible and adaptable to individual country situations.

Dr MAKASA (Zambia)¹ supported the proposed consultation process for developing a draft global action plan, whose main focus should be technical. Political will would be essential for its implementation. Member States needed more technical support for the development of national action plans and data collection, to ensure that future global status reports reflected the actual situation. His Government was committed to strengthening its health system so as to address interpersonal violence.

Mr CANDIA IBARRA (Paraguay)¹ welcomed the detailed report and noted its recommendations. Much work needed to be done and the consultative process and development of the draft global action plan must be open-ended and inclusive.

Mr PRAKASH (India),¹ underlining his country's commitment to reducing all violence, particularly sexual offences against women and children, outlined measures taken, including the adoption of legislation and the establishment of crisis centres for women and children. It was important to develop guidelines on non-violent disciplinary techniques for parents, teachers and carers, and to research the impact of violence depicted in television shows, films, and computer games on behaviour. In addition, injury and violence prevention should be incorporated into school, college, medical and nursing curricula in order to change attitudes.

Dr ANGKANA SOMMANUSTWEECHAI (Thailand)¹ expressed concern that the Global status report had not adequately addressed the potential role of the primary health care system at the local level, which needed to be enhanced. The draft global action plan should pay attention to rehabilitation of offenders, besides implementing policies and enforcing regulations, and to the link between the social determinants of violence and socioeconomic development. Timely, relevant and consistent information on violence should be collected from multiple sectors, rather than solely from the health sector.

Mr SAGUNI (Indonesia),¹ outlining the burden of violence in his country, said that his Government had adopted the key recommendations of the Global status report and was strengthening the policy framework on violence. More work was needed at the primary health care level to detect cases of violence and improve reporting.

Ms RUIZ VARGAS (Mexico)¹ said that her country was working to improve collection of data on violence and to address the issue from a health perspective, in collaboration with other sectors. WHO should play a leading role in assessing programmes to ensure their effectiveness. The global action plan should facilitate the strengthening of health systems and enable analysis to be made and actions to be taken based on individual country situations.

Mr DE MIRANDA (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, said that the proposed global action plan should recognize the significant impact of psychological violence on mental health and the need to engage men and boys to challenge traditional stereotypes of masculinity. Moreover, attention should be paid to violence and bullying between children and adolescents, including cyberbullying, and to ensuring that health care professionals were obliged to report all cases of domestic and sexual violence, be they against men or women.

Dr BUSTREO (Assistant Director-General) welcomed the suggestions made about the need for extensive consultations with countries during development of the draft global action plan. Those consultations would principally be technical in nature. The Secretariat would consult with related

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

bodies within the United Nations system, including UNICEF and UN Women, to ensure that the responsibilities of the health sector were clearly articulated in their approaches.

The Board noted the report and agreed to the proposed timeline for development of a draft global action plan on violence and health.

Global burden of epilepsy and the need for coordinated action at the country level to address its health, social and public knowledge implications: Item 6.6 of the Agenda (Document EB136/13) (continued from the fifth meeting, section 2)

The CHAIRMAN drew attention to a draft resolution sponsored by China, Maldives and the Russian Federation, which read:

The Executive Board,

Having considered the report on the global burden of epilepsy and the need for coordinated action at the country level to address its health, social and public knowledge implications,¹

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

The Sixty-eighth World Health Assembly,

(PP1) Considering resolution WHA66.8, in which the Health Assembly adopted the comprehensive mental health action plan 2013–2020, and resolution WHA67.22 on access to essential medicines;

(PP2) Acknowledging United Nations General Assembly resolution 68/269 and resolution WHA57.10 on road safety and health, resolution WHA66.12 on neglected tropical diseases, resolution WHA67.10 on the newborn health action plan, resolution WHA67.15 on strengthening the role of the health system in addressing violence, in particular against women and girls, and against children, and the discussions on the control of neurocysticercosis and its association with epilepsy at the Fifty-sixth World Health Assembly;²

(PP3) Noting the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases (resolution A/RES/66/2) at which Heads of State and Government recognized that mental and neurological disorders are an important cause of morbidity and contribute to the global noncommunicable disease burden, necessitating provision of equitable access to effective programmes and health-care interventions;

(PP4) Considering the Millennium Development Goals, the outcome document of the United Nations Conference on Sustainable Development entitled “The future we want” (resolution A/RES/66/288), and the Report of the Open Working Group on Sustainable Development Goals established pursuant to General Assembly resolution A/RES/66/288 which proposes a Goal 3 (Ensure healthy lives and promote well-being for all at all ages) and target 3.4 (by 2030 reduce by one-third premature mortality from non-communicable diseases (NCDs) through prevention and treatment, and promote mental health and well-being);

(PP5) Recognizing that epilepsy is one of the most common serious chronic neurological diseases, affecting 50 million people of all ages globally, and that people

¹ Document EB136/13.

² See document WHA56/2003/REC/3, summary record of the fourth meeting of Committee A.

with epilepsy are often subjected to stigmatization and discrimination because of ignorance, misconceptions and negative attitudes surrounding the disease, and that they face serious difficulties in, for example, education, employment, marriage and reproduction;

(PP5bis) Noting with concern that the magnitude of epilepsy affects people of all ages, gender, race and income levels, and further that poor populations and those living in vulnerable situations, in particular in low- and middle-income countries, bear a disproportionate burden, posing a threat to public health and economic and social development;

(PP6) Cognizant that large differences exist in the level of epilepsy management in different countries, with, for example, the median number of neurologists in low-income countries standing at only 0.03/100 000 population, that the essential antiepileptic medicines are often unavailable, that the treatment gap is estimated to be over 75% in low-income countries and substantially higher in rural areas than in urban areas;

(PP7) Noting that the majority of people with epilepsy can be free from seizures if appropriately treated with cost-effective, affordable antiepileptic medicines;

(PP8) Recognizing in addition that certain causes of epilepsy can be prevented and that such preventive action can be promoted in the health sector and in sectors outside health;

(PP9) Aware that in 1997, WHO and two international nongovernmental organizations, the International League Against Epilepsy and the International Bureau for Epilepsy, launched the Global Campaign against Epilepsy – “Out of the Shadows” and in 2008 WHO launched its mental health gap action programme, that provided a sound basis for WHO to further lead and coordinate global development work on epilepsy;

(PP10) Aware also that practice in China and some other low-income countries has proved that country-level coordinated action may be very effective in controlling the disease and improving the quality of life of millions of people with epilepsy at little cost;

(PP11) Recognizing the remarkable progress made recently in the technology of epilepsy management, from basic research to diagnosis and treatment;

(PP12) Considering that international governmental organizations, nongovernmental organizations, academic societies and other bodies have recently enhanced their investment in epilepsy management and have undertaken a significant amount of work in collaboration with national governments, as the International League Against Epilepsy and the International Bureau for Epilepsy, which have official relations with WHO and have been collaborating with WHO in epilepsy management for several decades;

(PP13) Recognizing the role of WHO to demonstrate further leadership and coordination and take effective action for epilepsy management, in view of the large public health impact,

(OP1) 1. URGES Member States:¹

(1) to strengthen effective leadership and governance, ensure that policies on general health, mental health and noncommunicable diseases include consideration of the specific needs of people with epilepsy, and make the financial, human and other resources available that have been identified, as necessary, to implement evidence-based plans and actions;

(2) to introduce and implement, where necessary and in accordance with international human rights norms and standards, national health care plans of action

¹ And, where applicable, regional economic integration organizations.

for epilepsy management, aiming to overcome inequalities and inequities in health, social and other related services, paying special attention to people with epilepsy living in conditions of vulnerability, such as those living in poor and remote areas, including by strengthening public health care services, and training local human resources with proper techniques;

(3) to integrate epilepsy management, within the context of universal health coverage, into primary health care, where appropriate, in order to help to reduce the epilepsy treatment gap, by training non-specialist health care providers to provide them with basic knowledge for the management of epilepsy so that epilepsy can be diagnosed and treated in primary health care settings, by ensuring a strong and functional referral system and by strengthening health information and surveillance systems to routinely collect, report, analyse and evaluate trends on epilepsy management;

(4) to support the establishment and implementation of strategies for the management of epilepsy, particularly to improve accessibility to and promote affordability of safe, effective and quality assured antiepileptic medicines and include essential antiepileptic medicines into national lists of essential medicines;

(5) to ensure public awareness of and education about epilepsy, in order to help to reduce the misconceptions, stigmatization and discrimination regarding people with epilepsy and their families that are widespread in many countries and regions;

(6) to improve investment in epilepsy research and increase research capacity;

(7) to engage with civil society and other partners in the actions referred to in subparagraphs 1(1) to 1(6) above;

(OP2) 2. INVITES international, regional, national and local partners from within the health sector and beyond to engage in, and support, the implementation of the actions set out in subparagraphs 1(1) to 1(6) above;

(OP3) 3. REQUESTS the Director-General:

(1) to review and evaluate actions relevant to epilepsy that WHO has been leading, coordinating and supporting in order to identify, summarize and integrate the relevant best practices with a view to making this information widely available, especially in low- and middle-income countries;

(2) to develop, in consultation with relevant stakeholders, on the basis of work requested in paragraph (1), a set of technical recommendations guiding Member States, in the development and implementation of epilepsy programmes and services, and to provide technical support to Member States in actions for epilepsy management, especially in low- and middle-income countries;

(3) to report back to the Seventy-first World Health Assembly on progress in the implementation of this resolution.

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

1. Resolution: Global burden of epilepsy and the need for coordinated action at the country level to address its health, social and public knowledge implications	
2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)	
Category: 2. Noncommunicable diseases	
Programme area(s): Mental health and substance abuse	Outcome: 2.2. Increased access to services for mental health and substance use disorders Output: 2.2.2. Mental health promotion, prevention, treatment and recovery services improved through advocacy, better guidance and tools on integrated mental health services
How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)? The review and evaluation of actions for epilepsy prevention and control, which WHO has been leading, coordinating and supporting, will establish a set of best practices to Member States, and especially to low- and middle-income countries. In addition, the introduction and implementation of national epilepsy programmes and services will provide technical and, wherever possible, financial support to Member States for epilepsy prevention and control. Most importantly, the implementation of actions as proposed in the resolution – strengthening of leadership, governance and implementation of policies and plans for epilepsy prevention and control; integration of epilepsy management in primary health care; increased awareness; investments in research; monitoring of the progress of Member States’ coordinated country-level actions for epilepsy prevention and control and the establishment of international partnerships – will altogether increase access to services for mental health and substance use disorders (Outcome 2.2).	
Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no) Yes.	
3. Estimated cost and staffing implications in relation to the Programme budget	
(a) Total cost Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000). (i) Five and a half years (covering the period July 2015 – December 2020, in accordance with the duration of the comprehensive mental health action plan 2013–2020). (ii) Total: US\$ 25 million (staff: US\$ 11 million; activities: US\$ 14 million).	
(b) Cost for the biennium 2014–2015 Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000). Total: US\$ 700 000 (staff: US\$ 200 000; activities: US\$ 500 000). Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant. Headquarters. Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no) Yes. If “no”, indicate how much is not included.	

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

No.

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

No additional staff will be required for the biennium 2014–2015. WHO staff will lead the conceptualization and introduction and formulate the timeline of the epilepsy programme for which implementation will begin in 2016. From January 2016, the following staff additions will be required:

At headquarters: 1.5 staff members (one international expert in public health and neurology (100% full-time equivalent) at grade P.4, and one secretary (50% full-time equivalent) at grade G.5).

In each of the six regions: 0.5 staff members (six international experts in public health and neurology with knowledge of the needs in their respective regions (50% full-time equivalent; grade P.4)).

4. Funding**Is the estimated cost for the biennium 2014–2015 indicated in 3(b) fully funded? (Yes/no)**

No.

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

US\$ 500 000 needs to be mobilized to cover the implementation of activities on the prevention and control of epilepsy from July to December 2015 through the Organization’s coordinated resource mobilization plan for dealing with funding shortfalls in the Programme budget 2014–2015. WHO collaborating centres and a network of experts and civil society stakeholders will be utilized for taking forward the activities. For the second half of 2015, implementation will be with existing staff, and additional qualified staff will be recruited from January 2016.

Ms RU Lixia (China) said that many low- and middle-income countries lacked adequately trained health professionals and diagnostic tools, with suitable medications being in short supply. Coordinated action at country level could enable those affected by epilepsy to control their symptoms and improve their quality of life at a relatively low cost.

