



WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD

141ST SESSION

GENEVA, 1 JUNE 2017

**RESOLUTIONS AND DECISIONS
ANNEXES**

SUMMARY RECORDS

**GENEVA
2017**

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

ASEAN	– Association of Southeast Asian Nations	UNAIDS	– Joint United Nations Programme on HIV/AIDS
FAO	– Food and Agriculture Organization of the United Nations	UNCTAD	– United Nations Conference on Trade and Development
IAEA	– International Atomic Energy Agency	UNODC	– United Nations Office on Drugs and Crime
IARC	– International Agency for Research on Cancer	UNDP	– United Nations Development Programme
ICAO	– International Civil Aviation Organization	UNEP	– United Nations Environment Programme
IFAD	– International Fund for Agricultural Development	UNESCO	– United Nations Educational, Scientific and Cultural Organization
ILO	– International Labour Organization (Office)	UNFPA	– United Nations Population Fund
IMF	– International Monetary Fund	UNHCR	– Office of the United Nations High Commissioner for Refugees
IMO	– International Maritime Organization	UNICEF	– United Nations Children’s Fund
IOM	– International Organization for Migration	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
OIE	– World Organisation for Animal Health	WMO	– World Meteorological Organization
PAHO	– Pan American Health Organization	WTO	– World Trade Organization

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

PREFACE

The 141st session of the Executive Board was held at WHO headquarters, Geneva, on 1 June 2017.¹

The Seventieth World Health Assembly elected 10 Member States to be entitled to designate a person to serve on the Executive Board² in place of those whose term of office had expired,³ giving the following new composition of the Board:

Designating country	Unexpired term of office ⁴	Designating country	Unexpired term of office ⁴
Algeria	2 years	Jordan	1 year
Bahrain	2 years	Kazakhstan	1 year
Benin	3 years	Libya	2 years
Bhutan	2 years	Malta	1 year
Brazil	3 years	Mexico	2 years
Burundi	2 years	Netherlands	2 years
Canada	1 year	New Zealand	1 year
Colombia	2 years	Pakistan	1 year
Congo	1 year	Philippines	1 year
Dominican Republic	1 year	Sri Lanka	3 years
Fiji	2 years	Swaziland	3 years
France	1 year	Sweden	1 year
Georgia	3 years	Thailand	1 year
Iraq	3 years	Turkey	2 years
Italy	3 years	United Republic of	
Jamaica	2 years	Tanzania	3 years
Japan	3 years	Viet Nam	2 years
		Zambia	3 years

The list of members and other participants is contained in document EB141/DIV./1 Rev.1.

¹ Decision EB140(16) (2017).

² Decision WHA70(8) (2017).

³ The retiring members had been designated by China, Democratic Republic of the Congo, Eritrea, Gambia, Kuwait, Liberia, Nepal, Russian Federation, United Kingdom of Great Britain and Northern Ireland and United States of America (see decision WHA67(7)) (2014).

⁴ At the time of the closure of the Seventieth World Health Assembly.

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¹ As adopted by the Board at its first meeting.

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EB141/2	Report of the Programme, Budget and Administration Committee of the Executive Board
EB141/3	Eradication of malaria
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EB141/DIV./1 Rev.1	List of members and other participants
EB141/DIV./2	List of decisions and resolutions
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COMMITTEES¹

Programme, Budget and Administration Committee²

Ms Faeqa Saeed Alsaleh (Bahrain, member ex officio), Dr Lyonpo Tandin Wangchuk (Bhutan), Ms Zhang Yang (China), Dr Mukengeshayi Kupa (Democratic Republic of the Congo), Dr Francisco Neftalí Vásquez Bautista (Dominican Republic), Professor Benoît Vallet (France), Mr Omar Sey (Gambia), Dr Mahmoud Al-Sheyyab (Jordan), Dr Jamal Mansour Al-Harbi (Kuwait), Dr Raymond Busuttil (Malta, member ex officio), Dr Stewart Jessamine (New Zealand), Ms Olivia Wigzell (Sweden), Dr Viroj Tangcharoensathien (Thailand) and Dr M. Wolfe (United States of America).

Twenty-sixth meeting, 18 and 19 May 2017:³ Dr Viroj Tangcharoensathien (Thailand, Chairman), Ms Faeqa Saeed Alsaleh (Bahrain, member ex officio), Dr K. Lhazeen (Bhutan, alternate to Dr Lyonpo Tandin Wangchuk), Ms Liu Yue (China, alternate to Ms Zhang Yang), Dr Mukengeshayi Kupa (Democratic Republic of the Congo, Vice-Chairman), Dr Francisco Neftalí Vásquez Bautista (Dominican Republic), Mr C. Tellier (France, alternate to Professor Benoît Vallet), Mr S. Ceesay (Gambia, alternate to Mr Omar Sey), Mr R. Khawaldeh (Jordan, alternate to Dr Mahmoud Al-Sheyyab), Dr Jamal Mansour Al-Harbi (Kuwait), Dr Raymond Busuttil (Malta, member ex officio), Dr Stewart Jessamine (New Zealand), Ms Olivia Wigzell (Sweden), Ms A. Blackwood (United States of America, alternate to Dr M. Wolfe).

¹ Showing current membership and the names of those who attended the meeting to which reference is made.

