EXECUTIVE BOARD
141st session

EB141/PSR/1
3 July 2017

PROVISIONAL SUMMARY RECORDS OF THE FIRST MEETING

WHO headquarters, Geneva
Thursday, 1 June 2017, scheduled at 09:00

Chairman: Dr R. BUSUTTIL (Malta)
later: Dr A. HAFEEZ (Pakistan)

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FIRST MEETING

Thursday, 1 June 2017, at 09:05

Chairman: Dr R. BUSUTTIL (Malta)
later: Dr A. HAFEEZ (Pakistan)

1. OPENING OF THE SESSION: Item 2 of the provisional agenda

The CHAIRMAN declared open the 141st session of the Executive Board.

2. EXPRESSION OF SYMPATHY AND SOLIDARITY WITH THE PEOPLE AND GOVERNMENT OF AFGHANISTAN FOLLOWING THE BOMB ATTACK IN KABUL

At the invitation of the CHAIRMAN, the Board observed a minute of silence in memory of all who had lost their lives in the bombing that had taken place in Kabul on 31 May 2017.

3. ELECTION OF CHAIRMAN, VICE-CHAIRMEN AND RAPPORTEUR: Item 1 of the provisional agenda

The CHAIRMAN said that the Board would proceed to elect its Chairman, Vice-Chairmen and Rapporteur before adopting its agenda. He drew attention to Rule 12 of the Rules of Procedure of the Executive Board, which set out the procedures for electing Officers of the Board. Following the principle of rotation among the WHO regions, Dr Assad Hafeez (Pakistan) had been nominated for the office of Chairman of the Executive Board.

Dr Assad Hafeez (Pakistan) was elected Chairman.

Dr Hafeez took the Chair.

The CHAIRMAN thanked the Board for electing him and paid tribute to his predecessor. He drew attention to Rule 12 of the Rules of Procedure, which set out the procedures for electing Officers of the Board. Following the principle of geographical rotation, and on the basis of consultations in the respective regions, the following nominations had been made for the four Vice-Chairmen: Dr Josiane Nijimbere (Burundi), Ms Sarah Lawley (Canada), Dr Viroj Tangcharoensathien (Thailand) and Mr Philip Davies (Fiji).

Dr Josiane Nijimbere (Burundi), Ms Sarah Lawley (Canada), Dr Viroj Tangcharoensathien (Thailand) and Mr Philip Davies (Fiji) were elected Vice-Chairmen.

The CHAIRMAN said that, under Rule 15 of the Rules of Procedure, if the Chairman was unable to act in between sessions, one of the Vice-Chairmen should act in his or her place; the order in

which the Vice-Chairmen would be requested to serve should be determined by lot at the session at which the election had taken place.

It was determined by lot that the Vice-Chairmen would serve in the following order: Mr Philip Davies (Fiji), Dr Josiane Nijimbere (Burundi), Ms Sarah Lawley (Canada), Dr Viroj Tangcharoensathien (Thailand).

The CHAIRMAN said that, pursuant to Rule 12 of the Rules of Procedure and in accordance with the principle of rotation among geographical regions, Professor Maksut Kulzhanov (Kazakhstan) had been nominated Rapporteur.

Professor Kulzhanov was elected Rapporteur.

4. ADOPTION OF THE AGENDA: Item 3 of the provisional agenda (documents EB141/1 and EB141/1(annotated))

The CHAIRMAN drew attention to a suggestion by the Secretariat to delete three items on the provisional agenda, as there were no reports to consider under those items: item 7.5 (Hosted partnerships – Proposals for WHO to host formal partnerships); item 7.7 (Amendments to the Financial Regulations and Financial Rules); and agenda item 9 (Amendments to the Statutes of the Sasakawa Health Prize).

It was so agreed.

The agenda, as amended, was adopted.

The CHAIRMAN suggested that the Board should take up its agenda items in numerical order.

It was so agreed.

Organization of work

The representative of MALTA, speaking on behalf of the European Union and its Member States, recalled that, as agreed in an exchange of letters in 2000 between WHO and the European Commission on the consolidation and intensification of cooperation, and without prejudice to any future general agreement between WHO and the European Union, the European Union attended sessions of the Board as an observer. He requested that, at the 141st session of the Board, as at previous sessions, representatives of the European Union should again be invited to participate, without vote, in the meetings of the Board and its committees, subcommittees, drafting groups or other subdivisions that addressed matters falling within the competence of the European Union.

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

It was so agreed.

5. OUTCOME OF THE SEVENTIETH WORLD HEALTH ASSEMBLY: Item 4 of the agenda

The representative of ALGERIA, speaking on behalf of the Member States of the African Region, expressed appreciation for the conduct of the Health Assembly and the smooth running of the process to elect the next Director-General. The African Region welcomed the pertinent remarks made by the Director-General and expressed deep appreciation for her leadership and efforts to facilitate reform of the Organization. He congratulated Dr Tedros on his election and underscored that he could count on the full support of the African Region. The Region had played an active and constructive role in the formal and informal discussions held during the Assembly. It had raised its concerns regarding the funding challenges facing WHO, issues of access to medicines, emerging communicable diseases, climate change, antimicrobial resistance and noncommunicable diseases. The Region believed that the Organization's work must facilitate the achievement of the targets of the 2030 Agenda for Sustainable Development, including the target on universal health coverage. In that regard, sufficient technical and financial assistance should be made available to Member States in the African Region so that their respective health systems could cope more effectively with health emergencies, including outbreaks of Ebola virus disease, Zika virus disease and yellow fever. He underscored that, in the light of the significant number of agenda items under consideration by the Health Assembly, it would be helpful to receive proposed draft decisions and resolutions on a timely basis so that delegations could consider the issues at stake more effectively.

The representative of the NETHERLANDS expressed his deep appreciation for the smooth running of the Health Assembly and the well organized process to elect the next Director-General. While his country welcomed the 3% increase in assessed contributions, it was disappointing that Member States had not agreed to the 10% rise that the Netherlands and several other countries had wanted. Access to medicines had been an important area of discussion at the Health Assembly and must be addressed thoroughly by the Board. He urged the Secretariat to prepare a detailed report on that subject.

The representative of BRAZIL expressed appreciation for the transparent and equitable process to elect the next Director-General and paid tribute to the outgoing Director-General's work and her inspiring legacy, particularly for women and girls. Welcoming the achievements of the Seventieth World Health Assembly, she emphasized that her country stood ready to work closely with other Member States and would fully support WHO's efforts to fulfil its mandate as the global health lead.

The representative of SRI LANKA assured the Board that that his country would play an active role in efforts to facilitate the achievement of WHO's global health objectives. He drew attention to his country's request for an expert committee to be established to examine the issue of alcohol control.

The representative of THAILAND expressed concern at WHO's increasing reliance on voluntary contributions and the failure of Member States to agree to a 10% increase in assessed contributions. He urged the Board to continue discussions on the matter, particularly given the funding shortages facing many of the Organization's programmes and initiatives. He welcomed the progress made in the WHO governance reform process and called for future Health Assemblies to consider that issue as a substantive agenda item.

The representative of ITALY said that the impact of climate change on health was of paramount importance and WHO's leadership in that area was crucial. His Government was ready to provide technical expertise and support to the budget review process to ensure that the Organization remained strong and independent.