Dr NIK JASMIN NIK MAHIR (Malaysia), endorsing the draft resolution, said that a global action plan on epilepsy prevention and control would provide guidance to Member States, particularly low- and middle-income countries. She expressed the hope that the resolution would be adopted and put into effect in a phased manner, so as to facilitate capacity-building activities that would enable the implementation of national programmes and services.

Given the floor by the CHAIRMAN in response to a request by Dr EERSEL (Suriname), Mrs BERGARA (Uruguay),¹ speaking on behalf of the Union of South American Nations, affirmed the existence of often-significant treatment gaps as a result of a lack of medicines, insufficient trained personnel and the low priority given to treatment of epilepsy. It was therefore necessary to strengthen national epilepsy programmes to include health promotion and disease prevention, with emphasis on the physical, psychological and social well-being of persons living with epilepsy. WHO should develop technical guidance for, and provide technical support to, Member States in that regard.

The meeting rose at 12:30.

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

FOURTEENTH MEETING

Monday, 2 February 2015, at 14:35

Chairman: Mr M.H. SHAREEF (Maldives)

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

Global burden of epilepsy and the need for coordinated action at the country level to address its health, social and public knowledge implications: Item 6.6 of the Agenda (Document EB136/13) (continued)

Dr CHAND (Nepal) supported the draft resolution but proposed several amendments. In subparagraph 1(1), the phrase “, ensure that” should be replaced by “for”, and the word “that” should be inserted after “diseases”, the amended sentence thus beginning: “to strengthen effective leadership and governance for policies on general health, mental health and noncommunicable diseases that include ...”. He proposed inserting a new subparagraph 1(6): “to promote actions to prevent causes of epilepsy, using evidence-based interventions, within the health sector and in other sectors outside health”, with the present subparagraphs 1(6) and 1(7) being renumbered accordingly. The rationale for the insertion was connected with the eighth preambular paragraph.

Dr AKSEL’ROD (Russian Federation) agreed that the amendments proposed by the member for Nepal improved the text. The global burden of epilepsy demanded the attention of WHO and needed wide-ranging measures, including improved treatment, policies that covered access to and availability and affordability of care and activities to reduce stigmatization. The Secretariat should prepare a set of technical recommendations, including guidelines, for Member States on how to develop and implement programmes and services for people with epilepsy, and provide technical support to low- and middle-income countries.

Mr JEON Man-bok (Republic of Korea) fully supported the draft resolution. He looked forward to close cooperation between the Secretariat and Member States.

Dr USHIO (Japan) welcomed the identification of the need to improve diagnosis and treatment capabilities at the primary health care level. To reduce geographical disparities, Japan was working to establish a regional medical care coordination system that would designate centres of expertise and create models of support structures. Japan wished to sponsor the draft resolution.

Mr MIŠKINIS (Lithuania) recognized the need for coordinated action at global, regional and national levels. He recalled the European Parliament’s statement on epilepsy in 2011 and the steps his country had taken to ensure treatment, rehabilitation and social integration of people with epilepsy, including the drafting of a national programme. He endorsed the proposed actions to improve epilepsy care, and supported the draft resolution.

Ms MUKUNDJI (Democratic Republic of the Congo), speaking on behalf of the African group, said that the Regional Office for Africa was finalizing the regional report on epilepsy that emphasized public awareness, research, policy development and community involvement. Countries such as Ethiopia and Nigeria had successfully integrated actions to tackle epilepsy in their health systems, and pilot projects had been implemented in Senegal, Zambia and Zimbabwe. With technical and financial

support from WHO, civil society organizations were active, with significant community involvement, in Benin, the Democratic Republic of Congo and Namibia. Countries needed to focus on awareness-raising, research and the availability of medicines, and coordinate the activities of stakeholders.

Ms HARB (Lebanon) endorsed the actions proposed in the report but identified obstacles to the provision of services in primary health care centres, principally access to and affordability of medicines. Social stigmatization had to be tackled through awareness campaigns. Strong health information and surveillance systems were needed to ensure sustainability of care. The action taken at country level needed to be closely coordinated, with significant civil society involvement.

Dr MOURAD (Egypt), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that epilepsy was one of the three most frequently encountered neurological disorders in primary care settings in 20 of the Region's 22 countries. She strongly supported the actions outlined in the report and requested the Director-General to provide technical support to Member States in order to counter stigmatization and discrimination through better understanding and awareness of mental health in general and epilepsy in particular; to ensure integrated provision of epilepsy care within the general health care system, with special emphasis on ensuring regular supplies of anti-epileptic medicines by strengthening implementation of the Mental Health Gap Action Programme; and to include actions for epilepsy prevention in programmes for road safety, antenatal and perinatal care, immunization, and prevention and control of noncommunicable diseases.

Dr ASADI-LARI (Islamic Republic of Iran) said that by integrating epilepsy detection and management into its health care network 20 years previously, his country had significantly improved the provision of care, but much remained to be done to reduce stigmatization. He supported the draft resolution and his country wished to cosponsor it. He proposed several minor amendments: in the first line of subparagraph 1(3), insertion of the phrase "including health and social care, particularly community-based services" after "management" and of the words "including community-based rehabilitation" after "universal health coverage"; in the fourth line of the same subparagraph, the words "diagnosed and treated" should be replaced by "diagnosed, treated and maintained as much as possible"; in the fifth line of that subparagraph, the phrase "as well as by empowering epileptic people and their carers for greater specified self and home care programmes" should be inserted after "settings"; and in subparagraph 1(5), the words "in particular in primary and secondary schools" should be inserted after "education about epilepsy,".

Mr KOLKER (United States of America) supported the draft resolution. He encouraged the Secretariat to provide guidance and technical support to Member States in implementing prevention and treatment programmes. Member States and their partners must combat the stigmatization associated with epilepsy. Increased multisectoral action was needed to disseminate, implement and evaluate effective prevention and treatment programmes in health care settings, communities and homes.

Ms ROA RODRIGUEZ (Panama) said that equal access to health care was essential and efforts must be made to strengthen health teams at the primary care level. Public awareness-raising was also central to overcoming the stigmatization related to epilepsy. Panama wished to cosponsor the draft resolution, which would strengthen leadership and governance.

Dr ASSIRI (Saudi Arabia) supported the amendments proposed by the member for the Islamic Republic of Iran. The current epilepsy burden, large treatment gap and widespread misconceptions about the causes and management of epilepsy warranted the actions proposed in the draft resolution. Implementation of the Mental Health Gap Action Programme should be strengthened. Resources must be used rationally: epilepsy was basically a clinical diagnosis, with other tests only required to confirm a diagnosis or determine the underlying cause. Action should be taken to improve road safety, enhance

antenatal and perinatal care, increase immunization coverage and strengthen the prevention and control of noncommunicable diseases.

Dr BEJTJA (Albania) said that more research and innovation were needed for early diagnosis and treatment of epilepsy. An integrated, broad-based, multisectoral approach anchored in human rights was essential to ensure equal access to treatment and care.

Dr EERSEL (Suriname) supported the draft resolution as amended. Although she agreed with concerns about the increasing number of resolutions and the resultant burden on Member States, increasing the visibility of epilepsy on health agendas should not be particularly complex or costly. It was essential to bridge the treatment gap and to raise awareness. Treatment guidelines should be issued and anti-epileptic medications should be included in lists of essential medicines.

Dr KREMER (Argentina) agreed that epilepsy should be recognized as a major public health problem. Systems to monitor prevalence should be strengthened, and efforts made to provide treatment free of charge. Despite targeted action in the Region of the Americas, shortcomings in the system for dealing with epilepsy remained. Argentina wished to be added to the list of cosponsors of the draft resolution. He proposed an amendment to subparagraph 1(3), to refer to access to health as well as “universal health coverage”.

Mr COTTERELL (Australia) affirmed the need for more coordinated action, in particular to reduce the stigmatization often associated with epilepsy: health care professionals, especially at primary level, should be trained to overcome any negative attitudes with regard to treating epilepsy patients. He supported the draft resolution, as amended by the member for Nepal.

Mr RASHEED (Maldives) agreed that coordinated action on epilepsy at the country level was urgently needed. In more than 50% of epilepsy cases, mostly in resource-poor low-income countries, the cause of the disease was not identified. Preventive measures must be carried out and appropriate care provided. He supported the draft resolution and the amendments proposed by the member for Nepal.

Mrs VALLINI (Brazil) said that the Strategy and Plan of Action on Epilepsy 2012–2021 for the Region of the Americas represented a milestone in the development of specific health programmes and legislation in the Region. She underscored the importance of multisectoral action to strengthen health systems in order to ensure correct diagnosis and access to treatment without stigmatization. She endorsed the amendment proposed by the member for Argentina.

Mr SEGARD (Canada)¹ emphasized the importance of a human rights-based approach to epilepsy, in particular of taking measures to overcome the stigma attached to it; a collaborative approach involving civil society and other health partners, and the role of local communities in communication and rehabilitation. More research was needed into neurological conditions such as epilepsy. Prevention was particularly important, and Member States should fill the gaps in mental health policy.

Ms STREȘINĂ (Romania)¹ supported the call for coordinated action at country level to raise awareness, improve treatment and share experiences and best practices in epilepsy management. She outlined the situation in her country, which had national programmes for treatment in place, but recognized that more needed to be done. She welcomed the political focus on epilepsy, the application of WHO's expertise in Member States, and the draft resolution.

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

Mr BERTONI (Italy)¹ said that epilepsy was best addressed through national health care plans to optimize practices and resources; his country recognized the need to adopt legislative improvements. Inclusion of epilepsy on the Board's agenda should stimulate coordinated action worldwide. He supported the draft resolution and said that epilepsy must be addressed through health care plans adopted at country level.

Mr MÍČ (Czech Republic)¹ strongly supported the actions proposed for care at national levels, in particular establishing specialized care centres for people with intractable epilepsy, raising public awareness and providing education (including information about first aid in the event of seizures), and ensuring access to essential medicines (such as the buccal form of midazolam, which can be administered by laymen as well as health professionals). WHO guidance at regional and global levels would be welcome.

Mr KRANIAS (Greece)¹ deplored the social stigmatization and restricted access to treatment and care faced by people with epilepsy, despite the availability of affordable medicines. His Government would work with WHO and other stakeholders to improve public awareness and enhance the quality of care for people with epilepsy and facilitate their integration into society.

Mr PRAKASH (India)¹ drew attention to the disproportionate impact epilepsy had in developing countries, and the need to reduce stigmatization and to focus on prevention and management. Large shortages of trained health professionals impaired efforts in that regard. He supported the draft resolution, as amended.

Dr THANAPHAN SUKSA-ARD (Thailand)¹ supported the draft resolution as amended by the member for Nepal and the amendment on universal access proposed by the member for Argentina. Prevention, early diagnosis, continuity of treatment and access to care were crucial within the strategy of universal health coverage, which she asked WHO and development partners to continue promoting. Efforts must be made to integrate epilepsy into national health care systems, promote human rights and prevent stigmatization.

Dr COVANIS (International Bureau for Epilepsy), speaking at the invitation of the CHAIRMAN, said that in many cases legislation to protect people with epilepsy was neither in place nor applied. His organization supported the draft resolution and stood ready to work with WHO and other stakeholders to increase public awareness and education, fight stigmatization, protect human rights, prevent epilepsy, fill the treatment gap and invest in epilepsy research.

Professor PERUCCA (International League Against Epilepsy), speaking at the invitation of the CHAIRMAN, said that, with appropriate and cheap treatment sudden unexpected deaths from seizures, which represented the second cause of mortality from neurological disease after strokes, could be prevented. His organization supported the draft resolution and was committed to working closely with WHO, particularly through efforts to foster capacity-building, promote North–South and South–South cooperation, train health care professionals at national and regional levels, and assist in developing cost-effective programmes for epilepsy treatment and care. People with epilepsy often suffered more from neglect and social isolation than from the physical manifestations of the disease.

Dr CHESTNOV (Assistant Director-General) thanked members for their proposed amendments and for the requests for technical support, including special support for low- and middle-income countries.

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

The Board noted the report.

After a discussion in which Mr COTTERELL (Australia), Mrs VALLINI (Brazil), Ms RU Lixia (China) and Mr KOLKER (United States of America) took part, Dr KREMER (Argentina) withdrew his proposed amendment to the draft resolution.