² Showing the membership as determined by the Executive Board in decision EB139(3) (2016), with changes of representatives for the Dominican Republic, Jordan, Kuwait, Thailand and the United States of America.

³ See document EBPBAC26/DIV./1.

PART I

RESOLUTIONS AND DECISIONS

ANNEXES

RESOLUTIONS

EB141.R1 Rheumatic fever and rheumatic heart disease¹

The Executive Board,

Having considered the report on rheumatic heart disease,²

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

The Seventy-first World Health Assembly,

Reaffirming resolutions: WHA66.10 (2013) 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; WHA68.7 (2015) on global action plan on antimicrobial resistance; WHA69.2 (2016) on committing to implementation of the Global Strategy for Women's, Children's and Adolescents' Health; and WHA69.25 (2016) 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;³

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;⁴

Recognizing that rheumatic heart disease is a preventable condition arising from acute rheumatic fever, a secondary sequela 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;

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;

¹ See Annex 3 for the financial and administrative implications for the Secretariat of this resolution.

² Document EB141/4.

³ Available at http://www.pascar.org/uploads/files/ADDIS_ABABA_COMMUNIQUE%C3%89_ON_ERADICATION_OF_RHEUMATIC_HEART_DISEASE_IN_AFRICA_-_Submission1.pdf, accessed 30 May 2017.

⁴ The Global Burden of Disease Study 2010.

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);

Recognizing that 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,

1. 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 and good-quality data collection and analysis that facilitate appropriate follow-up and contribute 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, affordable and reliable access to cost-effective 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;

2. 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;

¹ And, where applicable, regional economic integration organizations.

(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, affordable and reliable access to existing and cost-effective 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;

3. REQUESTS the Director-General:

(1) to reinvigorate engagement in, and 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 the 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 mobilizing resources, 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.

(Second meeting, 1 June 2017)

EB141.R2 Confirmation of amendments to the Staff Rules¹

The Executive Board,

Having considered the report on amendments to the Staff Regulations and Staff Rules,²

CONFIRMS, in accordance with Staff Regulation 12.2, the amendments to Staff Rules 410 and 1020 that have been made by the Director-General with effect from 1 January 2019.

(Second meeting, 1 June 2017)

¹ See Annex 1; see Annex 3 for the financial and administrative implications for the Secretariat of this resolution.

² Document EB141/11.

DECISIONS

EB141(1) Evaluation of the election of the Director-General of the World Health Organization

The Executive Board, having considered the report on the evaluation of the election of the Director-General of the World Health Organization,¹ decided to establish an evaluation management group, to be composed of the Vice-Chairmen and Rapporteur of the 141st session of the Executive Board, in addition to a member of the Executive Board from the Eastern Mediterranean Region, to take forward the work; and to be chaired by the first Vice-Chairman, with support from the WHO Evaluation Office.

(Second meeting, 1 June 2017)

EB141(2) Membership of the Independent Expert Oversight Advisory Committee

The Executive Board noted the report on membership of the Independent Expert Oversight Advisory Committee,² and appointed the following three new members of the Committee for a four-year non-renewable term of office, in accordance with resolution EB125.R1 (2009):

- starting in January 2018, Mr Christoph Gabriel Maetze (Germany) and Mr Jayant Karia (Uganda) to replace Mr Steve Tinton (United Kingdom of Great Britain and Northern Ireland) and Mr Mukesh Arya (India);
- starting in January 2019, Mr Christopher Mihm (United States of America) to replace Mr Robert Samels (Canada).

(Second meeting, 1 June 2017)

EB141(3) Membership of the Programme, Budget and Administration Committee

The Executive Board appointed as members of the Programme, Budget and Administration Committee Professor Smail Mesbah (Algeria), Dr Jabbin Mulwanda (Zambia), Ms Hilda Dávila Chávez (Mexico), Dr R.M.S.K. Amunugama (Sri Lanka), Mr Herbert Barnard (Netherlands), Mr Omar Bashir Al-Taher Mohammed (Libya), Dr Hiroki Nakatani (Japan), for a two-year period or until expiry of their membership on the Board, whichever is first, in addition to Dr Francisco Neftalí Vásquez Bautista (Dominican Republic), Lyonpo Tandin Wangchuk (Bhutan), Ms Olivia Wigzell (Sweden), Dr Mahmoud Al-Sheyyab (Jordan) and Dr Stewart Jessamine (New Zealand) who were already members of the Committee. Dr Assad Hafeez (Pakistan), Chairman of the Board, and Dr Viroj Tangcharoensathien (Thailand), Vice-Chairman of the Board, were appointed members ex officio. It was understood that, if any of the Committee members were unable to attend, except the two ex-officio members, his or her successor, or the alternate member of the Board designated by the

¹ Document EB141/6.

² Document EB141/14.

government concerned, in accordance with Rule 2 of the Rules of Procedure of the Executive Board, would participate in the work of the Committee.

(Second meeting, 1 June 2017)

EB141(4) Membership of the Léon Bernard Foundation Committee

The Executive Board, in accordance with the Statutes of the Léon Bernard Foundation, appointed Mr David Sergeenko (Georgia) as a member of the Léon Bernard Foundation Committee for the duration of his term of office on the Executive Board, in addition to the Chairman and Vice-Chairmen of the Board, members ex officio. It was understood that if Mr Sergeenko was unable to attend, his successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure of the Executive Board, would participate in the work of the Committee.