6. REPORT OF THE PROGRAMME, BUDGET AND ADMINISTRATION COMMITTEE OF THE EXECUTIVE BOARD: Item 5 of the agenda (document EB141/2)

The representative of THAILAND, speaking in his capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, reported on the three items considered by the Committee that did not appear separately on the Board's agenda, as reflected in document EB141/2 (the annual report of the Independent Expert Oversight Advisory Committee, the annual report on compliance, risk management and ethics, and the reports of the Joint Inspection Unit). He also reported on the Committee's consideration of hosted partnerships and paid particular tribute to the Alliance for Health Policy and Systems Research, which supported financing and health systems reform and capacity-building for health policy analysis. Many low- and middle-income countries had benefited greatly from that support. He commended the Norwegian Government and other partners who had established and continued to support the Alliance. In closing, he expressed his appreciation at having chaired the meeting and said that the Committee's members had taken part in lively and constructive deliberations.

The representative of MEXICO drew the Board's attention to the amendments made by the Committee to the Staff Regulations and Staff Rules with a view to harmonizing the mandatory age of separation at WHO with the mandatory age of separation of other organizations in the United Nations common system. He noted the Committee's recommendation that those amendments should come into effect on 1 January 2018.

The Board noted the report.

7. TECHNICAL AND HEALTH MATTERS: Item 6 of the agenda

Eradication of malaria: Item 6.1 of the agenda (document EB141/3)

The representative of the CONGO, speaking on behalf of the Member States of the African Region, welcomed WHO's efforts to combat malaria, which was still the primary cause of mortality and morbidity in some African countries. Progress had been made through a combination of vector management, free medical treatment for children and pregnant women and intensified prevention measures among the most vulnerable groups. Global initiatives on malaria had had mixed results in different countries because of the sometimes drastic, though necessary, conditions imposed. He suggested that the report should have mentioned multisectoral gaps in the efforts undertaken as well as steps needed to accelerate the production of an effective and accessible vaccine, safeguard the efficacy of existing antimalarial drugs, and enhance vector management. Countries with extensive forests or wetlands should receive substantial vector management support, and WHO and other partners should provide support to cross-border initiatives. He invited WHO, in collaboration with other relevant stakeholders, to publish feasibility studies and prepare a biennial evaluation framework providing for the submission of interim reports to the Board or the Health Assembly until 2025.

The representative of the DOMINICAN REPUBLIC said that almost all cases of malaria in his country were caused by *Plasmodium falciparum*, the most deadly species of malaria parasite, but that an antimalarial programme conducted jointly with Haiti since 2010 had led to a 70% drop in infection rates. The various actions taken, including the elimination of the breeding grounds of *Anopheles* mosquitoes, fumigation and residual spraying of homes and screening, demonstrated his country's

political commitment to combat the disease, in line with the three strategic pillars of the WHO global technical strategy.

The representative of BRAZIL said that her Government was fully committed to the implementation of WHO's recommendations for the elimination of malaria. To reduce mortality due to malaria and the seriousness of cases, and to combat resistance to antimalarial medicines, her country had invested in infrastructure, research and innovative diagnostic tools for outbreak monitoring. As a result, the number of malaria cases in Brazil had fallen by 77% between 2000 and 2015 and by a further 10% between 2015 and 2016. Her Government would continue to work with other South American and Portuguese-speaking countries to exchange experiences on combating the disease.

The representative of THAILAND said that malaria remained the largest single cause of child mortality in Africa. Challenges impeding the eradication of the disease included those related to climate change, which would have a significant impact on the prevalence of vector-borne diseases. That and other environmental factors, such as deforestation, meant that mitigation and adaptation strategies must play a key role in all malaria elimination programmes. Growing insecticide and drug resistance posed further challenges. Sustained financial and political commitment was needed to enhance vector control and facilitate the development of a malaria vaccine and new therapeutic drugs. Any interruption in funding would result in a resurgence of the disease. She also called for further research on epidemiological trends in countries affected by malaria, which would help ensure that interventions to combat the disease were more accurately targeted. She welcomed the establishment of the Strategic Advisory Group on Malaria Eradication.

The representative of BHUTAN said that her country aimed to reach the target of zero indigenous malaria cases by 2018 and certification of malaria elimination by 2022. The biggest challenge impeding Bhutan's efforts to achieve those goals was the cross-border reintroduction of malaria. Countries must develop robust surveillance systems and rapid response capacities to prevent reintroduction, and must address cross-border concerns as part of a globally coordinated approach. New drugs and insecticides were also needed as well as tools to monitor drug and insecticide resistance. Sustainable financing was essential. Initiatives that had been abandoned due to insufficient multisectoral collaboration or financial resources should be revisited. She urged the Strategic Advisory Group to consider all those issues.

The representative of SRI LANKA said his country had been malaria free since 2012 but he was not complacent: mobility and migration, urbanization, changes in land use and many other factors could threaten what had been achieved. He therefore welcomed the report, which would facilitate the development of new strategies to fight malaria.

The representative of BAHRAIN, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that all malaria-endemic countries should sustain their commitment to fighting the disease and increase domestic funding to ensure full implementation of their national malaria strategies and plans. She urged international donors and partners to increase and sustain their financial support for malaria control and elimination initiatives, paying special attention to countries experiencing humanitarian emergencies, in order to ensure continued progress towards targets and to prevent setbacks. Strategies to combat malaria should be carefully developed to ensure that life-saving interventions were made available to those who were at high risk of contracting the disease, who were often poor and marginalized.

The representative of JAPAN said that, although the eradication of malaria was a noble objective, it would not be easy to achieve and it was important to avoid setting countries impossible goals. Efforts to eradicate polio had made it abundantly clear how expensive eradication efforts could

be. The Strategic Advisory Group should dispassionately examine a variety of options for moving towards the goal of a malaria-free world. It was also important to harmonize the positions adopted by the Strategic Advisory Group and the Malaria Policy Advisory Committee. Eradication required complex and resource-intensive work; the Advisory Group should therefore undertake operational and financial assessments and should not consider only technical matters. He asked the Secretariat to ensure transparency regarding the membership of the Group, and any financial contributions they received, as that would enhance the credibility of the report on the work of the Group.

The representative of IRAQ said that intra- and interregional collaboration and exchange of experiences were essential prerequisites for malaria eradication. Because of the very difficult conditions in certain countries in the Eastern Mediterranean Region, it was particularly important to support those countries' malaria eradication efforts. The Member States of the Region had adopted approaches to ensure that those efforts continued, even in emergency situations.

The representative of MEXICO said that, to eradicate malaria, it was vital to scale up interventions to prevent transmission of the pathogen. His country was likely to reach the target of zero cases of malaria by 2020. Member States should continue their work to achieve the objectives of the global technical strategy for malaria 2016–2030, which would accelerate efforts to achieve Sustainable Goal 3.

The representative of COLOMBIA said that, in its efforts to combat malaria, his country had drawn upon lessons learned by other countries, and made use of recent scientific and technological developments. The climatic, geographical and epidemiological conditions in Colombia, as well as challenges related to illegal mining activities and the armed conflict in the country had impeded Colombia's efforts to combat malaria. The peace agreements that had recently been signed were therefore welcome, as former soldiers and populations in former conflict zones would be able to have access to treatment. His country was giving particular attention to capacity-building and social mobilization in its efforts to achieve the eradication of malaria, and was enhancing intersectoral coordination with a view to achieving that objective. He highlighted the need for a flexible, dynamic, multidisciplinary and multistakeholder approach in the work of the Strategic Advisory Group, with input from both public and private sector actors. It was necessary to develop institutions and response capacities at country level to guarantee the sustainability of prevention actions, and maintain opportunities for dialogue between Member States and the Strategic Advisory Group.