The resolution, as amended, was adopted.¹

2. PROGRAMME AND BUDGET MATTERS: Item 11 of the Agenda (continued)

Strategic budget space allocation: Item 11.3 of the Agenda (Document EB136/35) (continued from the twelfth meeting, section 1)

The CHAIRMAN drew attention to a revised draft decision which read:

The Executive Board, having considered the report on strategic budget space allocation² and the report by the Working Group on Strategic Budget Space Allocation,³

- (1) welcomed the report of the Working Group on the Strategic Budget Space Allocation and expressed its appreciation to the members of the Working Group for their diligence in developing a methodology in an objective and timely manner;
- (2) endorsed the guiding principles recommended by the Working Group;
- (3) requested the Director-General, with respect to the Proposed programme budget 2016–2017:
 - (a) to apply the recommendations of the Working Group with regards to operational segments 2 (provision of global and regional goods), 3 (management and administration) and 4 (response to emergency events, such as outbreak and crisis response);
 - (b) to propose, **in consultation with the Global Policy Group (GPG)**, an allocation of budget space for operational segment 1 (technical cooperation at country level), **by applying the guiding principles of the new methodology, the three pillars for the preparation of the 2016–2017 Programme budget (bottom-up approach, realistic costing of outputs and clear roles and responsibilities across the three levels of the Organization) as requested in decision WHA66(9), and taking into account the needs of various regions and comments made by the 136th session of the Executive Board;**
- (4) requested the Working Group on Strategic Budget Space Allocation to continue its work to further develop operational segment 1 (technical cooperation at country level) taking into consideration the issues raised during the 136th session of the Executive Board with regards to the **proposed methodology, the choice of appropriate indicators and availability of data, and written comments submitted by Member States to the**

¹ Resolution EB136.R8.

² Document EB136/35.

³ Document EB136/35, Annex.

Secretariat by 28 February 2015, and report to the Programme Budget Administration Committee ~~Executive Board~~ at its ~~137th~~ Twenty-second session in May 2015.

The DIRECTOR-GENERAL, summarizing the Board's discussions on the draft decision, said that Member States had wanted the consensus reached on segments 2, 3 and 4 to be applied, but had requested consultations on segment 1 between the Director-General and the six regional directors. Those consultations could be held in March 2015 before the final draft of the Proposed programme budget 2016–2017 was submitted to the Sixty-eighth World Health Assembly. Member States had also wanted the Working Group on Strategic Budget Space Allocation to continue its deliberations and its membership to be extended to two members from each region. The Working Group would report back in May 2015 on whether consensus had been reached on segment 1. When consensus was achieved and all Member States supported the Group's work, the Director-General would apply the agreed methodology to all four segments of the Proposed programme budget 2018–2019.

Mr COTTERELL (Australia), noting with satisfaction the Director-General's clarification on paragraph 3 of the draft decision, requested further reassurance on the principle of limiting the shift in the budget space allocation to no more than 2% per biennium, as proposed by the Working Group. Changes in budgeting should be smooth, to prevent the closure of offices and major staff losses. He supported the expansion of the Working Group membership but expressed concern that the Programme, Budget and Administration Committee could become overloaded as a result of the last amendment to paragraph 4 of the draft resolution, which requested the Working Group to report to the Committee instead of the Board, and the proposal made under another agenda item to shorten the duration of the Committee's meeting by one day.

Dr CHAND (Nepal) said that the reference to "comments made by the 136th session of Executive Board" contained in paragraph 3(b) should be expanded to reflect the burden of disease, poverty and health needs of the Member States. He endorsed the proposal to increase the membership of the Working Group.

Dr ASADI-LARI (Islamic Republic of Iran) also expressed support for the proposed extension of the Working Group membership.

Dr GRABAUSKAS (Lithuania) welcomed the proposal on the Working Group membership, but requested that Belgium continue to chair the Group.

The CHAIRMAN asked the member for Australia to elaborate on the suggested wording of amendments to the draft decision.

Mr COTTERELL (Australia) proposed a new paragraph 5 that would read: "decided to expand the membership of the Working Group on Strategic Budget Space Allocation to two Member States per region". In relation to the last amendment in paragraph 4, he suggested reverting to the original text.

The DIRECTOR-GENERAL noted the general agreement on expanding the membership of the Working Group and requested that the names of the new members be provided. On the 2% principle, no agreement had been reached on segment 1 and therefore none of the models could be used. She reassured the member for Australia that it was not WHO's intention to close offices or cut staff numbers.

The draft decision, as amended, was adopted.¹

3. FINANCIAL MATTERS: Item 12 of the Agenda

Draft financial strategy for WHO: Item 12.1 of the Agenda (Document EB136/36)

Dr GRABAUSKAS (Lithuania), speaking on behalf of the Nordic and Baltic countries, Denmark, Estonia, Finland, Iceland, Latvia, Lithuania, Norway and Sweden, welcomed the integration of different aspects of financial reform into one coherent document. The strategic direction of the work should be applied more clearly in future versions. On the area of programming and budgeting, he asked how adopted resolutions and their financial implications were taken into account in the budgeting process, and what was being done to ensure alignment of resolutions with the General Programme of Work and the related programme budgets, as requested in decision WHA67(8).

Regarding resource mobilization, he endorsed the four guiding principles of WHO's financing and said that resources should be mobilized in line with the approved Programme budget and in a coherent way throughout WHO. The financing dialogue for the Proposed programme budget 2016–2017 should be based on the format of the first financing dialogue. Broadening the contributor base was central to reducing the financial vulnerability of the Organization. Trust between the Secretariat, Member States and other contributors was essential for successful resource mobilization, and commitment to accountability and transparency was important to ensure healthy financing. He highlighted the need to ensure timely and good-quality reporting, bringing together financial and technical information, and to standardize agreements for voluntary contributions.

Dr DAHN (Liberia), speaking on behalf of the Member States of the African Region, said that the draft financial strategy met the Member States' expectations of mutual accountability. She noted with appreciation the bottom-up programme planning process and endorsed the establishment of a coordinated resource mobilization unit and the broadening of the contributor base. Strategies should be developed to "bring on board" Member States that were not providing a fair share of financing, and guidelines and a framework were needed to explore resource mobilization through philanthropic and multilateral institutions and global health initiatives. She commended the efforts to strengthen financial accountability and transparency.

Mr COTTERELL (Australia) welcomed the continued work to integrate programming and budgeting processes with resource mobilization, risk management and accountability, and the establishment of the coordinated resource mobilization unit. The clear financial strategy would contribute to attaining the objective of the financing dialogue, namely to ensure a match between WHO's resources and deliverables.

Ms PENEVEYRE (Switzerland)² said that the report provided a clear overview of the current work on financing, budgeting, management and reporting, and that the financing dialogue had helped to strengthen trust in the Organization. Further efforts were required, however, and should focus on more flexible funding. She also welcomed the establishment of the coordinated resource mobilization unit. Introducing risk management tools was pivotal to ensure the smooth running and credibility of WHO. Member States' support for tighter control of direct financial cooperation would ensure that good use was made of the resources available to WHO and that the potential risks associated with such activities were reduced. She welcomed the proposal to standardize agreements for voluntary

¹ Decision EB136(5).

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

contributions with a view to limiting the reporting burden. The combination of technical reports and financial information would help to provide a fuller picture and enable a direct link to be made with evaluation reports.

Dr TROEDSSON (Assistant Director-General) said that the Secretariat would consult further with Member States and reflect their views in an updated version of the report that would be submitted to the Board through the Programme, Budget and Administration Committee.

The Board noted the report.

Scale of assessments for 2016–2017: Item 12.2 of the Agenda (Document EB136/37)

The CHAIRMAN drew attention to the report of the Programme, Budget and Administration Committee (document EB136/3), which contained a recommendation that the Board adopt the draft resolution contained in document EB136/37.

The resolution was adopted.¹

4. MANAGEMENT AND GOVERNANCE MATTERS: Item 13 of the Agenda

Evaluation: Item 13.1 of the Agenda (Document EB136/38)

The CHAIRMAN drew attention to the discussion on the topic by the Programme, Budget and Administration Committee (document EB136/3, paragraphs 42–44).

The Board noted the report.

Real estate: update on the Geneva buildings renovation strategy: Item 13.2 of the Agenda (Document EB136/39)

The CHAIRMAN drew attention to the discussion on the topic by the Programme, Budget and Administration Committee (document EB136/3, paragraphs 45–51).

Ms MUKUNDJI (Democratic Republic of the Congo), speaking on behalf of the Member States of the African Region, supported the Secretariat's choice of option 1 for the renovation of the buildings on WHO's headquarters site. She encouraged WHO to continue to seek advice from other Geneva-based United Nations entities concerning their recent construction and renovation projects. She sought clarification on how the Organization proposed to meet the funding gap of 110 million Swiss francs for the project. It would be helpful to receive architectural plans that indicated which buildings would be renovated or demolished.

Ms HERNÁNDEZ NARVÁEZ (Mexico)² endorsed the view that the Secretariat should seek and share lessons learned from similar projects within the United Nations system. The United Nations capital master plan for the headquarters building in New York demonstrated the value of establishing a robust feasibility study, a risk assessment and risk mitigation approach, and a strong governance

¹ Resolution EB136.R9.

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

structure. The feasibility study should include a schedule of works, the total costs and a risk–benefit analysis, cash flow projections and an implementation plan. The governance structure must include a governing board to steer the project and ensure that it remained within financial and time limits. There should also be independent oversight of the project. She requested that the Organization keep Member States informed of the progress of the project in a detailed and transparent manner.

Mr LEWIS (Canada)¹ said that appropriate facilities were a key enabler for ensuring that WHO could fulfil its mandate. Although it would not be possible to have a full dossier on the headquarters renovation for the Health Assembly in May 2015, the Secretariat should provide Member States with key elements of information in order to enable them to carry out their governance function: what potential costs could arise over the course of the project and had they been included in the budget estimate; a more in-depth financing plan that included contingencies – WHO must apply the lessons acquired in the course of recent projects in the Geneva area; and a well-considered life-cycle management plan and maintenance strategy, in order to keep the facilities fit for purpose and to extend their lifespan.

Mr BOISNEL (France)¹ underscored the need to receive up-to-date information on the finances and the options available as the project progressed, so that Member States could exercise their governance role.

Dr TROEDSSON (Assistant Director-General) said that a full financing plan and a project proposal that included a risk analysis would be presented to Member States in 2016. An update, with details on the financing, would be provided in May 2015. Members' comments would be taken into account in preparing the information. There would be no funding shortfall as there would an interest-free loan from the Government of Switzerland and the Real Estate Fund would support the project.

The Board noted the report.

Reports of committees of the Executive Board: Item 13.3 of the Agenda

- **Standing Committee on Nongovernmental Organizations** (Document EB136/40)

The CHAIRMAN invited the Board to consider the draft resolution and draft decision contained in the report.

The resolution and the decision were adopted.²

- **Foundations and awards** (Document EB136/41)

Dr A.T. Shousha Foundation Prize

Decision: The Executive Board, having considered the report of the Dr A.T. Shousha Foundation Prize Committee, awarded the Dr A.T. Shousha Foundation Prize for 2015 to Dr Yagoub Yousef Al Mazrou from Saudi Arabia. The laureate will receive the equivalent of 2500 Swiss francs in United States dollars.³

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

² Resolution EB136.R10 and decision EB136(6), respectively.

³ Decision EB136(7).

Jacques Pariset Foundation Fellowship

The Board took note of the decision by the Foundation Committee of the Jacques Pariset Foundation to dissolve the Foundation.

Sasakawa Health Prize

Decision: The Executive Board, having considered the report of the Sasakawa Health Prize Selection Panel, awarded the Sasakawa Health Prize for 2015 to the Childbirth with Dignity Foundation (Poland). The laureate will receive US\$ 40 000.¹

United Arab Emirates Health Foundation Prize

Decision: The Executive Board, having considered the report of the United Arab Emirates Health Foundation Selection Panel, awarded the United Arab Emirates Health Foundation Prize for 2015 to the Akogo? Foundation (Poland). The laureate will receive US\$ 20 000.²

The State of Kuwait Prize for Research in Health Promotion

Decision: The Executive Board, having considered the report of the State of Kuwait Prize for Research in Health Promotion Selection Panel, awarded the State of Kuwait Prize for Research in Health Promotion for 2015 to Dr Alaa Eldien Mohamed El Ghamrawy (Egypt). The laureate will receive US\$ 20 000.³

The CHAIRMAN said that the State of Kuwait Health Promotion Foundation had requested that Article 6.3 of its Statutes be deleted and that Articles 4, 8 and 11 be revised for the reasons set out. In the absence of any objections, he took it that the Board agreed to the proposal.