(Second meeting, 1 June 2017)

EB141(5) Appointment of representatives of the Executive Board at the Seventy-first World Health Assembly

The Executive Board, in accordance with paragraph 1 of resolution EB59.R7 (1977), appointed its Chairman, Dr Assad Hafeez (Pakistan) and its first three Vice-Chairmen, Mr Philip Davies (Fiji), Dr Josiane Nijimbere (Burundi) and Ms Sarah Lawley (Canada), to represent the Executive Board at the Seventy-first World Health Assembly. It was understood that if any of those members were not available for the Health Assembly, the other Vice-Chairman, Dr Viroj Tangcharoensathien (Thailand) and the Rapporteur, Professor Maksut Kulzhanov (Kazakhstan), could be asked to represent the Board.

(Second meeting, 1 June 2017)

EB141(6) Place, date and duration of the 142nd session of the Executive Board and the twenty-seventh meeting of the Programme, Budget and Administration Committee of the Executive Board

The Executive Board decided that its 142nd session should be convened on Monday, 22 January 2018, at WHO headquarters, Geneva, and should close no later than Saturday, 27 January 2018. The Board further decided that the Programme, Budget and Administration Committee of the Executive Board should hold its twenty-seventh meeting on Thursday, 18 January and Friday, 19 January 2018, at WHO headquarters, Geneva.

(Second meeting, 1 June 2017)

EB141(7) Place, date and duration of the Seventy-first World Health Assembly and the twenty-eighth meeting of the Programme, Budget and Administration Committee of the Executive Board

The Executive Board decided that the Seventy-first World Health Assembly should be held at the Palais des Nations, Geneva, opening on Monday, 21 May 2018, and closing no later than Saturday, 26 May 2018. The Board further decided that the Programme, Budget and Administration Committee of the Executive Board should hold its twenty-eighth meeting on Thursday, 17 May and Friday, 18 May 2018, at WHO headquarters, Geneva.

(Second meeting, 1 June 2017)

EB141(8) Governance reform: follow-up to decision WHA69(8) (2016)

The Executive Board, having considered the report on governance reform: follow-up to decision WHA69(8) (2016),¹ decided:

- (1) to request the Officers of the Executive Board to apply, on a trial basis, the set of criteria and list of factors, and the tool for the prioritization of proposals for additional items, as set out in Annexes 1 and 2 to document EB141/5,² for the preparation of the provisional agenda of the 142nd session of the Executive Board in January 2018, and to report thereon at that session;
- (2) with a view to ensuring transparency, to request that the report under paragraph 1 include the scores resulting from the application of the tool for the prioritization of proposals for additional items;
- (3) to request that the Secretariat's analysis of current Rules of Procedure of the Executive Board and Rules of Procedure of the World Health Assembly in respect of additional, supplementary and urgent items, to be prepared in accordance with decision WHA69(8), also address other ambiguities, gaps and other shortcomings in the Rules of Procedure of the governing bodies.

(Second meeting, 1 June 2017)

¹ Document EB141/5.

² See Annex 2.

ANNEX 1

Confirmation of amendments to the Staff Rules considered necessary in the light of decisions taken by the United Nations General Assembly at its seventieth session¹

[EB141/11 – 15 May 2017]

410. RECRUITMENT POLICIES

...

410.2 Candidates under 20 or over 65 years of age shall not normally be considered for appointment.

.....

1020. RETIREMENT

1020.1 Staff members shall retire on the last day of the month in which they reach the age of 65, unless Staff Rule 1020.1.1, 1020.1.2 or 1020.1.3 applies.

1020.1.1 Staff members who became participants in the United Nations Joint Staff Pension Fund before 1 January 1990 may elect to retire on the last day of the month in which they reach the age of 60, or between the ages of 60 and 65, by giving at least three months' written notice of the elected date of retirement.

1020.1.2 Staff members who became participants in the United Nations Joint Staff Pension Fund from 1 January 1990 to 31 December 2013 inclusive may elect to retire on the last day of the month in which they reach the age of 62, or between the ages of 62 and 65, by giving at least three months' written notice of the elected date of retirement.

1020.1.3 Staff members shall not change their elected date of retirement once they have given their three months' notice under Staff Rules 1020.1.1 or 1020.1.2.

1020.1.4 In exceptional circumstances the Director-General may, in the interests of the Organization, extend a staff member's appointment beyond the age of 65, provided that such extensions shall not be granted for more than one year at a time and not beyond the staff member's sixty-eighth birthday.

¹ To take effect from 1 January 2019 (see resolution EB141.R2).