The representative of ALGERIA drew attention to the particular needs of countries, including his own, that were working towards certification of malaria elimination; those countries faced the double challenge of consolidating elimination and preventing reintroduction, which required political commitment and substantial financial resources. Efforts in Algeria were multisectoral and focused on surveillance, vector control and the provision of free treatment for all patients, including migrants, who accounted for nearly 60% of imported cases. He urged WHO to provide the necessary technical support to countries approaching elimination of malaria, to help them to reach that goal.

The representative of LIBYA said that although it had successfully eliminated malaria in 1973, his country was facing a new health crisis due to the arrival of large numbers of illegal migrants, and cases of malaria had been registered in 2016 and 2017 in areas where illegal migrants were concentrated. He urged the Secretariat to monitor that situation and provide assistance to Libya so that it could develop a plan of action to prevent further infections among the population.

The representative of ITALY expressed satisfaction with the report and highlighted the need to review mathematical modelling, particularly given increasing resistance to medicines, which was also exacerbated by the circulation of counterfeit drugs. He called for affected countries to dedicate

adequate resources to malaria control and underscored that without their strong financial commitment to that end, there would be no hope of eradicating malaria in the near future. Stronger support should be given to research to counter the risk of disinvestment triggered by a decrease in incidence. He highlighted the risk of vectors being imported into unaffected countries; suitable vector breeding conditions existed in Italy and many other Mediterranean countries. Stronger collaboration was required among the three WHO regional offices monitoring health in the countries surrounding the Mediterranean, particularly given that conflict in several of those countries had led to significant population movements.

The representative of VIET NAM welcomed the adoption of the global technical strategy for malaria 2016–2030, which her country had used to implement effective, evidence-based interventions. WHO should lead the eradication debate, and reaffirm its commitment to that goal. The Regional Committee for the Western Pacific had endorsed the Regional Action Framework for Malaria Control and Elimination in the Western Pacific 2016–2020. Intersectoral and intercountry collaboration was crucial in order to prevent malaria from moving across borders. Further efforts were needed to reach those most at risk, including mobile populations and those living and working in forested areas. The spread of drug-resistant malaria could threaten malaria elimination efforts. Financial stability was crucial in ensuring the success of malaria control at the regional and global levels.

The representative of the PHILIPPINES said that, despite progress in her country in urban areas, malaria remained a concern in rural areas. Measures in place included: early intervention, diagnosis and prompt treatment; continuous vector surveillance and control; case surveillance and epidemic management; and service quality assurance. However, such efforts were likely to be affected by climate change. Reports by the Strategic Advisory Group on products of innovation, population trends and land use would therefore be very useful.

The representative of PAKISTAN said that his country had drawn up a national strategic plan to combat malaria on the basis of the global technical strategy. Pakistan had districts in which malaria was endemic as well as one province that qualified for pre-elimination, and was endeavouring to strengthen malaria control and prevention in districts in which the disease was endemic at high and moderate levels and achieve malaria elimination in areas in which the disease was endemic at low levels. The targeted approach should lead to a significant decrease in infection rates, and ultimately to the elimination of malaria throughout the country.

The representative of the UNITED STATES OF AMERICA[1] said that malaria prevention and control remained a priority for his Government. Agreeing with the views expressed by the representative of Japan with regard to eradication, he suggested that, in future sessions of the Board, the title of the agenda item under consideration should be amended to read: “Future scenarios for malaria, including eradication”, which would reflect the mandate of the Strategic Advisory Group. He asked whether a member of the Board would second that proposal.

The representative of CANADA expressed support for the concerns that had been raised regarding the distinction between eradication and elimination, and said she would second the amendment to the title of the agenda item proposed by the representative of the United States of America.

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

The representative of NEW ZEALAND said that he was keen to discuss further amendments to the title if it was not quite what the Board expected.

The representative of the DOMINICAN REPUBLIC expressed support for the proposed amendment to the title of the agenda item.

The representative of ZIMBABWE[1] echoed the support for the proposals made by the representatives of Japan, Canada and the United States of America. Although Africa had been left out of past WHO eradication efforts, work on malaria control and elimination had been renewed in the 1990s and progress had been made towards the elimination of malaria in his country and subregion. He underscored the need to prioritize WHO's malaria elimination programme in Africa, with particular regard to scaling up indoor residual spraying and larval source management.

The representative of ANGOLA[1] said that her Government was fully committed to combating malaria – which continued to be a cause of high rates of mortality and morbidity– through the mobilization of domestic funding, prevention measures in local communities, and national and regional cooperation. She emphasized the importance of vector control and a multisectoral approach.

The representative of MONACO[1] said that her Government had contributed to several projects including: a malaria elimination project in eastern and southern Africa; a technical meeting between experts and health ministers to improve cooperation in the Sahel region; joint work with Medicines for Malaria Venture and improvements to the epidemiological monitoring system in Burkina Faso. She welcomed the clarification provided as to the distinction between elimination and eradication, recalling previous discussions regarding the funding needed for eradication campaigns, notably for polio. She commended the decision to set up the Strategic Advisory Group to study the feasibility and costs of malaria eradication, as well as factors such as climate change. She requested regular updates on progress so that informed decisions could be made.

The representative of AUSTRALIA[1] encouraged the new Strategic Advisory Group to focus on new treatments and diagnostic tools for artemisinin-resistant malaria, as drug resistance was a particular concern in the Greater Mekong subregion and threatened global malaria elimination. Elimination in that subregion was a priority, and his Government was contributing to regional mechanisms such as the Asia Pacific Leaders' Malaria Alliance. He welcomed the sustained efforts by the Secretariat and Member States to control and eliminate malaria and looked forward to the outcomes of the Strategic Advisory Group's analysis of future scenarios, technical and operational feasibility, potential strategies, and the expected costs of eradication. However, he agreed that it was important to have an open-minded approach when considering future scenarios for malaria. He agreed with the suggestion made by the representative of the United States of America to change the agenda item title to highlight the focus on future scenarios.

The representative of SPAIN[1] said that the report highlighted the problem of resistance to insecticides and medicines. His Government actively supported malaria elimination efforts through its support for WHO and participation in other multilateral partnerships. He looked forward to the results of the work of the Strategic Advisory Group on the emerging determinants of malaria, including environmental determinants, and his country would continue to support efforts to achieve the objectives set out in the global technical strategy for malaria 2016–2030.

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

The representative of NICARAGUA[1] noted the major progress made regarding malaria control worldwide and congratulated WHO on its efforts towards eradication, although he noted that there had been an increase in the number of cases in the Region of the Americas in recent years. He described efforts made in his country, including the provision of free treatment, vector control measures, an awareness campaign, and diagnosis and surveillance initiatives. He expressed commitment to tackling the challenge in line with the global technical strategy for malaria 2016–2030.