It was so decided.⁴

Dr LEE Jong-wook Memorial Prize

Decision: The Executive Board, having considered the report of the Dr LEE Jong-wook Memorial Prize Selection Panel, awarded the Dr LEE Jong-wook Memorial Prize to the Thalassemia International Federation (Cyprus). The laureate will receive US\$ 100 000.⁵

¹ Decision EB136(8).

² Decision EB136(9).

³ Decision EB136(10).

⁴ Decision EB136(11).

⁵ Decision EB136(12).

5. STAFFING MATTERS: Item 14 of the Agenda (continued)**Report of the International Civil Service Commission:** Item 14.5 of the Agenda (Document EB136/46)

The CHAIRMAN drew attention to the discussion on the topic by the Programme, Budget and Administration Committee (document EB136/3, paragraphs 52–54).

Ms HERNÁNDEZ NARVÁEZ (Mexico)¹ said that the International Civil Service Commission at its 81st session was expected to finalize its proposal for a revised compensation package, for presentation to the United Nations General Assembly at its seventieth session. In view of the strong budgetary pressure on bodies in the United Nations system with regard to staff costs, the package must be competitive but sustainable and take account of the particular situation of each body. With regard to the recommendation that the mandatory age of separation for current staff members should be raised to 65 years, she requested that an analysis of the impact of the decision on WHO be presented to the Programme, Budget and Administration Committee at its next meeting.

Dr TROEDSSON (Assistant Director-General) said that the requested information would be submitted to the Programme, Budget and Administration Committee at its next meeting.

The Board noted the report.

Statement by the representative of the WHO staff associations: Item 14.3 of the Agenda (Document EB136/INF./1)

Ms KONGAPE (representative of the WHO staff associations), summarizing key issues from the statement, said that she would focus on the involvement of staff members in the response to the outbreak of Ebola virus disease and on the policy on geographical mobility.

The outbreak of Ebola virus disease had challenged both Member States and the Secretariat and brought a dimension of urgency to the Board's discussions. Yet only four years previously, the staff associations had brought to the Board's attention the reality of a significant budgetary shortfall. During the period 2010–2012, WHO had lost nearly 1000 staff globally, the African Region being hardest hit in terms of staff loss, followed closely by headquarters. The reduction in staff numbers made it all the more difficult to respond to emerging diseases, and the Organization had been obliged to recruit temporary personnel and to subcontract some of its activities, leading to a reduction in staff costs and an increase in the costs of activities. Moreover, there had been a loss of experienced staff and staff morale had plummeted. Despite funding from development partners, health systems in many Member States, particularly in Africa, had become even more fragile. In the light of the Ebola crisis, she recommended that human resource policies be reviewed.

In October 2014, the WHO staff associations had met to discuss the new human resources strategy including geographical mobility of international professionals. WHO staff members supported the concept of geographical mobility although it was a matter of concern that its contribution to WHO's ability to fulfil its strategic role had not been articulated. Mobility would assist staff members' career development, but it was not evident how the policy would help in meeting health challenges such as the outbreak of Ebola virus disease. The Programme, Budget and Administration Committee had stated that mobility was not an end in itself. The staff associations had serious reservations about the readiness of WHO to implement the policy and awaited the results of feasibility studies conducted in cooperation with management. Furthermore, the modifications to staff contracts proposed as a result of the mobility policy were likely to be contested. She wondered whether Board members were aware of the changes proposed and their potential effect on recruitment and retention. For geographical

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

mobility to succeed, the right incentives needed to be created and further research conducted on how it could be effectively implemented. The staff associations believed that the policy needed phased implementation with feasible targets, operational goals and transparent costs.

Mr KOLKER (United States of America), in answer to the question whether Board members understood the impact of the mobility policy on recruitment and retention, said that it was also important to ask whether staff members were genuinely international if they were not mobile. Staff in Geneva received a 100% post adjustment allowance, as well as home leave and other benefits, because of their “international” status. The advantages of mobility were evident, for both individuals’ careers and the Organization. Rather than viewing the mobility scheme as an obligation that staff must comply with, it might be worth redefining what was meant by “international staff”.

Mr SEY (Gambia) expressed appreciation for the excellent work done by WHO staff members who had been, and were currently, fighting the outbreak of Ebola virus disease. WHO had not reacted too slowly to the outbreak: its staff members had done everything within their capability to respond. African countries should pay their African Public Health Emergency Fund contributions, Member States should pay their dues to WHO and the international community should commit itself to accountability and coordination. Most of the deaths due to Ebola virus disease were not due to a lack of resources, but a lack of coordination.

Dr DAHN (Liberia), speaking on behalf of the Member States of the African Region, highlighted the difficult conditions in which WHO staff members were working to eliminate Ebola virus disease. WHO’s staff capacity needed to be increased for it to respond to the crisis effectively. It was important that lessons learned from the outbreak and other crises informed the WHO staff reform process. If WHO was to remain a technical agency, Member States must do everything possible to retain its technical capacity: staff members must not be lost for financial reasons. Staff at all duty stations should have access to fair and transparent, formal and informal conflict resolution mechanisms; she looked forward to the results of joint staff–management work to that end. It was positive that management was taking steps to address problems with the Staff Health Insurance scheme.

The DIRECTOR-GENERAL appreciated members’ awareness of, and gratitude for, the work of WHO staff members fighting the Ebola virus disease outbreak. WHO had deployed staff members from the Regional Office for Africa, headquarters and the other regional offices, and recruited people from local communities; it currently had almost 7000 people on the ground. It must do its utmost to avoid situations similar to the one it had confronted in 2010, when it had had to dismiss 1000 staff.

With regard to conflict resolution mechanisms, management and the staff associations had co-funded an independent study of the WHO internal justice system, which had resulted in a good recommendation that should be implemented as a priority. Equal access to fair justice systems was extremely important, and the Secretariat would work with the staff associations and regional offices to ensure that justice was equitable within the Organization.

Post adjustment actually applied to international professional staff in all offices, although the percentages varied. The mobility of staff members’ families was factored into international staff pay packages through such allowances as the education allowance. Some organizations in Geneva had stopped paying international benefits to their staff members who chose to become local. If staff members did not want to implement the mobility policy, it would be necessary to consider whether they were entitled to allowances intended for international staff. The mobility policy had never yet been implemented properly, and headquarters had a worse record than the regional offices. The right balance must be found: staff concerns regarding mobility must be considered. The representative of the staff association’s comments were also relevant – it was necessary to consider what benefits mobility brought: for example, whether it did in fact incentivize career progression and improve experience. To find a way forward, Member States must consider what they wanted. Her proposal was to address staff concerns in the implementation plan for the mobility policy, on which she was ready to

collaborate with different staff groups. Equity should be given serious consideration. Staff tended to want to remain in Geneva, but it was important that staff from other duty stations came to Geneva, and some headquarters staff should be deployed to difficult locations. Mobility was valuable: it broadened staff's experience and contributed to their career development, and WHO must provide an incentive for it.

Dr ZUBER (Headquarters staff association) assured the Board that the staff associations recognized the need for greater mobility and were not contesting the idea that staff members from other duty stations should have the opportunity to come to Geneva. However, the implementation of the proposed scheme presented challenges: it would mean, for example, that information technology staff based in Geneva and Kuala Lumpur would be required to move every five years – here, mobility would become an end in itself. It was perhaps necessary to re-examine, as the member for the United States had proposed, what was meant by “international staff”. The proposed abrupt changes to the Staff Rules and Staff Regulations could lead to the inequitable use of administrative privileges; most of the scheme could be implemented in 2015 under the current rules and regulations.

Dr KUPA (Democratic Republic of the Congo) expressed gratitude for the work done by WHO staff members in his country which had also experienced an outbreak of Ebola virus disease. Staff at all levels of the Organization had spared no effort to reach remote villages that were affected. WHO had truly fulfilled its role: it had provided leadership and coordinated the action extremely well and had succeeded in containing the disease and controlling the outbreak.

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

Human resources: update: Item 14.4 of the Agenda (Documents EB136/45 and EB136/INF./9)

The CHAIRMAN drew attention to the discussion of the topic by the Programme, Budget and Administration Committee (document EB136/3, paragraphs 31–37).

Dr USHIO (Japan) said that the mobility policy must be implemented fairly and surely, to ensure a stronger Secretariat. However, three considerations should be borne in mind. The Secretariat should provide an implementation plan and report on progress; staff mobility should serve to balance the demand for and supply of technical staff in different regions, and the policy must cover both selection and rotation of staff members. The policy must build on WHO's recruitment policy, and ensure geographical and gender balance with numerical targets in all offices. The Secretariat must identify rotational and non-rotational posts with great care, to ensure that it preserved the agency's technical excellence.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) emphasized the necessity of the flexibility and deployability of WHO's workforce, qualities that allowed it to fulfil its mandate, including response to emerging threats. To capitalize on flexibility, three elements were needed: a clear understanding of, first, what posts, skills and capabilities were needed and where and, second, what skills and capabilities were available; and the ability to deploy, support and manage the right staff, in the right place and at the right time. She applauded the proposed skills inventory, mobility policy and Performance Management and Development Framework. The inventory should include the soft skills of management, leadership and communication, as well as specialist competences. Regarding mobility, she requested reports on the benefits gained by both the staff and the Organization from movement between different offices and regions, and across the three levels of the Organization. The Performance Management and Development Framework must recognize that support for staff included both rewards for excellence and management of underperformance. The work being undertaken was underpinning reform.

Dr NCHABI KAMWI (Namibia), speaking on behalf of the Member States of the African Region, welcomed the progress made on human resources reforms but urged continued efforts to improve geographical representation, diversity and gender balance. Member States in the Region remained under-represented, in particular in senior professional positions. Lessons should be learned from the Ebola virus disease outbreak, resulting in appropriate management tools to ensure more rapid deployment of staff in future crises. The proposed mobility scheme should be applied across the whole Organization, not to only five of the six regional offices.

Dr GRABAUSKAS (Lithuania), speaking on behalf of the Nordic and Baltic countries Denmark, Estonia, Latvia, Finland, Iceland, Lithuania, Norway and Sweden, repeated long-standing concern at the slow progress towards gender balance, and asked what measures were being taken by the Secretariat, through its human resources strategy, to accelerate that progress. He proposed that all human resources data be disaggregated by sex. He welcomed the development of generic job descriptions and the personnel pooling process, and asked how policies on recognizing and rewarding excellence and managing underperformance would be implemented. He strongly supported the proposed geographical mobility policy and the consequent amendment of the Staff Regulations and Staff Rules, but insisted on the need for commitment from all regional and country offices. Focus on legacy planning for staff funded through the polio programme must be maintained, and he sought further information and proposals at the Sixty-eighth World Health Assembly. He also urged the Secretariat to submit its plan for comprehensive emergency response teams, as called for in resolution EBSS3.R1 on Ebola.

Mr COTTERELL (Australia) supported calls for a mobility policy covering all WHO regions, an implementation plan that placed emphasis on recruitment and a balance between generalist and specialist staff, and attention to be paid to a mix of skills including management. He paid tribute to the dedication of WHO staff members in responding to the outbreak of Ebola virus disease.

Mr KOLKER (United States of America) said that disruptions caused by temporary reassignments to work on the response to the Ebola virus disease outbreak had highlighted the need for a new model for staffing in acute emergencies. He welcomed the harmonized process for selection to posts in the professional and higher-level categories; the primary consideration for selection was merit. The Director-General should have a larger role in senior regional staffing decisions and therefore in accountability. He also welcomed the introduction of the Performance Management and Development Framework in early 2015. WHO should prioritize implementation of the geographical mobility policy across the Organization; the appropriate participation of the Region of the Americas was entirely justified, given WHO's contribution to PAHO's base programme.

The establishment of a separate fund for terminal emoluments related to legacy planning for the polio programme was welcome. He requested additional specific proposals for the reform of human resources management, for example with regard to the composition of selection panels. The human resources strategy should explicitly recognize the personnel needs for WHO's main functions: providing expert guidance, scientific expertise and technical support; and responding to emergencies.

Ms ZHANG Yang (China) commended the work on the mobility policy. Effective measures should be taken to improve gender balance and geographical representation. She supported the implementation of the human resources strategy, in line with WHO reform; specific indicators should be identified in the Proposed programme budget 2016–2017.

She expressed her appreciation for the work of WHO staff members in managing the outbreak of Ebola virus disease.