ANNEX 2

Governance reform: follow-up to decision WHA69(8) (2016)¹

Proposed criteria and list of factors for considering proposals for additional items for inclusion on the provisional agenda of the Executive Board, and proposed tool for prioritizing proposals

[EB141/5, Annexes 1 and 2 – 10 April 2017]

1. The Health Assembly in decision WHA69(8) (2016) decided “to request the Bureau of the Executive Board, taking into account inputs from Member States, to review the criteria currently applied in considering items for inclusion on the provisional agenda of the Board, and to develop proposals for new and/or revised criteria for the consideration of the 140th session of the Executive Board.”
2. The Officers of the Board met and reviewed the criteria for additional items on the Board’s provisional agenda, which were agreed upon by the governing bodies in resolution EB121.R1 (2007) and decision WHA65(9) (2012), taking into account inputs provided by Member States throughout the governance reform process.
3. Based on such review, the Officers of the Board developed a revised set of five major criteria and a list of factors relating thereto for the Board’s consideration at its 140th session. Furthermore, the Officers proposed to establish an objective and transparent tool for the prioritization of proposals, which would support the Officers in the implementation of the criteria but would be without prejudice to the Officers’ discretion in accepting proposals and recommending the deferral or exclusion of proposals received.
4. The Board at its 140th session considered the Officers’ proposals, in support of which consensus emerged in the ensuing discussions. Several delegations, however, underlined the need for certain adjustments. The Secretariat has incorporated Member States’ comments into the Officers’ proposal and this report summarizes that process.
5. The proposed criteria and list of factors are contained in Appendix 1 to this report. Should the Board agree to endorse these criteria, they would supersede the criteria established by the governing bodies in resolution EB121.R1 and decision WHA65(9).
6. The prioritization tool is presented in Appendix 2. The tool provides a relative weighting to the various criteria and factors that would be used by the Officers of the Board in considering whether to include a proposed item on the provisional agenda of the following session of the Board. The

¹ Decision EB141(8).

weightings were determined through a process whereby Officers of the Board assigned a score to each of the criteria and, where applicable, the underlying factors. Finally, a weighting score was generated by multiplying the score assigned to each criterion by the scores assigned to the factors relating thereto.

7. All the proposals received would be scored by the Officers of the Board in line with the determined weightings for the various criteria and factors. It is proposed that such scores be submitted and that the average of the scores assigned to each proposal be compiled through an on-line system to be developed by the Secretariat. At the teleconference among the Officers of the Board and the Director-General at which the provisional agenda of the Board is prepared, the Officers would thus have at their disposal an objective weighting of each of the proposals under consideration, which could be used not only to determine those proposals that warranted being dealt with by the Board but could also provide an indication of the respective priority for consideration.

Appendix 1

**PROPOSED CRITERIA AND FACTORS FOR THE INCLUSION OF ITEMS ON
THE PROVISIONAL AGENDA OF THE EXECUTIVE BOARD**

Criterion A The proposal addresses a global public health issue

Factors to consider under this criterion include:

- | | |
|------------|---|
| Factor A.1 | The current health situation, including changes, if any, in demographic and epidemiological trends. |
| Factor A.2 | The public health burden the public health issue has at global/regional and country levels. |
| Factor A.3 | The extent to which the proposal addresses an urgent, emerging or neglected health issue. |
| Factor A.4 | The extent to which the public health issue is perceived as being a global public health threat. |

Criterion B The proposal addresses a new subject within the scope of WHO

Factors to consider under this criterion include:

- | | |
|------------|---|
| Factor B.1 | The proposed new subject falls within the mandate and capacities of WHO. |
| Factor B.2 | The comparative advantage of WHO in addressing the proposal. |
| Factor B.3 | The proposal introduces a subject that is deemed to be of interest to public health and that has never been discussed at WHO. |
| Factor B.4 | The proposal raises for re-discussion an issue that has not been discussed within WHO global fora for the past four years. |

Criterion C The proposal brings up for discussion internationally agreed instruments that involve or impact health or declarations, agreements, resolutions or decisions adopted in other WHO international fora

Factors to consider under this criterion include:

- | | |
|------------|--|
| Factor C.1 | The added value reopening the discussion of the subject will bring to public health. |
| Factor C.2 | The need for collective action through WHO for the implementation of any commitments. |
| Factor C.3 | The need for Member States to seek country technical support from the Secretariat for the implementation of any commitments. |
| Factor C.4 | The existence of other resolutions or decisions taken by the governing bodies that could fulfil the perceived need in factors C.2 and C.3 above. |

Criterion D The existence of evidence-based, cost-effective interventions to address the subject being proposed

Factors to consider under this criterion include:

- | | |
|------------|---|
| Factor D.1 | The solidity of the evidence submitted by proponent. |
| Factor D.2 | The cost-effectiveness of the proposal. |
| Factor D.3 | The potential for using knowledge and innovative science and technology to address the subject. |
| Factor D.4 | The potential impact on the human and financial resources of the Organization. |

Criterion E The urgency of the proposal

Factors to consider under this criterion include:

- | | |
|------------|--|
| Factor E.1 | The extent to which immediate action is required to address the public health issue with potential global impact being raised. |
| Factor E.2 | The criticality of negative impact of a delay in addressing such public health issue. |
| Factor E.3 | With due consideration of factors E.1 and E.2, the impact the introduction of the item will have on the workload, effective management and running of the Board's session. |
| Factor E.4 | The feasibility of postponing the proposal for inclusion on the agenda of future sessions. |

Criterion F The linkages that the proposals for additional items have with the priorities of the Organization as reflected in the General Programme of Work of the Organization.

Criterion G The linkages that the proposals for additional items have with the health-related components of the Sustainable Development Goals.