The representative of KENYA[1] shared the progress made in her country, which had seen a significant decrease in the burden of malaria in recent decades thanks to concerted efforts by local and global partners. The national strategic framework had been revised in response to the evolving context and the emerging need for equitable resource allocation to malaria control products and services. As the burden of malaria decreased, more innovative strategies and tools would be required to progress towards the pre-elimination and elimination phases. Patients from Kenya were due to participate in the malaria vaccine pilot programme, but noted that substantial resources would be required. The private sector would provide an impetus for new innovations in malaria control and the provision of commodities. She looked forward to the report of the Strategic Advisory Group.

The representative of the RUSSIAN FEDERATION[1] drew attention to previous technical and financial efforts made by his country at the national, regional and global levels. New approaches, such as intersectoral programmes and plans, were needed to face new challenges. He echoed the comments made by the representative of Monaco that the Strategic Advisory Group would bring new opportunities for further success and expressed support for the comments made by the representative of the United States of America regarding the need for correct terminology when tackling the issue.

The ASSISTANT DIRECTOR-GENERAL (HIV/AIDS, Tuberculosis, Malaria and Neglected Tropical Diseases) thanked Member States for their interventions and welcomed the efforts and investments that have been made so far to achieve a malaria-free world. The WHO global technical strategy for malaria 2016–2030 aimed at a reduction in malaria case incidence and mortality rates of at least 90%,and this ambition was also reflected in the Sustainable Development Goals. Given this background, it was timely to launch discussions on future scenarios to combat malaria. The Strategic Advisory Group on malaria eradication had been established to provide advice on the technical and operational feasibility of malaria eradication, as well as the expected costs and potential timelines for that effort. The Strategic Advisory Group would submit its report to the Director-General following further meetings. Lessons learned from poliomyelitis eradication had been shared with the Strategic Advisory Group.

He emphasized that the 2040 target for the eradication of malaria declared by certain partners had not been set by the United Nations or WHO. The Organization remained optimistic, however, that current trends would continue and the global malaria burden would further decrease, despite the many challenges. The strategic approach contained in the global vector control response 2017–2030, which was welcomed by Member States at the Seventieth World Health Assembly, would optimize national responses and accelerate progress in the fight against malaria. He looked forward to working with all stakeholders on an integrated response. In conclusion, he took note of the proposed amendment to the title of the agenda item, which reflected the purpose of the Strategic Advisory Group.

The representative of ALGERIA asked whether the proposed amendment to the title of the agenda item would be reflected in the agenda that had already been adopted for the current session of the Board.

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

The representative of the OFFICE OF THE LEGAL COUNSEL explained that the proposed new title would be used for future work on malaria, not during the current session.

The Board noted the report.

Rheumatic heart disease: Item 6.2 of the agenda (document EB141/4)

The CHAIRMAN drew the Board's attention to a draft resolution on rheumatic heart disease, proposed by Australia, Brazil, Canada, Cook Islands, Ecuador, Fiji, Japan, Namibia, New Zealand, Pakistan, Samoa, Tonga and Tuvalu, which read:

The Executive Board,
Having considered the report on rheumatic heart disease,[1]

RECOMMENDS to the Seventy-first World Health Assembly the adoption of the following resolution:

The Seventy-first World Health Assembly,

PP1 Reaffirming resolutions: WHA66.10 on follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases; WHA69.2 on committing to implementation of the Global Strategy for Women's, Children's and Adolescents' Health; and WHA69.25 on addressing the global shortage of medicines and vaccines, and the safety and efficacy of children's medicine; and the 2015 African Union Addis Ababa Communiqué on Eradication of Rheumatic Heart Disease in Africa;[2]

PP2 Noting with concern that rheumatic heart disease is a significant, preventable cause of morbidity and mortality for people in all WHO regions which, even with incomplete data, is known to affect at least 33 million individuals and cause over 300 000 deaths annually, especially among vulnerable and marginalized groups including children, adolescents, pregnant women and poor and indigenous populations;[3]

PP3 Recognizing that rheumatic heart disease is a preventable condition arising from acute rheumatic fever, a secondary sequelae of group A beta haemolytic streptococcal pharyngitis, and that early detection and diagnosis of this form of pharyngitis, acute rheumatic fever and rheumatic heart disease, with judicious antibiotic treatment of group A beta haemolytic streptococcal pharyngitis and appropriate antibiotic prophylaxis for those who have experienced acute rheumatic fever, can substantially reduce morbidity and mortality in a cost-effective way;

PP4 Concerned with a lack of reliable access to essential medicines for the prevention and treatment of group A beta haemolytic streptococcal pharyngitis, acute rheumatic fever and rheumatic heart disease;

PP5 Recalling that global initiatives can provide much-needed leadership, awareness and momentum to "beat" rheumatic heart disease, as demonstrated by the WHO global programme for the prevention and control of rheumatic heart disease (1984–2002);

[1] Document EB141/4.

[2] Available at http://www.pascar.org/uploads/files/ADDIS_ABABA_COMMUNIQU%C3%89_ON_ERADICATION_OF_RHUEMATIC_HEART_DISEASE_IN_AFRICA_-_Submission1.pdf, accessed 30 May 2017.

[3] The 2010 Global Burden of Disease report.

PP6 Recognizing rheumatic heart disease is a preventable disease of poverty, and pursuit of the Sustainable Development Goals to end poverty and achieve universal health coverage is therefore critical, and that reducing barriers to effective prevention and control is consistent with the WHO Constitution and priority work areas,

OP1 URGES Member States:[1]

(1) to accelerate multisectoral efforts towards reducing poverty and improving socioeconomic standards by all means, tackling the known root determinants of rheumatic heart disease, including poor housing, overcrowding and reduced access to care;

(2) to estimate their burden of rheumatic heart disease, and, in the case of countries where the disease is endemic, in accordance with their national context and priorities, implement and resource rheumatic heart disease programmes that foster multisectoral work focused on prevention, improved disease surveillance, good-quality data collection and analysis that facilitates appropriate follow-up and contributes to a broader understanding of the global disease burden;

(3) to improve access to primary health care, including through investing in a community and primary health care workforce trained in prevention, diagnosis and evidence-based management of group A beta haemolytic streptococcal pharyngitis, acute rheumatic fever and rheumatic heart disease with its potential complications, alongside improving understanding of prevention and control of rheumatic heart disease among at-risk populations;

(4) to ensure timely and reliable access to essential laboratory technologies and medicines for the diagnosis, prevention and treatment of acute rheumatic fever and rheumatic heart disease; and

(5) to strengthen national and international cooperation to address rheumatic heart disease, including through setting global and national measures for reducing the burden of disease, utilizing and sharing best practice methodologies for prevention and control, and creating national and regional networks for specialist diagnosis and treatment, when needed;

OP2 INVITES relevant international stakeholders such as nongovernmental organizations, academic institutions, private sector entities and philanthropic foundations, as appropriate, to assist in driving forward global efforts for the prevention and control of rheumatic heart disease, and collaborate:

(1) to put people living with rheumatic heart disease at the centre of the prevention and control agenda, and continue to advocate on behalf of communities at risk of, or affected by rheumatic heart disease;

(2) to raise the profile of rheumatic heart disease and other noncommunicable diseases of children and adolescents on the global agenda, with a view to strengthening health systems in low- and middle-income countries, eradicating poverty, and addressing health inequities; and

(3) to facilitate timely access to existing and new medicines and technologies for prevention and control of rheumatic heart disease by supporting research and development, including gaining a greater understanding of the pathogenesis and epidemiology of acute rheumatic fever and rheumatic heart disease, and by providing open-access resources;

[1] And, where applicable, regional economic integration organizations.