Mr BOISNEL (France)¹ welcomed the shift from discussion of strategic directions to implementation, and supported in particular the creation of a staff skills inventory and the mobility policy. Despite the legal issues noted in document EB136/INF./9, the proposed policy should be implemented across the Organization, in order to have “one WHO”. Further steps were needed to attain gender balance in the Organization.

He bore witness to the commitment of all WHO staff members during the Ebola outbreak.

Dr ASSIRI (Saudi Arabia) supported the comments by the member for China on the need to ensure better recruitment processes and geographical representation in WHO.

Dr TROEDSSON (Assistant Director-General), acknowledging the support for the implementation of the human resource strategy, assured the Board that the proposed geographical mobility policy would be implemented gradually, from end- 2015 and throughout 2016 and 2017, with adjustments made as necessary. Incentives for participating in the mobility policy had to be recognized, and the Organization ought to consider whether international staff members remained international if they declined mobility. To lead public health internationally, WHO needed a mobile workforce that had a broad understanding of the Organization’s work across levels and functions. Mobility was therefore crucial to staff development. The aim was to implement an Organization-wide mobility policy. The Secretariat would collaborate closely with PAHO and did not view its legal status as a cause for particular concern for collaboration on mobility. The placement of staff should be determined by the Organization’s needs. The mobility policy should improve the gender balance and ensure diverse geographical representation across the Organization, of which both were issues that would be taken into account in the drafting of the related implementation plan. No compromises would be made with regard to technical qualifications, and staff would be matched to positions according to their profiles. It was estimated that the proposed geographical mobility policy would involve 300–400 staff members moving location per year at a cost of US\$ 8–10 million. Those costs could be reflected in the Proposed programme budget 2016–2017. The outbreak of Ebola virus disease had demonstrated the need for a staff skills inventory that would provide immediate information on staff members available for emergency deployment in a given situation. The teams responsible for information technology and telecommunications and for human resources management were already working on that initiative.

The DIRECTOR-GENERAL welcomed the recognition of the commitment and talent of WHO staff members. The WHO staff associations and the management team were collaborating on initiatives to improve staff performance. There should be incentives for good performance, and those who underperformed should receive advice and training to improve their skills. Staff performance was vital, as staff costs comprised more than half the Organization’s budget. It was important to attract the best talent and motivate staff members to perform to the best of their ability.

The Board noted the report.

Amendments to the Staff Regulations and Staff Rules: Item 14.6 of the Agenda (Documents EB136/47 and EB136/47 Add.1)

The CHAIRMAN drew attention to the report of the Programme, Budget and Administration Committee (document EB136/3), which contained a recommendation that the Board should adopt the five draft resolutions contained in document EB136/47.

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

Mr GHILAGABER (Eritrea), speaking on behalf of the Member States of the African Region, supported the amendments to the Staff Regulations and Staff Rules and recommended adoption of the draft resolutions.

The resolutions were adopted.¹

6. NONCOMMUNICABLE DISEASES: Item 6 of the Agenda (resumed)

Follow-up to the 2014 high-level meeting of the United Nations General Assembly to undertake a comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases: Item 6.4 of the Agenda (Documents EB136/11 and EB136/11 Add.1) (continued from the thirteenth meeting)

The DIRECTOR-GENERAL said that, following negotiations, a new version of the draft decision had been prepared, which read:

The Executive Board requested the Director-General to publish a technical note during the next month on how the Director-General will report in 2017 to the United Nations General Assembly on the national commitments included in the 2014 outcome document and the 2011 Political Declaration using existing survey tools and taking into account existing indicators at the global and regional levels.

Dr ALHAMAD (Kuwait) expressed her appreciation for the work of the Board and the Secretariat on the text.

The decision was adopted.²

The meeting rose at 18:00.

¹ Resolutions EB136.R11–EB136.R15.

² Decision EB136(13).

FIFTEENTH MEETING

Tuesday, 3 February 2015, at 09:05

Chairman: Mr M.H. SHAREEF (Maldives)

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

Health and the environment: Item 7.2 of the Agenda (continued from the eighth meeting, section 2)

- **Addressing the health impact of air pollution** (Document EB136/15)

The CHAIRMAN drew attention to a revised version of the draft resolution, which read:

The Executive Board,
Having considered the report on air pollution and health,¹

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

(PP1) Noting with deep concern that indoor and outdoor air pollution are leading avoidable causes of disease and death globally, and the world's largest single environmental health risk;

(PP2) Acknowledging that 4.3 million deaths occur each year from exposure to household (indoor) air pollution and that 3.7 million deaths a year are attributable to ambient (outdoor) air pollution, at a high cost to societies;²

(PP3) Aware that exposure to air pollutants, especially fine particulate matter, is a leading risk factor for noncommunicable diseases in adults, including ischemic heart disease, stroke, chronic obstructive pulmonary disease, asthma and cancer, and poses a considerable health threat to future generations;

(PP4) Concerned that half of the deaths due to pneumonia in children aged less than five years may be attributed to household air pollution, making it a leading risk factor for childhood mortality;

(PP5) Further concerned that ambient air pollution, and particularly its fine particulate component, is classified as a cause of lung cancer by IARC, which has classified diesel and coal combustion products (the principal causes of household and ambient air pollution) carcinogenic in humans;³

(PP6) Aware that exposure to both short- and long-term exposure to air pollution has a negative impact on public health, with a potentially much greater impact resulting from long-term exposure, causing chronic diseases such as cardiovascular disease, chronic obstructive pulmonary disease (COPD) and other respiratory diseases, and also

¹ Document EB136/15.

² WHO. Burden of disease from ambient air pollution for 2012. http://www.who.int/phe/health_topics/outdoorair/databases/AAP_BoD_results_March2014.pdf?ua=1 (accessed 1 December 2014).

³ IARC Monograph 109.

that for some pollutants, such as particles, it is not possible to identify a threshold of exposure below which there would be no health effects;

(PP7) Noting the strong significance of air pollution and its health effects to the objectives and targets contained in the WHO NCD global action plan 2013–2020;

(PP8) Noting that air pollution is a cause of global health inequities, affecting in particular women, children and old persons, as well as low-income populations who are often exposed to high levels of ambient air pollution as a result of living near busy roads or industrial sites, or in homes that have no choice but to rely on polluting fuels and technologies for cooking, heating and lighting; [and noting also that air pollution is getting worse in many cities in developing countries while the situation is improving in the developed world,] and that improving air quality are among the measures with the greatest potential impact on health equity;

(PP9) Cognizant that most air pollutants are emitted as a result of human activity in a range of sectors, with indoor air pollution typically being a result of home use of polluting fuels inefficient technologies for heating, cooking and lighting, smoking, or emission of harmful chemicals from building materials and household products, with outdoor air pollution resulting inter alia from energy production, motorized transportation, patterns of industrial and urban development, waste disposal, agriculture and burning of biomass and other household sources of energy; and noting also that there is a significant interrelation between outdoor and indoor air quality;

[(PP9 bis) Cognizant that there are also other air pollutants, not resulting from human activity which cause significant health threats, radon in particular, and that exposure to indoor radon is an important cause of lung cancers in the general population and that this exposure can be substantially reduced by awareness raising programmes aimed at the general public and in particular property owners, as well as by prevention and remediation measures in buildings];

[(PP9 ter) Underscoring that the root causes of air pollution and its adverse health impacts are socioeconomic in nature, and recognizing that rapid and uncontrolled urbanization is a major driver for air pollution, especially in developing countries];

(PP9 quart) [Reaffirming that poverty eradication is the greatest global challenge facing the world today, and is an indispensable requirement for sustainable development, including finding sustainable solutions for air pollution];

(PP9 cinc) [Recognizing that ensuring open channels for technology transfer and providing support for innovation is essential for addressing indoor and outdoor air pollution];

(PP10) Acknowledging recent global efforts to promote air quality as well as the many national and regional initiatives to mitigate the health impacts of indoor and outdoor air pollution, while noting the need for the health community to contribute to a coordinated global strategy to reduce outdoor or indoor air pollution, so as to prevent consequent disease and ill-health, loss of quality of life and life expectancy;

(PP11) Recognizing that the sources of air pollution, its impacts on health, and the policy options for tackling it, are specific to context and place, and that outdoor air pollution may also be transported over long distances, thereby requiring cooperation across sectors at the local, regional, and global level for the identification and implementation of policies with maximal health and social benefits (“win-win actions”), and that in order to contribute to policy choices that protect health and reduce health inequities, the health sector will need to engage in cross-sectorial approaches to health, including adopting health-in-all policies approach;

(PP12) Noting that WHO's air quality guidelines for both ambient air quality¹ (2005) and indoor air quality² (2014) provide [guiding principles, recommendations and targets] for clean air that protect human health, but with a need outstanding for activities, such as the promotion of policies that provide access to clean fuels and clean and efficient home energy solutions, as well as global, regional, national and local sectorial policies in transport, energy, land use planning and construction to reduce air pollution from emission sources;

(PP13) Acknowledging that while many of the most important and cost-effective actions against outdoor and indoor air pollution require the involvement and leadership of national governments as well as regional and local authorities, cities are both particularly affected by the consequences of air pollution and well-placed to reduce air pollution and its associated health impacts, and can complement national air quality measures and emission standards through policies and investments in more energy-efficient and healthy urban planning, more sustainable and healthy transport, building housing and energy systems, and that the health sector can contribute to identifying, communicating and evaluating the healthiest policy options for indoor and outdoor air quality;

(PP14) [Acknowledging that re-tooling household, urban and industrial infrastructure which generates air pollution, involves huge financial and technological investments, requiring mobilization of adequate resources, at national, regional and international levels, and] aware that both established and expanding clean-energy technologies and renewable energy solutions offer cost-effective opportunities to reduce energy poverty while facilitating a shift to cleaner energy sources, particularly at community and household level;

[(PP15) [*Underscoring* the fact that sources of air pollution contributes to climate change through both emissions of greenhouse gases and near-term climate forcers], [that emission reduction in air pollutants both benefit human health as well as the fight against climate change, and that any action in favour of one is mutually beneficial];]

(PP15 bis) Underscoring that climate change (i.e., higher temperatures) can also exacerbate air pollution and its impacts, for example through the generation of detrimental climatic conditions, such as more frequent heat waves that exacerbate the health consequences of air quality;

(PP16) Underscoring that air pollution-related health impacts can be a health-relevant indicator for sustainable development policies, particularly with regard to sustainable energy, sustainable cities and clean and sustainable transport, and that due consideration should be given to these impacts in post-2015 Sustainable Development Goal and climate change discussions;

(PP17) Considering due attention to the geographical distribution of pollution, across the production chain,

(OP1) 1. URGES Member States³ to:

1. [Increase their efforts to reduce air pollution of any kind across all levels.];
2. [Within their capabilities to promote and facilitate, transfer, diffusion and access to up to date environmentally sound alternative technologies, to

¹ WHO air quality guidelines for particulate matter, ozone, nitrogen dioxide and sulfur dioxide – global update 2005: summary of risk assessment. Geneva: World Health Organization; 2006 (document WHO/SDE/PHE/OEH/06.02).

² WHO indoor air quality guidelines: household fuel combustion; 2014; ISBN 978 92 4 154887 8 (<http://www.who.int/indoorair/guidelines/hhfc/en/>).

³ And, where applicable, regional economic integration organizations.

developing countries; supported by the private sector and other stakeholders as appropriate;

3. Reaffirm commitment to promote facilitate and finance, as appropriate, access to and the development, transfer and diffusion of environmentally sound technologies particularly clean air technologies, and corresponding know-how, in particular to developing countries.]