Appendix 2

**TOOL FOR THE PRIORITIZATION OF PROPOSALS FOR ADDITIONAL ITEMS
ON THE PROVISIONAL AGENDA OF THE EXECUTIVE BOARD**

Criterion A The proposal addresses a global public health issue	Relative weighting	Score by the Officer of the Board
Factor A.1 The current health situation including changes, if any, in demographic and epidemiological trends	Up to 9	
Factor A.2 The public health burden the public health issue has at global/regional and country levels	Up to 11	
Factor A.3 The extent to which the proposal addresses an urgent, emerging or neglected health issue	Up to 10	
Factor A.4 The extent to which the public health issue is perceived as being of a global public health threat	Up to 15	

Criterion B The proposal addresses a new subject within the scope of WHO	Relative weighting	Score by the Officer of the Board
Factor B.1 The proposed new subject falls within the mandate and capacities of WHO	Up to 10	
Factor B.2 The comparative advantage of WHO in addressing the proposal	Up to 8	
Factor B.3 The proposal introduces a subject which is deemed to be of interest to public health and which has never been discussed at WHO	Up to 10	
Factor B.4 The proposal raises for re-discussion an issue that has not been discussed within WHO global fora for the past four years	Up to 3	

Criterion C The proposal brings up for discussion internationally agreed instruments which involve or impact health or declarations, agreements, resolutions or decisions adopted in other WHO international fora	Relative Weighting	Score by the Officer of the Board
Factor C.1 The added value reopening the discussion of the subject will bring to public health	Up to 5	
Factor C.2 The need for collective action through WHO for the implementation of any commitments	Up to 4	

Criterion C The proposal brings up for discussion internationally agreed instruments which involve or impact health or declarations, agreements, resolutions or decisions adopted in other WHO international fora	Relative Weighting	Score by the Officer of the Board
Factor C.3 The need for Member States to seek country technical support from the Secretariat for the implementation of any commitments	Up to 2	
Factor C.4 The existence of other resolutions or decisions taken by the governing bodies that could fulfil the perceived need in factors C.2 and C.3	Up to 3	

Criterion D The existence of evidence-based, cost-effective interventions to address the subject being proposed	Relative weighting	Score by the Officer of the Board
Factor D.1 The solidity of the evidence submitted by proponent	Up to 8	
Factor D.2 The cost effectiveness of the proposal	Up to 6	
Factor D.3 The potential for using knowledge and innovative science and technology to address the subject	Up to 3	
Factor D.4 The potential impact on the human and financial resources for the Organization	Up to 3	

Criterion E The urgency of the proposal	Relative weighting	Score by the Officer of the Board
Factor E.1 The extent to which immediate action is required to address the public health issue with potential global impact being raised	Up to 19	
Factor E.2 The criticality of negative impact of a delay in addressing such public health	Up to 15	
Factor E.3 With due consideration of factors E.1 and E.2 in mind, the impact the introduction of the item will have on the workload, effective management and running of the Board's session	Up to 11	
Factor E.4 The feasibility of postponing the proposal for inclusion on the agenda of future sessions	Up to 5	

Criterion F	Relative weighting	Score by the Officer of the Board
The linkages that the proposals for additional items have with the priorities of the Organization as reflected in the General Programme of Work of the Organization	Up to 20	

Criterion G	Relative weighting	Score by the Officer of the Board
The linkages that the proposals for additional items have with the health-related components of the Sustainable Development Goals	Up to 20	

ANNEX 3

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

Resolution EB141.R1 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 will contribute.	<p>Twelfth General Programme of Work, 2014–2019 outcome(s):</p> <ul style="list-style-type: none"> – 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. <p>Programme budget 2016–2017 output(s):</p> <p>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;</p> <p>Output 1.4.3. New knowledge, solutions and implementation strategies that respond to the health needs of disease-endemic countries developed;</p> <p>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;</p> <p>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.</p>
2. Brief justification for considering the 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.	<p>Not applicable.</p>
3. Estimated time frame (in years or months) for implementation of any additional deliverables.	<p>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.</p>

B. Budgetary implications			
1. Estimated total cost to implement the resolution, 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, 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 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.

Resolution EB141.R2 Confirmation of amendments to the Staff Regulations and Staff Rules	
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 will contribute.	<p>Twelfth General Programme of Work, 2014–2019 outcome(s): None.</p> <p>Programme budget 2016–2017 output(s): None.</p>
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.	<p>The amendments described in document EB141/11 stem from the decision taken by the United Nations General Assembly at its Seventieth session, in resolution 70/244 adopted on 23 December 2015,¹ on the basis of recommendations made by the International Civil Service Commission in its report for the year 2015.²</p>
3. Estimated time frame (in years or months) for implementation of any additional deliverables.	<p>The amendments related to the extension of the mandatory age of separation to 65 for staff members appointed on or before 1 January 2014, taking into account their acquired rights, will enter into force:</p> <p>(a) with effect from 1 January 2018 (in which case the Board was to be invited to adopt draft resolution 1);³</p> <p>or</p> <p>(b) with effect from 1 January 2020 (in which case the Board was to be invited to adopt draft resolution 2).</p>
B. Budgetary implications	
1. Estimated total cost to implement the resolution, in US\$ millions:	<p>If resolution 1 is adopted, WHO could potentially incur additional liabilities of about US\$ 10 million for the biennium 2018–2019 (see section 3).</p>
2.a. Estimated additional budgetary requirements in the current biennium, in US\$ millions:	<p>No budgetary implications for the current biennium.</p>

¹ See http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/70/244 (accessed 10 May 2017).

² See <http://icsc.un.org/resources/pdfs/ar/AR2015.pdf> (accessed 10 May 2017).