OP3 REQUESTS the Director-General:

(1) to reinvigorate engagement, lead and coordinate global efforts on prevention and control of rheumatic heart disease, ensuring adequate resourcing, with rheumatic heart disease considered broadly across relevant WHO work areas, extending beyond the noncommunicable disease programme;

(2) to support Member States in identifying rheumatic heart disease burden and, where appropriate, in developing and implementing rheumatic heart disease programmes and strengthening health systems in order to improve disease surveillance, increase availability and training of the community and primary health care workforce, and ensure reliable access to affordable prevention, diagnostic and treatment tools;

(3) to foster international partnerships for resource mobilization, sharing best practice methodologies, developing and supporting a strategic research and development agenda, and facilitating access to existing and new medicines and technologies;

(4) to assess and report on the magnitude and nature of the problem of rheumatic heart disease according to agreed measures, and monitor efforts for the prevention and control of rheumatic heart disease; and

(5) to report on implementation of this resolution to the Seventy-fourth World Health Assembly.

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

Resolution: Rheumatic heart disease

A. Link to the general programme of work and programme budget

1. Outcome(s) in the Twelfth General Programme of Work, 2014–2019 and output(s) in the Programme budget 2016–2017 to which this resolution would contribute if adopted.

Twelfth General Programme of Work, 2014–2019 outcome(s):

- Increased access to interventions to prevent and manage noncommunicable diseases and their risk factors;
- Increased access to interventions for improving health of women, newborns, children and adolescents;
- Increased intersectoral policy coordination to address the social determinants of health;
- Improved access to, and rational use of, safe, efficacious and quality medicines and health technologies;
- 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.

Programme budget 2016–2017 output(s):

Output 2.1.3. Countries enabled to improve health care coverage for the management of cardiovascular diseases, cancer, diabetes and chronic respiratory diseases and their risk factors through strengthening health systems;

Output 1.4.3. New knowledge, solutions and implementation strategies that respond to the health needs of disease-endemic countries developed;

Output 3.1.1. Countries enabled to further expand access to, and improve quality of, effective interventions for ending preventable maternal, perinatal and newborn deaths, from pre-pregnancy to postpartum, focusing on the 24-hour period around childbirth;

Output 4.3.1. Countries enabled to develop or update, implement, monitor and evaluate national policies on better access to medicines and other health technologies; and to strengthen their evidence-based selection and rational use.

2. Brief justification for considering the draft resolution, if there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017.

Not applicable.

3. Estimated time frame (in years or months) for implementation of any additional deliverables.

A process to set appropriate targets and develop a comprehensive plan of action will be developed by the Secretariat during the biennium 2016–2017. Other activities referred to in the resolution will be carried out during the bienniums 2018–2019, 2020–2021 and 2022–2023.

B. Budgetary implications

1. Estimated total cost to implement the resolution if adopted, in US$ millions:

US$ 13.75 million.

2.a. Estimated additional budgetary requirements in the current biennium, in US$ millions:

Level	Staff	Activities	Total
Country offices	0.00	0.00	**0.00**
Regional offices	0.00	0.10	**0.10**
Headquarters	0.30	0.20	**0.50**
Total	**0.30**	**0.30**	**0.60**

Budgetary requirements for the remainder of the biennium 2016–2017 will be accommodated within the ceiling of the Programme budget 2016–2017.

2.b. Resources available during the current biennium

– **Resources available in the current biennium to fund the implementation of the resolution if adopted, in US$ millions:**

US$ 0.60 million.

– **Extent of any financing gap, in US$ millions:**

None.

– **Estimated resources, not yet available, which would help to close any financing gap, in US$ millions:**

Not applicable.

3. Estimated additional budgetary requirements in 2018–2019 (if relevant), in US$ millions:

1. To assess and report on the magnitude and nature of the problem of rheumatic heart disease according to agreed targets, and monitor efforts for the prevention and control of rheumatic heart disease:
   – staff at P3 level at headquarters to support work on rheumatic heart disease at headquarters: US$ 0.45 million.
2. To support Member States in implementing national rheumatic heart disease programmes and strengthening health systems through improved disease surveillance, increased availability and training of the community and primary health care workforce, and ensure reliable access to affordable prevention, diagnostic and treatment tools:
   – updating technical guidelines on primary and secondary prevention of rheumatic heart disease: US$ 0.50 million;
   – providing country technical support: US$ 3.50 million.

Total: US$ 4.45 million

Level	Staff	Activities	Total
Country offices	1.00	1.50	**2.50**
Regional offices	0.60	0.40	**1.00**
Headquarters	0.45	0.50	**0.95**
Total	**2.05**	**2.40**	**4.45**

Has this been included in the Proposed programme budget 2018–2019?

Yes.

4. Estimated additional budgetary requirements in future bienniums (if relevant), in US$ millions:

2020–2021

1. To assess and report on the magnitude and nature of the problem of rheumatic heart disease according to agreed targets, and monitor efforts for the prevention and control of rheumatic heart disease:
   - staff at P3 level at headquarters to support work on rheumatic heart disease at headquarters: US$ 0.45 million;
   - activities: US$ 0.40 million.
2. To support Member States in implementing national rheumatic heart disease programmes and strengthening health systems through improved disease surveillance, increased availability and training of the community and primary health care workforce, and ensure reliable access to affordable prevention, diagnostic and treatment tools:
   - country technical support: US$ 3.50 million.

Total: US$ 4.35 million

Level	Staff	Activities	Total
Country offices	1.00	1.50	**2.50**
Regional offices	0.60	0.40	**1.00**
Headquarters	0.45	0.40	**0.85**
Total	**2.05**	**2.30**	**4.35**

2022–2023

1. To assess and report on the magnitude and nature of the problem of rheumatic heart disease according to agreed targets, and monitor efforts for the prevention and control of rheumatic heart disease:
   - staff at P3 level at headquarters to support work on rheumatic heart disease at headquarters: US$ 0.45 million;
   - activities: US$ 0.40 million.
2. To support Member States in implementing national rheumatic heart disease programmes and strengthening health systems through improved disease surveillance, increased availability and training of the community and primary health care workforce, and ensure reliable access to affordable prevention, diagnostic and treatment tools:
   - country technical support: US$ 3.50 million.

Total: US$ 4.35 million

Level	Staff	Activities	Total
Country offices	1.00	1.50	**2.50**
Regional offices	0.60	0.40	**1.00**
Headquarters	0.45	0.40	**0.85**
Total	**2.05**	**2.30**	**4.35**

> The total additional costs for these two bienniums (US$ 8.70 million) are to be planned within the respective proposed programme budgets.

The representative of NEW ZEALAND underscored the severity of rheumatic heart disease, which was the cause of around 300 000 deaths a year and disproportionately affected vulnerable groups. Given that early intervention could prevent premature mortality, the draft resolution would encourage leadership and action in that respect. The precursors, risk factors, pathogenesis and management of rheumatic heart disease were covered by various sectors and rendered the coordination of an appropriate response challenging. The draft resolution called upon Member States and the Secretariat to work with all stakeholders, including civil society, to implement prevention and control strategies, and drive innovation to tackle rheumatic heart disease. It was essential to consolidate and share experience across regions to ensure effective action. She called on the Secretariat to work across all levels of the Organization and with Member States to build stronger health systems that interacted with other sectors in order to address the main risk factors of poverty, overcrowding and poor access to health care. That would reduce the barriers to the effective prevention, control and treatment of the disease. She encouraged all stakeholders to support the draft resolution.