(1) Redouble their efforts to identify, address and mitigate the health effects of air pollution, by developing and strengthening, as appropriate, multisectorial cooperation on the regional and national levels, and through targeted, multisectorial measures in accordance with national priorities, by contributing to enhanced global data collection, monitoring, research, informing the development of normative standards, engaging in cooperation and sharing of best practices and through dissemination of good practices and lessons from implementation;

(2) Enable health systems, including health protection authorities, to take a leading role in raising awareness in the public and among all stakeholders of the impacts of air pollution on health and opportunities to reduce or avoid exposure, including by [[, as appropriate according to national context and on a voluntary basis], strengthening health systems capacity to provide information about the health effects of air pollution] guiding and sensitizing preventive measures to help reduce these health effects, and to interact effectively with the relevant sectors and other relevant public and private stakeholders to inform about sustainable solutions, to ensure that health concerns are integrated into relevant national, regional and local policy, decision making and evaluation processes, including public health prevention, preparedness and response measures as well as health system strengthening;

(3) Facilitate research [on interventions aimed at minimizing air pollution related health effects and evaluating the results of such interventions,] including statistics on morbidity, mortality, health impact assessment, the use and costs of health-care services and the societal costs associated with ill health, supporting identification of research priorities and strategies, engaging with academia to address knowledge gaps, and supporting the strengthening of national research institutions and international cooperation in research to identify and implement sustainable solutions;

(4) Contribute[, as appropriate according to national context and on a voluntary basis,] to global and regional initiatives to address air pollution and its health effects, [emphasising in particular the monitoring of health effects of air pollution, including, as appropriate, by collecting and sharing data on air pollution exposure and relevant health outcomes]and by working towards harmonization of health related indicators which could be used by decision makers;

(5) [Increase, [as appropriate according to national context and on a voluntary basis], coverage of air quality monitoring systems that monitor critical air pollutants through, as appropriate, multisectorial cooperation, and gradually integrate the measuring of specific pollutants that are associated with health impacts, thereby developing a better understanding of the current level of air quality in the Member States];

(6) Improve and optimize the morbidity and mortality registry for all illnesses, especially those related to air pollution, to facilitate obtaining information that may be related to the registries of critical pollutants and other more specific registries in the Member States;

- (7) Encourage and promote clean cooking, heating, and lighting practices, technologies and fuels that will lead to meaningful progress to reduce levels of indoor air pollution as identified in the WHO guidelines for indoor air quality, as well as measures promoting and implementing the aims of the WHO guidelines for ambient air quality, while recognizing the differing capacities and resources of Member States;
- (8) Take into account the WHO Air Quality Guidelines and WHO Indoor Air Quality Guidelines and other relevant information, [within the national context], in the development of a multisectorial national response to air pollution;
- (9) Take effective steps, as appropriate, to address air pollution specifically associated with health care activities, including by implementing the WHO guidelines for ambient air quality and for indoor air quality in health care facilities;
- (10) [Develop policy dialogue and information sharing between different sectors to facilitate a coordinated, multisectorial basis for participation in future regional and global processes to address the health effects of air pollution;] [in particular by securing an active engagement of the health sector in all efforts to combat climate change and adapt to its impacts];
- [(10bis) Identify and prioritize actions by the health sector that reduce health inequities related to air pollution and work closely with the communities at risk who can gain the most from effective equitable and sustained actions];
- (11) Meet the commitments made at the 2011 UN High level meeting on noncommunicable diseases and to use, as appropriate, the road map and policy options contained in the WHO global action plan for noncommunicable diseases;
- (12) [Reaffirm commitment to promote facilitate and finance, as appropriate, access to and the development, transfer and diffusion of environmentally sound technologies, particularly cleaner technologies and corresponding know-how in particular to developing countries];
- (13) [Collaborate with regional and international organizations in developing partnerships to mobilize adequate technical and financial resources that can support wide scale and sustained adoption of clean air technologies, particularly in low and middle income settings];

2. REQUESTS the Director-General:

- [1. To [consider establishing] a Program for Health and Air Pollution, in order to deliver;]

OR

- [1. To provide]:

- (a) Support and guidance for the implementation of the Air quality Guidelines and Indoor Air Quality Guidelines;
- (b) Enhanced technical support and guidance to Member States, [that takes into account transboundary air pollution] including through appropriate capacities in regional and country offices to support [country] activities;
- (b) bis [to support technical capacity building on air quality monitoring and focus on cost-effective methodologies [such as remote sensing and modelling];
- (c) The further identification, development and updating of air quality guidelines and cost-benefit tools to support effective and efficient decision making;

- (d) Increased technical capacity within the WHO to collect and analyse data on air quality, making full use, as appropriate of partnerships with other relevant international, regional and national actors;
 - (d) Alt: Enhanced technical capacity of the WHO in collaboration, as appropriate, with relevant international regional and national actors, to collect and analyze data on air quality, with particular emphasis on the health related aspects of air quality;
 - (e) Assistance to Member States to increase awareness and communicate to the general public and stakeholders, in particular communities at risk, about the effects of air pollution and actions to reduce it;
 - (f) Dissemination of evidence-based best practices on effective indoor and ambient air quality interventions and policies related to health;
 - (g) Enhanced ability of WHO to convene, guide and influence research strategies in the field of air pollution and health, in conjunction with the WHO Global Health Observatory;
 - (h) The development of appropriate advisory capacity and support tools to assist the health and other sectors at all levels of government, especially the local level and in urban areas, taking into account different sources of pollution in tackling air pollution and their health effects;
 - (i) [The development of appropriate advisory capacity and support tools at regional level to help Member States to address the health effects of transboundary air pollution, taking into account local and regional sources of air pollution];
2. To exercise global health leadership and maximize synergies while avoiding duplication of efforts with relevant global efforts that promote air quality, [pollution] [reduction] and health improvements, [particularly in areas such as climate change, sound management of chemicals and waste, sustainable energy and sustainable transport];
- 2bis. To work with other UN partners, programmes and agencies, in particular with reference to the UN Environment Assembly resolution on Air Quality;
3. To strengthen, and where applicable forge, links with existing global health initiatives that can benefit from air pollution reduction, including global efforts to reduce noncommunicable diseases (such as the WHO global action plan for noncommunicable diseases) and improve children's health;
- 3bis. To set aside adequate resources for the work in the secretariat, in line with the Programme budget PB 2014/15 and PB 2016/17 and the twelfth General Programme of Work (GPW) 2014/19;
4. To report to the Sixty-ninth World Health Assembly on the implementation of this resolution [and its progress in mitigating the health effects of air pollution];
5. To propose to the Sixty-ninth World Health Assembly a road map for an enhanced global response to the health effects of air pollution.

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

1. Resolution: Health and the environment: addressing the health impact of air pollution	
2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)	
Category: 3. Promoting health through the life-course	
Programme area(s): Health and the environment	<p>Outcome: 3.5. Reduced environmental threats to health</p> <p>Outputs: 3.5.1. Country capacity strengthened to assess health risks, develop and implement policies, strategies or regulations for the prevention, mitigation and management of the health impacts of environmental risks</p> <p>3.5.2. Norms, standards and guidelines to define environmental and occupational health risks and benefits associated with air quality, chemicals, water and sanitation, radiation, nanotechnologies, and climate change</p> <p>3.5.3. Public health issues incorporated in multilateral agreements and conventions on the environment and sustainable development</p>
How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?	
The resolution will strengthen capacity of the health sector and health systems to prevent diseases and the seven million deaths each year due to air pollution.	
Does the Programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)	
Yes.	
3. Estimated cost and staffing implications in relation to the Programme budget	
(a) Total cost	
Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).	
(i) The initial estimate covers the period from 2015 to the end of 2019, in line with the period covered by the Twelfth General Programme of Work, 2014–2019. Work on air pollution and health is likely to continue beyond 2019. However, the next general programme of work will be developed and a review undertaken in parallel, which may result in modifications to the programme budget depending on changes to the Organization's wider priorities.	
(ii) Total: US\$ 35.49 million ¹ (staff: US\$ 12.41 million; ² activities: US\$ 23.08 million).	
(b) Cost for the biennium 2014–2015	
Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).	
Total: US\$ 3.64 million (staff: US\$ 1.31 million; activities: US\$ 2.33 million).	
Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.	
All levels of the Organization.	

¹ Figures are inclusive of programme support costs (13%).

² Staff cost figures are based on post cost averages for the biennium 2016–2017 plus programme support costs.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)
Yes.

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

(c) Staffing implications

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

Yes, for the biennium 2014–2015. However, additional staff will be required to implement the resolution from 2016 onwards.

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.

As indicated, for the biennium 2014–2015 current staffing levels are adequate. However, from 2016 onwards it is expected that two additional technical staff at grade P.4 and one at grade G.5 will be needed at headquarters, and one additional technical staff at grade P.4 will be needed in each of the regional offices. One part-time national professional officer will also be needed in each of the six pilot countries for enhanced cooperation.

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).

Mr LA Ki-tae (Republic of Korea) welcomed the strategies for reducing the health impacts of air pollution outlined in the report. The health sector should engage with other sectors in order to inform their policy options and ensure that health was taken into account. In his country, the health and environment ministries cooperated closely in developing guidelines for the general public, patients with heart and respiratory diseases and allergies, and health workers. Expressing support for the draft resolution, he urged WHO to exercise leadership by encouraging cross-sectoral and international coordination of global efforts to tackle air pollution, sharing evidence and lessons learned, strengthening monitoring, building its capacity and providing technical support to Member States.

Mr CORRALES HIDALGO (Panama), speaking on behalf of the Member States of the Region of the Americas, agreed that WHO needed greater capacity to tackle the effects of air pollution on health but noted that air pollution was not included among the causes of noncommunicable diseases in WHO’s global action plan for the prevention and control of noncommunicable diseases. Cross-sectoral action was the most effective way to reduce air pollution and its impact on health. The health sector should therefore contribute to policy-making in sectors that had a direct influence over the sources of air pollution, including transport, energy, industry and urban planning. The form of such engagement had to be defined; the adoption of a resolution with clear guidelines on the role and contribution of the health sector would be a welcome first step. In the Region, technical cooperation and stronger national capacity in evaluating exposure to air pollution were important in order to devise ways of reducing health impacts. Member States must ensure that WHO had the capability to make progress in tackling air pollution.

Mr RASHEED (Maldives), supporting the draft resolution, said that his country’s geography made it one of the most environmentally vulnerable countries in the world. Several interventions had been initiated or were under development. The adverse effects of transboundary air pollution on health were exacerbated by dependency on fossil fuels. Recognition of the burden of air pollution had led to the development of a regional target on household air pollution in the context of the global strategy on noncommunicable diseases. As chair of the Alliance of Small Island States, Maldives called for greater consideration of the health impacts of climate change.

Ms BRODEY (United States of America) strongly agreed that WHO should work collaboratively and across sectors in order to better measure and quantify the effects of air pollution on health; to inform mitigation policies; to support improved health impact assessment of pollution reduction strategies; and to take steps to limit the health sector's own emissions. The text of the draft resolution needed further development before consideration for adoption by the Sixty-eighth World Health Assembly.

Mr CHANG Jile (China) endorsed the actions outlined in the report and emphasized the importance of cross-sectoral work, with the health sector playing a facilitating role. His Government had implemented a national plan of action on prevention and control of air pollution, including intensified surveillance and assessment of the likely impact of air pollution on public health. He looked forward to enhanced cooperation and exchanges of information on the subject with other countries and the Secretariat.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) expressed regret that, despite overwhelming support at the Board's 135th session for inclusion of the subject on the agenda of the current session,¹ the draft resolution was unnecessarily politicized. She exhorted Member States to engage constructively, in order to allow adoption of a resolution on such an important issue by the Health Assembly in May. She commended WHO's work, in particular advocacy in relevant multilateral forums. She emphasized the need for strong and coordinated multisectoral action at national, regional and global levels.

Mr BOWLES (Australia) welcomed the draft resolution and agreed that further work on the text was needed before its submission to the Sixty-eighth World Health Assembly.

Mr MATCHOCK MAHOURI (Chad), speaking on behalf of the Member States of the African Region, said that reducing air pollution levels would require an intersectoral approach to policy-making, with proper coordination of the different sectors and stakeholders while taking into account national situations. The effects of climate change were aggravating both traditional and new environmental health risks and posed a threat to health development. Among measures to improve global health, he highlighted the importance of strengthening technology transfers and adaptation. In resolution AFR/RC61/R2, the Regional Committee for Africa approved a framework for public health adaptation to climate change in the African Region. He called for strong collaboration between the three levels of the Organization in order to mitigate the problem.

Dr KUPA (Democratic Republic of the Congo) said that measures against climate change and air pollution must be based on the principles of equity and shared, but differentiated, responsibility.

Ms PENEVEYRE (Switzerland)² said that Switzerland wished to cosponsor the draft resolution. All countries were affected by air pollution, and especially their vulnerable populations, but targeted interventions could make a difference. Combating indoor and outdoor air pollution would not only improve people's health and the environment but would also lead to cost savings. The finalization of a robust resolution would ensure that health took its rightful place in the outcome of the 21st session of the Conference of the Parties to the United Nations Framework Convention on Climate Change, to be held in Paris in December 2015.

¹ See document EB135/2014/REC/1, summary record of the first meeting, section 1.

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

Ms LANTERI (Monaco)¹ stressed the need to address the socioeconomic implications of climate change on health, particularly the impact of air pollution on global morbidity and mortality. She expressed regret that attempts had been made to politicize the negotiations on climate change and health, and urged Member States to reach agreement on a robust draft resolution for consideration by the Health Assembly.