³ When the Executive Board considered this item, members were unable to choose between option 1 and option 2, as reflected in the two resolutions. Agreement was reached on a compromise proposal, namely, that the amendments to the Staff Rules relating to extending the mandatory age of separation be implemented with effect from 1 January 2019. The resolution was amended accordingly (see summary records of the Executive Board at its 141st session, second meeting, section 3). In order to ascertain the budgetary implications of the resolution, the figures for the budgetary implications in respect of draft resolution 1 (in which the amendments would take effect in January 2018) should be halved.

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:**
Not applicable.
- **Extent of any financing gap, in US\$ millions:**
Not applicable.
- **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:

The extension of the mandatory age of separation to 65 for staff members appointed on or before 1 January 2014 will have budgetary implications in terms of delaying a more cost-effective realignment of the WHO staffing structure.

For draft resolution 2:

As 359 staff members are due to retire in 2018 and 2019 (164 staff members in professional and higher categories; 151 general service staff members; 44 national professional staff members), WHO could avoid additional liabilities of about US\$ 10 million for the biennium 2018–2019, if the extension was delayed by two years, based on:

- (i) an estimate of the additional statutory separation costs for staff members who choose to stay on, but whose posts are subsequently abolished, with the largest group being staff members working for the Global Polio Eradication Initiative (US\$ 3–4 million of the approximately US\$ 10 million additional costs). It is likely, however, that some other WHO programmes will also be affected, given the overall budgetary outlook;
- (ii) the higher salary grade/step of staff members who would have retired compared with that of the younger staff members who would be appointed to replace them (51% of the staff members due to retire in 2018 and 2019 have reached the maximum step in their grades);
- (iii) the fact that many of the positions currently occupied by staff due to retire in 2018 and subsequent years could be downgraded and would thereby create additional, more cost-effective opportunities for recruitment at more junior levels;
- (iv) the fact that 12.5% of the staff members who would have been due to retire in 2018 and 2019 will be able to meet the 10-year eligibility for ASHI, thus increasing WHO liabilities that could have been avoided otherwise.

Regarding the United Nations Joint Staff Pension Fund, the impact of the extension appears to be cost-neutral: there would be additional pension payouts as a result of longer service, possibly offsetting additional income arising from the pension contributions payable for an additional three years, funded one third by staff members, and two thirds by WHO.

Has this been included in the Programme budget 2018–2019?

Not applicable.

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

See section 3.

PART II

SUMMARY RECORDS

SUMMARY RECORDS

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 that 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 AMERICA¹ 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.

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.

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

The representative of ZIMBABWE¹ 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 ANGOLA¹ 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 MONACO¹ 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 AUSTRALIA¹ 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 SPAIN¹ 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.

The representative of NICARAGUA¹ 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.

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

The representative of KENYA¹ 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 FEDERATION¹ 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.

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.

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

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);

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,

¹ Document EB141/4.

² Available at http://www.pascar.org/uploads/files/ADDIS_ABABA_COMMUNIQUE%C3%89_ON_ERADICATION_OF_RHEUMATIC_HEART_DISEASE_IN_AFRICA_-_Submission1.pdf, accessed 30 May 2017.

³ The 2010 Global Burden of Disease report.

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;

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;

¹ And, where applicable, regional economic integration organizations.

- (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.	<p>Twelfth General Programme of Work, 2014–2019 outcome(s):</p> <ul style="list-style-type: none"> – 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. <p>Programme budget 2016–2017 output(s):</p> <p>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;</p> <p>Output 1.4.3. New knowledge, solutions and implementation strategies that respond to the health needs of disease-endemic countries developed;</p> <p>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;</p> <p>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.</p>
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.	<p>Not applicable.</p>

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.

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 SUDAN¹ 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 KENYA¹ 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.

The representative of AUSTRALIA¹ 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.

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

The representative of SOUTH AFRICA¹ 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 UGANDA¹ 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 NORWAY¹ 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 BANGLADESH¹ 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 AMERICA¹ 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 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.

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

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 FEDERATION¹ 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.

The representative of KENYA¹ 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 FEDERATION¹ 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.

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

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 that the selective pressure due to inappropriate and excessive use of antibiotics results 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, Norway, Sweden 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.

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.

SECOND MEETING

Thursday, 1 June 2017, at 14:30

Chairman: Dr A. HAFFEZ (Pakistan)

1. TECHNICAL AND HEALTH MATTERS: Item 6 of the agenda (continued)

Rheumatic heart disease: Item 6.2 of the agenda (document EB141/4) (continued from the first meeting, section 7)

The representative of NEW ZEALAND, recalling that several amendments to the draft resolution on rheumatic heart disease had been proposed during the first meeting, said that informal discussions had taken place and asked the Secretariat to read out the amendments that had been agreed.

At the request of the CHAIRMAN, the SECRETARY read out the proposed amendments to the draft resolution on rheumatic heart disease. The new title should read: “Rheumatic fever and rheumatic heart disease”. The words “WHA68.7 on global action plan on antimicrobial resistance” should be added to preambular paragraph 1 on the third line after the semicolon and before “WHA69.2”. In paragraph 1(4), the word “affordable” should be added after “to ensure timely,” and the word “cost-effective” should be added after “and reliable access to”. In paragraph 2(3), the words “, affordable and reliable” should be added after “to facilitate timely,” and the word “cost-effective” after “to existing and”.