The representative of BENIN, speaking on behalf of the Member States of the African Region, said that the report showed that rheumatic heart disease was increasingly recognized as an important developmental issue and that international instruments addressing the problem had been endorsed. The report also highlighted certain barriers to progress, in response to which recommendations had been formulated that must be fully implemented in all countries. He welcomed the inclusion of rheumatic heart disease management in the package of essential noncommunicable disease interventions for primary health care. Surgical interventions for heart disease should also be developed. He recommended that countries should register national incidence of rheumatic heart disease in order to take effective action.

The representative of IRAQ, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the devastating yet preventable disease under discussion remained a problem in certain countries in his region. It had been demonstrated that simple and cost-effective measures against rheumatic heart disease could considerably reduce the burden placed on individuals' lives and on health systems. The Organization's work in that area should be stepped up and further technical assistance should be provided to all countries. He welcomed the draft resolution and discussion to reach consensus on the recognition of rheumatic heart disease as a health priority.

The representative of the NETHERLANDS said that he had several reservations concerning the governance aspects of the item. In order to ensure that the agendas of the Organization's governing bodies remained manageable, the draft resolution, which addressed one specific disease, should preferably have been discussed at the regional level or within the broader context of cardiovascular diseases. Moreover, he was concerned that issues raised during a January session of the Board would then require further dialogue at the spring session of the Board, particularly when a draft resolution was tabled. At the 2016 session of the Regional Committee for Europe, a discussion had been held on the number of new matters that had been added to the agenda. Many Member State representatives had agreed that the number of items was unmanageable, which had given way to a reflection on the criteria for tabling new policy documents and resolutions. It seemed to be the prevalent view that a policy document and accompanying resolution was the only way to tackle a health issue; such a fundamental governance issue had to be addressed.

Nevertheless, he acknowledged the work carried out to raise awareness of rheumatic heart disease and therefore expressed support for the draft resolution. He emphasized that rheumatic heart

disease could be addressed through several existing programmes and activities so as not to further overload WHO's workplan.

The representative of the PHILIPPINES noted the eight recommended actions for Member States contained in the report, which would be taken into account in the development of the national health agenda in her country. She agreed that it was unnecessary to create new frameworks to combat rheumatic heart disease, as strengthening health systems in general would achieve the overarching health goals, including the eradication of rheumatic heart disease. She looked forward to the outcomes of the Secretariat's work.

The representative of SRI LANKA said that the report had accurately reflected the situation regarding rheumatic heart disease, which heavily affected South-East Asia. Experience in Sri Lanka had shown that a strong health care system was essential to addressing the disease in a sustainable way. Highlighting national efforts to control the disease, he said that various factors, such as the use of antibiotics for the treatment of upper respiratory tract infections, had resulted in a reduction in the number of cases. However, he noted the recommendation on the development of a safe and effective group A streptococcal vaccine, in light of the resistance brought about by the overuse of antibiotics. He commended the authors of the draft resolution and requested that paragraph 1(4) should include a reference to prophylactic penicillin therapy at the primary care level.

The representative of TURKEY said that approaching the issue of rheumatic heart disease from a new angle was timely and critical. Antigen detection tests, which were used in Turkey, limited the unnecessary use of antibiotics in upper respiratory tract infections and therefore helped to address antibiotic resistance.

The representative of CANADA said that the incidence of rheumatic heart disease was dramatically higher among remote indigenous communities in Canada than in the general population and her Government was committed to reducing that inequality by addressing the key determinants of health, such as overcrowding and low socioeconomic status. Through a whole-of-government approach, access to primary health care and infrastructure in indigenous communities was being improved.

The representative of the CONGO recalled the scale of the problem of rheumatic heart disease in the Congo, where most children were not screened or treated. The problem was amplified by a lack of information and a resistance to information among the marginalized population, resulting in the hospitalization of children in the late stages of the disease. Health strategies must prioritize measures against poverty and also prioritize universal health coverage. While health ministries should take a leadership role, the issue required a multisectoral approach. WHO and other international organizations should support training in order to facilitate screening, treatment and reinsertion into society of children affected by the disease. Noting that paragraph 3(5) of the draft resolution requested the Director-General to report on the implementation of the draft resolution to the Seventy-fourth World Health Assembly, he asked why, given the seriousness of the issue, a follow-up report would not be presented at an earlier Health Assembly.

The representative of BAHRAIN said that rheumatic heart disease had been contained in Bahrain by improving living standards and raising awareness of healthy eating and lifestyles. She outlined other measures that the Bahraini ministries responsible for health and education were taking to treat people with rheumatic heart disease, in addition to measures related to prevention and screening. She agreed that more needed to be done to address the problem, and to that end expressed her support for the draft resolution.

The representative of JAPAN said that rheumatic heart disease was preventable but had been neglected by the global public health agenda. The draft resolution encouraged Member States to make progress in combating the disease by enhancing training of health personnel, improving access to antibiotics and constructing referral systems.

The representative of MEXICO expressed concern at the failure to collect reliable data on rheumatic heart disease in most regions. It was essential to scale up implementation of programmes that addressed the social determinants of health, together with preventive actions such as the appropriate use of antibiotics. He highlighted the importance of training and increasing human resources to enable early diagnosis and treatment. He supported proposals to strengthen the coordinated global response to combat the disease, particularly measures to: improve information on the global epidemiological situation; assist countries where the disease was endemic in formulating national preventive programmes; and improve research into the disease with a view to developing medicines and vaccines. He supported the draft resolution.

The representative of COLOMBIA said that the information contained in the report, would assist in public policy decision-making and thus strengthen Member States' response to rheumatic heart disease. Various care packages were being implemented in Colombia within the framework of a comprehensive health care model, including perinatal maternity care and care for populations at risk of cardiovascular diseases. The present discussion provided the opportunity to place the issue of rheumatic heart disease on the global public health agenda. The cost–effectiveness and feasibility of rapid detection tests for group A streptococcal infections must be evaluated, given the high mortality rate associated with rheumatic heart disease. Detection of pharyngitis and rheumatic fever symptoms should be strengthened and capacity-building among health care providers was required.

The representative of SWEDEN, welcoming the draft resolution, echoed the concerns expressed by the representative of the Netherlands. Preparing adequately for discussions on resolutions at the spring sessions of the Board, immediately following the Health Assembly, proved challenging. The current agenda item had been no exception in that respect. Furthermore, the issue of rheumatic heart disease should be addressed within a wider context to safeguard governance and efficiency, rather than as an individual disease. She also asked how the implementation of the resolution would be funded, given the budgetary implications.

The representative of BHUTAN said that the number of cases of rheumatic heart disease had increased in recent years in Bhutan. She welcomed the proposal to launch a coordinated global response related to rheumatic heart disease. Technical support on developing and implementing national programmes for the prevention and control of rheumatic heart disease should be offered not only to endemic areas but also to all interested Member States. The response should take into account the socioeconomic dimensions of the disease and focus on prevention. She welcomed the draft resolution.