Mr BOISNEL (France)¹ emphasized that climate change was a scientifically-proven reality and, with air pollution, had harmful effects on health globally. In the period leading up to the 21st session of the Conference of the Parties to the United Nations Framework Convention on Climate Change, WHO had a vital role to play in promoting intersectoral solutions to air pollution and should develop comprehensive cross-cutting approaches to transport, urban planning and land use that took account of health concerns. He outlined activities being undertaken in his country, including a national plan for environmental health that emphasized the role of towns.

Mr PRAKASH (India)¹ noted that India had added indoor air pollution to its adapted monitoring framework of the global action plan for the prevention and control of noncommunicable diseases 2013–2020. Health policy-makers must adopt an intersectoral approach to tackling air pollution and should conduct regular advocacy activities with a variety of stakeholders on climate change and health issues. The Secretariat could provide Member States with evidence-based guidelines and technical assistance to enable them to reduce the health impacts of air pollution and facilitate their transition to clean technologies and energy sources. WHO's endeavours to tackle air pollution must not divert attention from overall work on climate change.

Mrs REITENBACH (Germany)¹ said that multisectoral approaches were required to tackle air pollution, and commended WHO's indoor and ambient air quality guidelines. The Secretariat should support Member States in increasing awareness of the link between air pollution and public health. She asked for her country to be added to the list of sponsors of the draft resolution and looked forward to contributing constructively to its further elaboration and adoption at the Sixty-eighth World Health Assembly.

Mr AASLAND (Norway)¹ said that the Board's unequivocal agreement on the need to discuss air pollution was the basis for preparing the draft resolution. Its aims included increasing WHO's capacity and giving the Director-General a strong mandate to develop an international response. Despite modest engagement thus far by WHO in addressing environmental degradation, international cooperation and assistance were hugely beneficial in achieving health for all. It was time to mount a response that properly reflected the negative health impacts of air pollution, including its significant contribution to the global burden of disease. The draft resolution accordingly called for expanding WHO's capacity at all three organizational levels, to provide normative guidance and technical support to Member States, and to increase collaboration with other relevant partners.

Dr SAIPIN CHOTIVICHIE (Thailand)¹ noted that the Member States of the South-East Asia Region had adopted the target of a 50% reduction in indoor air pollution for controlling noncommunicable diseases. Although indoor air pollution could be tackled at national level, ambient air pollution and its health impacts required transnational multisectoral efforts. She urged WHO to continue facilitating multisectoral cooperation, supporting the transition to clean technology and sustainable energy, developing guidelines to strengthen air quality surveillance, and researching the health impact of air pollution.

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

Ms HALÉN (Sweden)¹ supported the statements made by the members for Panama and the United Kingdom. She welcomed the draft resolution, requesting that her country be added to the list of sponsors, and urged Member States to continue to work constructively in ongoing negotiations, recognizing the clear scientific evidence of the health impacts of air pollution.

Dr SARIWATI (Indonesia)¹ confirmed her country's commitment to controlling air pollution as a means of preventing noncommunicable diseases and noted the importance of pollution-free cooking stoves in reducing indoor air pollution and reducing childhood pneumonia. She supported the draft resolution, emphasizing the need for action by all stakeholders at national, regional and international levels. Successful air pollution control initiatives required strong government policy and community involvement, and should be able to be implemented quickly and efficiently across the country.

Mr CORRALES HIDALGO (Panama), speaking as co-chairperson of the drafting group, said that consensus had not been reached and requested the Board to agree to the continuation of discussions during the intersessional period, in order to reach consensus on a text before the Health Assembly in May 2015.

Dr REYNDERS (Belgium), speaking on behalf of the European Union and its Member States, thanked the member for Panama and the representative of Norway for their leadership of consultations on the draft resolution, in which the European Union and its Member States would continue to participate before the Health Assembly. He endorsed the key role of WHO in providing expertise and guidance on the health impacts of air pollution.

Dr BUSTREO (Assistant Director-General) noted the affirmation of air pollution as a major global public health challenge with a significant but preventable impact on health, particularly that of vulnerable populations and children. She acknowledged the encouragement of WHO's activities, including production of the air quality guidelines and gathering evidence of the health impact of air pollution. The health sector had a key role to play in raising awareness and guiding policy in areas such as clean energy use and sustainable transportation. The draft resolution was the first of its kind, and the Secretariat would continue to support Member States in their negotiations before the next Health Assembly.

The DIRECTOR-GENERAL reiterated that scientific evidence confirmed the preventable nature of deaths and diseases resulting from air pollution; the evidence had to be translated into policies and action, led by the health ministers present at the session. She acknowledged the work done thus far in preparing the draft resolution and encouraged Member States be flexible and constructive in order to reach agreement before the Health Assembly. The Secretariat would provide any required support in that regard.

Mr BOISNEL (France)¹ welcomed the Secretariat's support for the consultation process. He noted the agreement of Member States on the urgent need to move forward and expressed surprise that greater progress had not been made, owing to the politicization of the discussions. He called on all Member States to work constructively so that the Sixty-eighth World Health Assembly could adopt the draft resolution.

The CHAIRMAN took it that the Board wished to adopt a decision noting the ongoing discussions on the draft resolution and encouraging Member States to finalize that work in order for the draft resolution to be duly considered by the Sixty-eighth World Health Assembly.

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

The decision was adopted.¹

- **Climate and health: outcome of the WHO Conference on Health and Climate** (Document EB136/16)

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) welcomed the success of WHO's first carbon-neutral meeting and endorsed the proposals for revising the WHO work plan on climate change and health for 2014–2019. WHO should do more to raise awareness about the co-benefits to health of climate change mitigation as part of its involvement in the process for the United Nations Framework Convention on Climate Change.

Dr NIK JASMIN NIK MAHIR (Malaysia) strongly supported WHO's efforts to promote health within the United Nations Framework Convention on Climate Change and looked forward to implementation of the revised WHO work plan.

Dr BEJTJA (Albania) appreciated the WHO work plan and supported the proposal to conduct pilot projects to test new approaches to climate change mitigation, although the projects should be preceded by vulnerability assessments of health care systems of the countries concerned. More support should be made available to WHO's European Centre for Environment and Health for it to continue its work on developing resilient national health systems.

Ms BRODEY (United States of America) supported the proposed revisions to the WHO work plan. There were important co-benefits in mitigating the health impacts of climate change and air pollution, and she was pleased to see the emphasis placed on that area, as well as on partnerships and locally-specific information tools.

Mr CORRALES HIDALGO (Panama) urged the Secretariat to strengthen the work plan and devise technical guidelines to enable Member States to respond in a cross-cutting manner to the various climate-related risks to people's health.

Dr TAKIAN (Islamic Republic of Iran) stressed the need for technology transfer to developing countries in order to cope with the consequences of climate change. A proactive approach was needed to mitigating the risks at global, regional and national levels, and regional working groups and training hubs could be one way forward. He supported the continuing discussion on the text of the draft resolution which should be adopted by the Sixty-eighth World Health Assembly.

Ms MUKUNDJI (Democratic Republic of the Congo), speaking on behalf of the Member States of the African Region, affirmed that climate change mitigation efforts be accompanied by adaptation measures, following the principle of shared responsibility and equity. WHO should promote capacity-building, research, technology transfer, awareness-raising and information-sharing initiatives. Implementation of the revised WHO work plan and the establishment of a partnership platform should strengthen the implementation of the framework for public health adaptation to climate change approved by the Regional Committee for Africa.

Dr KREMER (Argentina) called for more attention to be paid in the revised work plan to strengthening the role and capacity of local government to promote appropriate intersectoral climate change strategies and initiatives at the local level. He proposed that the wording of objective 2 should be amended to include other civil society groups besides nongovernmental organizations and youth

¹ Decision EB136(14).

groups, and objective 3 should refer (as the existing work plan did) to promoting and supporting the generation of scientific evidence.

Ms BERGARA (Uruguay)¹ said that a cross-cutting approach must be taken towards climate change and regional and national information-sharing mechanisms should be enhanced. She urged the Secretariat to provide technical support to Member States in building strong and resilient national health systems that could respond to climate-related health issues. Member States must pay particular attention to the handling of hospital waste and chemicals as part of their efforts to reduce pollution.

Mr AASLAND (Norway)¹ said that the WHO Conference on Health and Climate had reinforced both the involvement of the health community in national and international policy discussions on climate change and the idea that health systems must be ready to meet the future challenges of climate change, particularly in developing countries. Welcoming the strong collaboration between WMO and WHO, he encouraged the Secretariat to formalize the establishment of a joint project office and links to WMO's programmes dealing with climate-sensitive health issues.

Ms BOTERO HERNÁNDEZ (Colombia)¹ confirmed that the revised WHO work plan on climate change and health would be in line with Colombia's own public policies on adaptation to climate change and air pollution. She particularly welcomed objectives 2, 3 and 4.

Mr REALINI (Monaco)¹ congratulated WHO on the results of its recent conference, and supported the revision of the WHO work plan, which provided a robust framework for climate-related activities. He particularly welcomed the reference in the report to assessing and promoting actions that reduced the burden of disease associated with air pollution.

Dr SARIWATI (Indonesia)¹ said that the global climate change model had identified her country as being highly vulnerable to the effects of climate change. In cooperation with WHO, Indonesia was mobilizing resources for evidence-based policies; updating a national plan to promote health adaptation to climate change; and finalizing a training manual for the South-East Asia Region. Nevertheless, global action was needed to raise awareness among governments and communities, and more attention should be paid to climate change resilience in the revised work plan and in health-related community interventions.

Mr BOISNEL (France)¹ said that France appreciated the WHO Conference on Health and Climate and its outcome, the revision of the WHO work plan and the synergetic collaboration between WMO and WHO.

Dr SHUMAKE-GUILLEMOT (World Meteorological Organization) said that much of the potential damage resulting from climate change could be averted and many lives saved through strategic action, better preparedness, greater resilience to disasters and climate risks, and improved air quality. WMO stood ready to support WHO's proposed actions to protect health from the risks of extreme weather and climate change, and would ensure that reliable information on weather and climate was available and understandable to the health sector. The new WMO-WHO joint office for climate and health was an excellent platform for synergizing efforts and ensuring closer operational collaboration. She commended WHO's active participation in the Global Framework for Climate Services. That international initiative was an important tool at national level to build health sector capacity.

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

Ms DE TROEYER (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, said that the proposals for the revision of the work plan did not cover strategies for adaptation to the adverse effects of climate change, and failed to mention some of the key driving forces of climate change, such as the promotion of the international supply chain through free trade agreements and the relocation of polluting industries to low- and middle-income countries. WHO should advocate a shift in energy, transport and agriculture policies and ensure that less developed countries had access both to alternatives and to assistance for building local climate resilience.

Mr DE MIRANDA (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, said that, despite links between climate change and health being clearer than ever, during the recent 20th session of the Conference of the Parties to the United Nations Framework Convention on Climate Change, Member States had been reluctant to include any mention of health co-benefits in the conference documents. Eventually, they had been referenced but not in the important document on elements for a draft negotiating text. Country representatives should persuade colleagues in government to make health a priority, especially in time for the intended nationally determined contributions due for submission in March 2015. He called on WHO to recognize climate change as a public health emergency, promote the right to health during climate talks, and assist countries to implement health-related national policies. Inclusion of young people and medical students at the Conference had been most welcome.

Dr BUSTREO (Assistant Director-General) said that WHO would continue to provide evidence of the impact of climate change on health and to analyse the policy options available, particularly in the build-up to the 21st session of the Conference of the Parties to the United Nations Framework Convention on Climate Change. She had taken note of the suggestions to include references to greening the health sector; to pay more attention to adaptation to the impact of climate change; and to ensure that global work plans built on regional commitments. She also welcomed the suggestion to promote the involvement of young people in the climate change debate. Consultations were already planned with young people on the item of adolescent health, and WHO would ensure that environmental factors were included in those discussions.

The DIRECTOR-GENERAL emphasized that WHO had forged partnerships to work on climate change not only with WMO but with many other international organizations, including UNDP and UNEP. She reserved particular praise for the comments of the representative of the International Federation of Medical Students' Associations, who had reminded members that health was still not a prominent enough topic on the agenda of the 21st session of the Conference of the Parties to the United Nations Framework Convention on Climate Change.

The CHAIRMAN took it that the Board wished to note the report and approved the revised work plan, requesting the Secretariat to take into account the comments made on the work plan during the discussion.

It was so agreed.¹

¹ Decision EB136(15).