The representative of THAILAND said that his Government wished to join the list of sponsors of the draft resolution.

The resolution, as amended, was adopted.¹

The Board noted the report.

2. MANAGEMENT AND GOVERNANCE MATTERS: Item 7 of the agenda

Governance reform: follow-up to decision WHA69(8) (2016): Item 7.1 of the agenda (document EB141/5)

The CHAIRMAN drew the Board’s attention to the draft decision contained in document EB141/5.

¹ Resolution EB141.R1.

The representative of the UNITED REPUBLIC OF TANZANIA, speaking on behalf of the Member States of the African Region, said that the increasing number of items on the agendas of the Executive Board and the Health Assembly had put the Region at a disadvantage in discussions. He therefore welcomed the proposed set of criteria and factors for the inclusion of additional items on the provisional agenda of the Board as well as the tool for prioritization of proposals for additional items on the provisional agenda of the Board. However, he asked why the relative weighting scores, which spanned from 2 to 20, were so diverse. Criteria should be scored out of 10 since higher numbers made scoring more subjective and therefore more complicated. The Secretariat should also develop definitions for each of the factors to ensure that scoring was objective. He agreed that the Director-General should report on the implementation of the proposed criteria and prioritization tool at the 146th session of the Board.

The representative of THAILAND said that his Government welcomed the proposed criteria, factors and relative weighting system. He noted that the factors under criterion C had been given a lower weighting and noted the higher relative weighting for criteria F and G. Under factor D.4, he asked whether an item would be given lower priority if it had a greater potential impact on human and financial resources. Under factor E.3, he asked whether an item would be given lower priority if it had a greater impact on the workload, effective management and running of the Board's session. Under factor E.4, he asked whether it would be more likely that an item would be postponed if it had been given a high feasibility score. If that was the case, factors D.4, E.3 and E.4 would be negative indicators. It was important to ensure transparency and mutual accountability among the Member States proposing additional items, the Officers of the Board and the Director-General. All Member States should be informed about the criteria, factors and relative weighting, in order to prevent disputes.

The representative of the NETHERLANDS said that his Government supported the draft decision. Pursuant to decision WHA69(8) (2016), the Secretariat was preparing a report for the Seventy-first World Health Assembly identifying gaps or ambiguities in the rules of procedure relating to the inclusion of urgent items of the agenda of the Board or the Health Assembly. He proposed that the Secretariat should bring to the Board's attention in that report other procedural matters that may also require clarification, such as the possibility of electronic voting, delivery and processing of credentials at the Health Assembly and the permissibility of submitting written statements rather than making oral interventions, as well as any other matters the Secretariat deemed appropriate.

The representative of MEXICO welcomed the proposed criteria and weighting system, the reference to regional issues and the general programme of work, and the linkages with the Sustainable Development Goals. Although the proposals would have a positive impact, they would only be effective if Member States limited themselves to requesting issues of priority. Country-specific issues should be addressed using technological tools or with the support of regional or country offices.

The representative of BRAZIL said that the proposed criteria must be applied through broad member-driven decision-making, rather than by a decision of the Secretariat or the Officers of the Board. It would not be adequate to apply the proposed criteria as an automated tool kit since agenda items often had crucial technical and political importance. The proposed criteria should be aligned with WHO's constitutional mandate and any relevant overarching frameworks, including the 2030 Agenda for Sustainable Development. Establishing priorities through a bottom-up process and with the involvement of the regional committees should also be considered, and should appear in the proposed list of criteria. Moreover, care should be taken to limit the number of agenda items, as Member States with smaller delegations were at a disadvantage. Members must be consulted and informed of the positions taken by Officers of Board on whether to include an item. In factor A.4, the word "emergency", instead of "threat", would better reflect WHO's mandate under the International Health Regulations (2005). His Government would prefer to discuss the proposed criteria and prioritization tool further before endorsing the draft decision.

The representative of CANADA said that factor A.3 should distinguish between public health issues that were urgent, and those that were emerging or neglected. The relative weighting score should also be adjusted accordingly. Similarly, it was important that weighting scores distinguished between public health burdens at the global, regional and country levels. For criterion B, she questioned whether items that had never been discussed, or had not been discussed in the previous four years, should be included. Urgency and importance, not novelty, should be most important when considering new agenda items. She asked when the proposed new criteria would be introduced, given that a draft provisional agenda had already been prepared for the 142nd session of the Board. She agreed with the comments on governance reform made by the representative of the Netherlands and encouraged the Secretariat to broaden its analysis of agenda management issues, in particular the official status of written statements submitted by Member States and their inclusion in the official records of the meeting.

The representative of COLOMBIA said that the proposed criteria and prioritization tool would help to determine the relevance, urgency and importance of items proposed for discussion by the Board. His Government therefore supported the draft decision.

The representative of JAPAN said that he supported the proposed criteria in Annex 1. However, he concurred with the questions raised by the representative of Thailand on negative indicators and requested further clarification in that regard. Noting the proposal made by the representative of the Netherlands, he said that he shared the concerns expressed but noted that the proposal had been very broad and would require a lot of work. More urgently, he sought clarity on procedural issues relating to exactly how the prioritization tool would be used, and particularly whether proposed agenda items would have to be submitted in a specific format.