The representative of FIJI said that rheumatic heart disease was a leading cause of mortality among children and young people in Fiji, second only to drowning. There was a need for greater recognition of rheumatic heart disease on the global health agenda as the incidence of the disease was increasing in developing and developed countries. The disease should be addressed at all levels of health care, through partnerships and with the full support of governments, agencies and donors, to reduce the burden of the disease and even aspire to its eventual elimination.

The representative of KAZAKHSTAN said that there was a particular need for more research on rheumatic diseases. Effective national plans for the prevention and control of rheumatic heart disease could then be developed and implemented. Special attention should also be paid to the role of

primary health care; it was essential that a sufficient number of specialists should be trained in how to monitor and treat the disease effectively. The development of new medicines was equally important. His Government supported the draft resolution.

The representative of LIBYA, expressing support for the draft resolution, said that research had the potential to be more effective than other preventive measures, which were governed by complex economic and social factors. He called on Member States to give more support to research in order to enhance understanding of the disease and develop a more effective vaccine for high-risk groups. People affected by the disease, who often needed expensive surgery and follow-up throughout their lives, should not be forgotten.

The representative of ITALY said that rapid diagnostic test equipment for rheumatic heart disease should be made available to primary health care staff, provided that they were properly trained. Appropriate reporting systems and registers should also be developed. There was a need to educate civil society, particularly parents and schoolteachers, on the early signs and symptoms of the disease, as well as on screening and treatment protocols. Given its characteristics, the disease could be easily managed, or even eliminated, by competent and effective primary health care systems. He expressed support for the draft resolution, particularly given his Government's experience with poverty and migration, which were considered to be risk factors for the disease.

The representative of THAILAND said that rheumatic heart disease should be addressed in a comprehensive manner ensuring equitable access to diagnosis and prevention tools. Whereas rapid diagnostic on-site testing reportedly cost between US$ 5 and US$ 10, penicillin cost just a few cents, making it one of the most powerful and most affordable interventions. On the other hand, inappropriate use of penicillin could lead to resistance of the pathogen. More consideration of the issues at stake seemed necessary. He called for more comprehensive intersessional consultations prior to the 142nd session of the Board.

The representative of BRAZIL said that his country, like many others, had experienced shortages of penicillin and he therefore urged the Secretariat and Member States to examine market dynamics and production processes to ensure an adequate supply. While seeking to address the social determinants of health, as outlined in the draft resolution, efforts should be made to align actions with the relevant and interrelated targets of the Sustainable Development Goals. Given the costs involved, resources would be best spent on prevention.

The representative of PAKISTAN noting the devastating effect of rheumatic heart disease, recommended that multicentre, population-based surveys should be carried out at the national level to ascertain the true burden of the disease in every country. Evidence-based guidelines for the management and prevention of rheumatic heart disease were also needed, alongside strategies such as poverty alleviation, teaching good hygiene practices, better access to primary health care facilities, and awareness-raising campaigns.

The representative of the UNITED REPUBLIC OF TANZANIA said that he welcomed the Secretariat's report, but he had noticed that paragraph 19(b) of document EB141/4, on updating technical documents and guidelines, did not appear in the draft resolution. He requested that the two documents be aligned before the resolution was adopted.

The representative of ALGERIA recognized that rheumatic heart disease was preventable. Previously, the Government of Algeria had had to pay for treatment abroad. Subsequently, through a combination of training of health care professionals, awareness-raising of the early symptoms of

infection, alleviating poverty and reducing inequalities, the disease had been virtually eliminated from the country.

The representative of NEW ZEALAND, referring to suggestions that the work of the Board should be broader in focus and not include single-disease items, said that the draft resolution set out a cross-cutting programme.

In relation to suggestions that the Board should only consider substantive resolutions at its January sessions, he wished to recall that there had not been any space on the agenda to discuss the item at the 140th session of the Board, despite informal consultations having taken place. Furthermore, in many years, substantive resolutions had been discussed at the session of the Board following the Health Assembly.

Member States had been widely consulted through informal discussions, teleconferences and regional meetings. Given that the draft resolution had a large number of sponsors and was supported by all the Member States of the Western Pacific Region, he saw no reason to defer a decision to the 142nd session of the Board, for which the agenda was already heavy. As many of the countries affected by rheumatic heart disease were small island States with limited resources and little or no representation in Geneva, intersessional work was not a favoured option.

He expressed support for the amendments proposed to paragraphs 1(4) and 2(3), which would improve consistency within the document, and as such he supported their inclusion. On the other hand, the proposal made by the representative of Sri Lanka to mention intermuscular penicillin specifically, while technically accurate, was not necessary; an appropriate reference already appeared in paragraph 1(3).

The representative of THAILAND said that, as penicillin was both inexpensive and effective as a treatment, the advantages of rapid diagnostic testing would need to be weighed against its costs. He asked the Secretariat to clarify the cost of a rapid diagnostic test before a decision was made on the draft resolution.

The representative of SUDAN[1] said that there was a relatively high incidence of rheumatic heart disease in rural areas in his country. Severe cases required surgical intervention, which was neither readily available nor affordable, all for a disease that could be simply prevented. While a national control programme had been launched in 2012, a lack of financial resources had hindered its implementation in the rural areas where it was most needed. He requested the support of WHO country and regional offices to help the Government of Sudan and its international partners to tackle the disease effectively.

The representative of KENYA[1] said that WHO should continue to play a leading role in the prevention and control of rheumatic heart disease. He called for the adoption of policies on primary and secondary prevention, as indicated in Appendix 3 of the global action plan for the prevention and control of noncommunicable diseases 2013–2020. The approach towards the prevention, control and elimination of rheumatic disease should be multisectoral and integrated into the broader 2030 Agenda for Sustainable Development. His Government wished to be added to the list of sponsors of the draft resolution.

The representative of the NETHERLANDS said that he shared the view of the representative of New Zealand that the amendment proposed by the representative of Sri Lanka to paragraph 1(4) of the draft resolution should not be accepted.

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

The representative of AUSTRALIA[1] said that efforts to achieve the Sustainable Development Goals, end poverty, and ensure access to quality health services for all would be essential to reducing the incidence of rheumatic heart disease worldwide. Reliable access to essential treatments would be critically important. In Australia, work was under way to expand the rheumatic fever strategy to include primary prevention activities and also to address the social determinants of health and thereby tackle the comparatively high incidence of rheumatic heart disease in indigenous communities.

The representative of SOUTH AFRICA[1] said that rheumatic heart disease was a major public health concern in her country, although data on the disease were not readily available. Patients from her country had participated in the Global Rheumatic Heart Disease Registry project, and intersectoral collaboration efforts were under way at the national level to combat the disease. She supported the recommended actions to be taken by the Secretariat and Member States. Her Government asked to be added to the list of sponsors of the draft resolution.

The representative of UGANDA[1] said that, despite the establishment of a rheumatic heart disease registry in Uganda, there was still limited capacity to enable early diagnosis of the disease. WHO should continue to provide assistance in order that gaps in response could be filled. He hoped that in the future, acute rheumatic fever would be prevented through primary prevention and primordial prevention. The recommended actions for Member States were practical and reasonable. His Government wished to be added to the list of sponsors of the draft decision.

The representative of ZAMBIA strongly supported the comments made by the representative of New Zealand. There had been wide consultations on rheumatic heart disease over a reasonable period of time and it was clear that rheumatic heart disease was a major public health problem affecting people in all regions and should be made a priority. He therefore supported the draft resolution and his Government wished to be added to the list of sponsors.