2. WHO REFORM: Item 5 of the Agenda (continued)

Overview of reform implementation: Item 5.3 of the Agenda (Document EB136/7) (continued from the sixth meeting, section 2)

The CHAIRMAN drew attention to the revised version of the draft decision proposed by Argentina, Chile, Colombia, Mexico, Panama, Paraguay, Peru and the United States of America, which read:

The Executive Board,

Recalling WHO relevant documents and agreements on WHO Reform;

Having considered the report of the Secretariat on the Overview of Reform Implementation;

(PP1) Recognizing that the pillar of WHO governance reform is essential to bringing the transformational reform process to the desired outcome that the governing bodies have been working on for more than four years;

(PP2) Recognizing also that the governance pillar can benefit from relevant outcomes from other aspects of WHO Reform, and underlining that the process outlined below has a separate mandate and that it should not in any way impede ongoing reform initiatives, emphasizing in particular the outcomes from the EBSS3;

(PP3) Having considered also the recent Report of the Independent Expert Oversight Advisory Committee contained in document EBPBAC21/2, in particular paragraphs 29 and 30, that states that slow progress on the Governance Reform pillar could impede the overall WHO reform agenda, and paragraph 28, which expresses concern at the lack of alignment in priorities at the three levels of the Organization,

DECIDES:

(OP1) TO ESTABLISH an inclusive Member States¹ consultative process on governance reform, to complete its work by the Sixty-ninth World Health Assembly, providing recommendations through the Executive Board on how to improve WHO governance efficiency, with the mandate to address:

(a) working methods of Governing Bodies, including relevant proposals by the Secretariat and the WHO Reform Stage 2 Evaluation, as well as agenda-setting, including the significant growth in the number of agenda items, resolutions and decisions and its impact on governance, and the functioning of the Executive Board Bureau and officials of the World Health Assembly;

(b) concrete ways to improve the alignment of the governance of all three levels of the organization, so as to improve accountability and effectiveness;

(OP2) that the Member States¹ consultative process should include two meetings open to all Member States with equal participation, as well as the creation of a working group which will further develop detailed recommendations on both the sub-elements above concerning the mandate of this consultative process. The working group will be made up of two members with relevant experience from each region whose selection and work will be facilitated by the Geneva-based regional coordinators so as to ensure inclusiveness;

(OP3) to urge Member States¹ to provide their inputs and proposals relevant to the sub-elements in paragraph 1 through the online platform as outlined below, by 2nd March, 2015;

¹ And, where applicable, regional economic integration organizations.

(OP4) that the first Member States meeting will take place at a one-day session back to back with the 22nd meeting of the PBAC in May 2015, which will be reduced to two days, and provide concrete inputs to the working group for its work;

(OP5) that the second Member States meeting will take place by November 2015, and will provide recommendations to the 138th meeting of the Executive Board;

(OP6) that the working group will meet at least once prior to the first Member States meeting and will provide a preliminary report to it based on inputs from Member States and the Secretariat as outlined below, and have at least one other meeting before the second Member States meeting, for which it will produce a final report including recommendations;

(OP7) to request the Director-General:

(a) to establish an online platform to facilitate sharing of Member States¹ inputs and proposals, prior to the first Member States meeting and to maintain it throughout this inclusive Member States consultative process;

(b) to provide the following on the online platform established according to 7(a):

(i) a compendium of existing relevant background documents related to governance reform for the first meeting of the working group and the first Member States meeting, including reports, evaluations, resolutions and decisions;

(ii) an overview of the last ten years of the number of agenda items, number of documents, decisions and resolutions for the Executive Board and World Health Assembly, as well as the number of formal and informal meetings during and in between sessions of the governing bodies, and the associated costs;

(iii) current costing of formal and informal meetings during and in between sessions of the governing bodies, including price differences relating to location in Geneva;

(OP8) to request the Member States consultative process to report to the 138th Executive Board on governance reform, under a separate agenda item, with a view to considering final recommendations from this process, preparatory to consideration by the Sixty-ninth World Health Assembly.

Ms ROA RODRIGUEZ (Panama), speaking in her capacity as co-chairperson of the drafting group, said that the aim of the draft decision was to facilitate changes to the structure of WHO's governing bodies in order to make their work more efficient, strategic and focused. Two drafting meetings had been held, with the active participation of many delegations, resulting in consensus on the text.

Mr SEGARD (Canada)² and Ms ANDERSSON (Sweden)¹ requested that their countries be added to the list of sponsors of the draft decision.

The decision was adopted.³

¹ And, where applicable, regional economic integration organizations.

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

³ Decision EB136(16).

3. **HEALTH SYSTEMS:** Item 10 of the Agenda (continued)

Global strategy and plan of action on public health, innovation and intellectual property: Item 10.5 of the Agenda (Document EB136/31) (continued from the ninth meeting)

The CHAIRMAN drew attention to a revised version of the draft decision proposed by Argentina, Brazil, Ecuador, India and South Africa, which read:

The Executive Board,

Having considered the report on Evaluation of the global strategy and plan of action on public health, innovation and intellectual property,¹ decided the following:

- (1) to recommend to the Sixty-eighth World Health Assembly to extend the deadline of the overall programme review of the global strategy **and plan of action** on public health, innovation **and intellectual property** on its achievements, remaining challenges and recommendations on the way forward to 2018, recognizing it was not presented in 2015, as requested by resolution WHA62.16;
- (2) to recommend to the Sixty-eighth World Health Assembly to extend the time frame of the plan of action on public health, innovation and intellectual property until 2022;
- (3) to request the Director-General to provide a report for the Sixty-eighth World Health Assembly on options, in consultation ~~and with the involvement of~~ Member States, for **the conduct of the comprehensive evaluation and** the overall programme review of the global strategy **and plan of action** on public health innovation **and intellectual property**, on its achievements, remaining challenges and recommendations on the way forward, **including whether to combine the two instruments, sequencing, terms of reference, timing and options for establishing an evaluation management group with the goal of completing this exercise by 2018.**

Mrs VALLINI (Brazil), speaking in her capacity as chairperson of the informal consulting group on the draft decision, expressed appreciation to Member States for their constructive approach in the discussions.

The decision was adopted.²

4. **MANAGEMENT AND GOVERNANCE MATTERS:** Item 13 of the Agenda (continued)

Provisional agenda of the Sixty-eighth World Health Assembly and date, place and draft provisional agenda of the 137th session of the Executive Board: Item 13.4 of the Agenda (Document EB136/42)

Ms ROSE-ODUYEMI (Governing Bodies and External Relations) read out amendments to the provisional agenda of the Sixty-eighth World Health Assembly. As a result of decisions taken by the Board during the current session, the following subitems would be deleted: subitem 11.3 on the method of work of the governing bodies; subitem 12.3 on strategic budget space allocation;

¹ See document EB136/31.

² Decision EB136(17).

subitem 13.5 on the global status report on violence and health; the second element of subitem 14.5 on climate and health: outcome of the WHO Conference on Health and Climate; subitem 21.2 on the draft financial strategy for WHO; and subitem 24.1 on evaluation. Under item 14, a new subitem on the health in the post-2015 development agenda would be added.

Two new items would be added to the draft provisional agenda of the 137th session of the Executive Board, on strategic budget space allocation and evaluation.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) welcomed the addition of an agenda item on the post-2015 sustainable development agenda. She suggested that the General Committee hold more meetings during the Sixty-eighth World Health Assembly, if necessary.

Mr MUSTONEN (Finland)¹ suggested that the request in resolution EBSS/3.R1 on Ebola, adopted by the Board at its third Special Session, to the Director-General to report to the Sixty-eighth World Health Assembly on all level 3 emergencies should be reflected in the provisional agenda.

The CHAIRMAN took it that the Board wished to adopt the draft decision contained in document EB136/42, as amended.

It was so decided.²

The CHAIRMAN proposed that the 137th session of the Executive Board be held on 27 and 28 May 2015, in Geneva.

It was so decided.³

The CHAIRMAN said that, in compliance with Rule 8 of the Rules of Procedure of the Executive Board, the draft provisional agenda for the Board's 137th session would be drawn up by the Director-General and circulated to Member States and Associate Members within four weeks of the closure of the current session.

He proposed that, in light of the decision EB136(16) on the overview of reform implementation, which included a provision for reducing the length of meetings of the Programme, Budget and Administration Committee, the twenty-second meeting of the Committee would be held on 14 and 15 May 2015.

It was so decided.⁴

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

² Decision EB136(18).

³ Decision EB136(19).

⁴ Decision EB136(20).

5. MATTERS FOR INFORMATION: Item 15 of the Agenda**Reports of advisory bodies:** Item 15.1 of the Agenda

- **Expert committees and study groups** (Documents EB136/48 Rev.1 and EB136/48 Add.1)

The Board noted the reports.

6. CLOSURE OF THE SESSION

The DIRECTOR-GENERAL congratulated the Chairman on his leadership and commended the productive approach taken by Member States. She noted their strong commitment to learn lessons from the outbreak of Ebola virus disease and use those lessons to drive changes; to ensure equitable access to health care; to achieve universal health coverage; and to make WHO fit for purpose, while preserving the technical integrity of the Organization. The Board had tasked the Secretariat with a number of activities to be completed before the Sixty-eighth World Health Assembly and work on them had already started.

After the customary exchange of courtesies, the CHAIRMAN declared the 136th session of the Executive Board closed.

The meeting rose at 12:25.

LIST OF MEMBERS AND OTHER PARTICIPANTS

MEMBERS, ALTERNATES AND ADVISERS

MALDIVES

Mr M.H. SHAREEF, Minister in the President's Office, Male, **(Chairman)**

Alternates

Mr H. RASHEED, Minister of State for Health, Ministry of Health, Male

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

Ms A. SAMIYA, Deputy Director-General, Ministry of Health, Male

Ms M. ABOOBAKURU, Director, Ministry of Health, Male

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

ALBANIA

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

Alternate

Mrs F. KODRA, Ambassador, Permanent Representative, Geneva

Advisers

Mr F. DEMNERI, First Secretary, Permanent Mission, Geneva

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

ANDORRA

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

Alternate

Mme E. CANADAS, Deuxième Secrétaire, Mission permanente, Genève

ARGENTINA

Dra. A. CARBONE, Subsecretaria de Relaciones Sanitarias e Investigación, Ministerio de Salud, Buenos Aires

Alternates

Dra. C. MADIES, Asesora de la Subsecretaría de Políticas, Regulación y Fiscalización, Ministerio de Salud, Buenos Aires

Dr. P.A. KREMER, Director Nacional de Relaciones Internacionales, Ministerio de Salud, Buenos Aires

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

Sr. D. ALONSO, Coordinador de Administración, Recursos Humanos y Relaciones Internacionales, Ministerio de Salud, Buenos Aires

Sr. D.G. MAGALLANES, Funcionario de la Dirección Nacional de Relaciones Internacionales,
Ministerio de Salud, Buenos Aires

Sra. M. KEMP, Asistente Privada de la Subsecretaria de Relaciones Sanitarias e Investigación,
Ministerio de Salud, Buenos Aires

Adviser

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

AUSTRALIA

Mr M. BOWLES, Secretary, Australian Government Department of Health, Canberra

Alternates

Mr J. QUINN, Ambassador, Permanent Representative, Geneva

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

Mr B. DAVID, Principal Health Sector Specialist, Development Policy Division, Australian
Government Department of Foreign Affairs and Trade, Canberra

Advisers

Ms M. HEYWARD, Health Adviser, Permanent Mission, Geneva

Mrs S. ELLIOTT, Development Counsellor (Health), Permanent Mission, Geneva

Dr T. POLETTI, Health Adviser, Permanent Mission, Geneva

Ms J. KAINE, First Secretary, Permanent Mission, Geneva

AZERBAIJAN

Professor O. SHIRALIYEV, Minister of Health, Baku

Alternates

Dr M.N. NAJAFBAYLI, Ambassador, Permanent Representative, Geneva

Dr S. ABDULLAYEV, Head, International Relations Department, Ministry of Health, Baku

Mr E. ASHRAFZADE, Third Secretary, Permanent Mission, Geneva

Mrs S. SULEYMANOVA, Third Secretary, Permanent Mission, Geneva

BELGIUM

Dr D. CUYPERS, Président du Comité de Direction, SPF Santé publique, Sécurité de la Chaîne
alimentaire et Environnement, Bruxelles

Alternate

M. B. de CROMBRUGGHE, Ambassadeur, Représentant permanent, Genève

Advisers

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