The representative of NORWAY[1] agreed with the governance concerns raised by the representatives of Sweden and the Netherlands. The June meeting of the Board was largely shaped by the fact that it followed the Health Assembly, which limited Member States' capacity for preparation and participation. Single disease topics benefited from the presence of relevant specialized competence, which was rarely available at Board sessions immediately following the Health Assembly. He hoped there would not be a trend towards tabling resolutions at the June Board as it was challenging, particularly if the text required negotiation. He appreciated the thorough and successful job that the representative of New Zealand had done on consulting on the draft resolution in advance of the meeting, but thought it would have been better discussed at the January meeting. Having registered those concerns, he nonetheless supported adoption of the draft resolution.

The representative of BANGLADESH[1] said that epidemiological elimination should be an area of focus if the burden of heart disease was to be minimized in an era of transition from communicable to noncommunicable disease. He supported the proposal made by the representative of Thailand for further in-depth discussion of the costing and treatment issues in reference to paragraphs 1(4) and 2(3).

The representative of the UNITED STATES OF AMERICA[1] welcomed the call for global action to combat the high burden of rheumatic heart disease. Prevention and control programmes were needed in countries and populations with a high incidence of the disease, and systems should be developed to understand better the burden of the disease and the impact of control programmes in

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

those populations and globally. He expressed concern about the inconsistent supply of benzathine benzylpenicillin and encouraged WHO to find solutions that would ensure a reliable source. He supported vaccine development for prevention of group A streptococcal infections and affordable rapid diagnostic tests of group A streptococcal pharyngitis as indicated in the draft resolution. While he supported the draft resolution, he also agreed with the procedural issues that had been raised by the representatives of Sweden, the Netherlands and Norway.

The representative of BURUNDI said that rheumatic heart disease was preventable and that the correct treatment of ear, nose and throat infections in children would reduce its incidence significantly. He supported the draft resolution and his Government wished to be added to the list of sponsors.

The representative of the RUSSIAN FEDERATION[1] said that rheumatic heart disease should be a priority for Member States, not least because of the high social and economic burden it imposed. It was a clear example of a public health issue that required an interdisciplinary approach. Effective treatment was available, but care should be taken when using antibiotics, bearing in mind efforts to combat antimicrobial resistance. In order to optimize the use of resources and avoid duplication, and to streamline the agendas of WHO's governing bodies, he proposed adding a reference to the Health Assembly resolution on antimicrobial resistance to preambular paragraph 1 of the draft resolution. Additionally, he proposed that paragraph 1 should call upon Member States to examine the issue of rheumatic heart disease within the framework of existing political, financial and technical decisions and in the light of national strategies and action plans. He supported the draft resolution.

The representative of the WORLD HEART FEDERATION, speaking at the invitation of the CHAIRMAN, commended WHO for proposing a coordinated global response to rheumatic heart disease and asked the Secretariat to maintain the proposed intersectoral approach. She encouraged Member States to embrace the recommendations outlined in the report and the draft resolution, in particular to embed programmes on rheumatic heart disease in national health structures, mobilize resources and address the known determinants of rheumatic fever and rheumatic heart disease, which were prevalent worldwide. Civil society was ready to play its part and she would welcome suggestions from the Secretariat and Member States on how civil society organizations could best support the implementation of the recommendations. She called for people living with rheumatic heart disease to be involved in the planning and execution of the global response.

The representative of NEW ZEALAND, responding to questions regarding why the draft resolution requested a report to the Seventy-fourth World Health Assembly and not earlier, said that his experience suggested that it would take up to four years to put the infrastructure, materials and programmes in place and allow enough time to elapse for improvements to be measureable, so reporting earlier would not be informative.

Responding to the proposal by the representative of the Russian Federation, he argued that paragraph 1(2) already captured the need for national capacity to be taken into account.

In response to comments about antimicrobial resistance, he said that studies in New Zealand had looked at the increase in antibiotic prescribing and found that there had not been an increase in prescribing penicillin, which was the treatment of choice. There was no evidence of misuse or overuse of penicillin and while the inappropriate use of antibiotics was a concern, sometimes the consequences of not using an antibiotic were severe. Previous experience had shown that campaigns, with or without diagnostic testing, had significantly reduced the number of deaths from what was a preventable disease.

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

The representative of KENYA[1] said that he supported a report being submitted to the Seventy-fourth World Health Assembly but he expressed the concern that, after that, it would not be reported on again. He therefore asked the Secretariat if it could then be reported on at subsequent Health Assemblies as part of reporting on noncommunicable diseases.

The representative of the RUSSIAN FEDERATION[1] reiterated that while effective treatment for rheumatic heart disease was available, concerns had been noted relating to multiple sources and multiple resources for such treatment. In that regard, an interdisciplinary approach could be useful. That was the reason behind his proposal to include a reference to antimicrobial resistance in the draft resolution. He therefore proposed adding resolution WHA67.25 (2014) on antimicrobial resistance to the list of resolutions in preambular paragraph 1.

The representative of THAILAND quoted several papers on the primary form of prevention and cost-effective management of rheumatic heart disease: clinical diagnosis, noting that the cost of rapid diagnostic tests was prohibitively high. Noting that the Secretariat's report made repeated reference to rheumatic fever and rheumatic heart disease, he proposed amending the title of the draft resolution to read "Rheumatic fever and rheumatic heart disease" in order to capture the whole issue and send a strong signal to support primary prevention efforts.

The representative of JAPAN seconded the proposal made by the representative of the Russian Federation.

The representative of THAILAND supported the rationale behind the proposal made by the representative of the Russian Federation. However, rather than amending preambular paragraph 1, he proposed adding an additional preambular paragraph 6bis, which would read: "Recognizing the selected pressure on inappropriate and excessive use of antibiotics result in the emergence of resistant pathogens".

The representative of MALTA, speaking on behalf of the European Union and its Member States, supported the proposal made by the representative of the Russian Federation.

The DIRECTOR-GENERAL welcomed the very rich discussion on rheumatic heart disease, and noted the importance of a multisectoral approach, mentioning in particular that efforts under communicable diseases, noncommunicable diseases, health systems, and maternal, newborn and child health services were involved in treatment and prevention. Other relevant sectors included access to medicines, and research and development for diagnosis and vaccines. She noted that although the cost of diagnostic tests was high, those tests were not all necessary. Although some Member State representatives had implied that rheumatic heart disease was a stand-alone disease, in fact it required the involvement of many parts of the Secretariat if the high disease burden that affected all regions was to be reduced.

Responding to comments made by the representatives of the Netherlands, Sweden, Norway and Thailand, she said the agenda item on rheumatic heart disease had been discussed at the current session of the Board because there had not been time at previous sessions. She thanked the representative of New Zealand for his leadership in preparing the draft resolution, and said the amendments that had been proposed could be accommodated in the existing draft resolution. She encouraged Member States to make a decision on the draft resolution and not to postpone it to the 142nd session of the Board.

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

Responding to the question asked by the representative of Sweden, she said that, although noncommunicable diseases had been among the top priorities for the Secretariat and Member States for many years, they were constantly underfunded; an "unfunded mandate" was not unique to the item under discussion. The issue of sustainable and sufficient funding had to be tackled in the wider context of governance, and she welcomed the fact that the Board would be discussing that topic.

(For continuation of the discussion, see the summary records of the second meeting, section 1.)

The meeting rose at 12:40.

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