The representative of VIET NAM, welcoming the proposed criteria, said that it would be difficult to implement some criteria simultaneously. That was the case for criteria D and E since not every urgent proposal coincided with evidence-based, cost-effective interventions. Additionally, factors B.1 and B.2 could also be applied under criterion C to ensure that all agenda items were related to the Organization's mandate. Finally, while the criteria took account of global issues, they did not consider the specific needs of individual Member States, for which there should be a separate provision.

The representative of SWEDEN, while welcoming the proposed criteria, said that insufficient progress had been made on governance reform, hindering Member States' ability to prepare for and participate in governing bodies meetings. WHO could only make an impact on global health if its resources were not spread over too many issues. His Government supported the draft decision and the proposal made by the representative of the Netherlands.

The representative of BAHRAIN welcomed the proposed criteria and prioritization tool, which would make the process of selecting issues with a major health impact more effective. She took note of the process of assigning weighting scores to proposed agenda items.

The representative of the PHILIPPINES said that her Government appreciated the proposed criteria and prioritization tool. She noted that the tool recognized the need to give attention to urgent, emerging and neglected health issues under criterion A and the need to discuss urgent issues that had not appeared in the agenda under criterion B. Expressing concern that there were some gaps between the criteria, she encouraged the Officers of the Board to prioritize, but not exclude, items that were important to Member States even if they fell below the global level of concern. She agreed that the tool should be used without prejudice and at the Officers' discretion when accepting proposals and recommending the deferral or inclusion of proposals received. Her Government supported the draft decision and the proposal made by the representative of the Netherlands regarding the inclusion of other measures in the Secretariat's next report.

The representative of KAZAKHSTAN said that there was a risk that regional public health issues would be excluded under global public health issues in criterion A and thus proposed amending it to read: “The proposal addresses a global/regional public health issue”. With regard to criteria B and D, he said that any new item would necessarily have to be evidence-based and cost-effective, and as such those two criteria could be merged. He also noted that a significant amount of information would be required to determine whether an intervention was evidence-based and cost-effective under criterion D. His Government supported the proposal made by the representative of the Netherlands.

The representative of NEW ZEALAND questioned whether some of the proposed criteria were subjective and whether they should be used as positive or negative weighting factors. His Government had tested several projects using the proposed prioritization tool to assess how large, non-specific but high-impact programmes would fare, and had ascertained that they would not fare well. Appreciating the need to prioritize and select agenda items and to align the priorities of the Board with the Sustainable Development Goals, his Government would be prepared to consider the application of the proposed criteria and prioritization tool at the 142nd session of the Board. If the prioritization tool was to be tested, its output would need to be assessed as early as possible. Given that the Board would be asked to review and consider the report on reform implementation contained in document A70/50 Add. 1 at its 142nd session, the Board might also wish to consider the prioritization tool and its impact during that session.

The representative of MALTA said that he welcomed efforts to streamline the work of the Board and supported the proposal made by the representative of the Netherlands.

The representative of ITALY appreciated efforts to classify and objectively analyse proposals, particularly with regard to coherence, namely under Criterion G. Noting that it would be useful to include a reference to the One United Nations initiative, he proposed amending the wording of factor B.2, to read, “The comparative advantage of WHO in addressing the proposal and advocating for it within the United Nations system”.

WHO should anticipate future priority issues by reinforcing an approach based on foresight and its organizational strengths. He suggested amending factor A.1, by replacing the words “current health situation” with “current health situations and trends”, while factor A.3 should be amended to read, “The extent to which the proposal addresses an urgent or neglected health issue and/or anticipates an emerging issue likely to become a priority given the available evidence”.

A trial of the prioritization tool could be conducted before endorsing Annex 2, in order to assess or amend the weighting scale.

The representative of FIJI expressed support for the draft decision in principle. However, he suggested that a more conventional approach to weighting factors should be used, namely that all criteria should be scored on a uniform scale with weighting factors subsequently applied as multipliers, in order to avoid confusion. He supported the idea of performing a simulation of the new method. As a government with limited representational capacity, the Government of Fiji was interested in the proposal to introduce a broader review of agenda management and meeting processes, put forward by the representative of the Netherlands.

The representative of IRAQ noted that the proposed criteria had been amended to take into account the opinions of Member States. He agreed with the factors relating to urgency because countries in the Eastern Mediterranean Region faced many urgent issues linked to displaced populations and refugees. With regard to public health issues with potential global impact, regional contexts and capacities, and WHO’s coordinating role, should be taken into account. With regard to factor B.1, mention should be made of the action WHO could take in partnership with other bodies. Criterion D, and factor D.1 in particular, needed to be more specific to ensure that they were applied effectively. Factors D.2 and D.4 were similar, and could be combined. Criterion E might also require

clarification. He also agreed that a single weighting scale from 1 to 10 would be preferable if the system was to be used accurately.

The representative of ALGERIA said that his Government requested clarification with regard to the proposed ranges for the relative weighting under the various proposed factors. Objectivity could also be an issue in the application of certain factors. For example, while factor D.2 assessed the cost-effectiveness of a proposal, it was not clear whether that assessment covered economic or social and health-related costs. Similar problems also arose under other criteria, making an objective assessment difficult. No matter how relevant or appropriate the criteria might be, care must still be taken in their application. There was a need for greater transparency, given that the new prioritization system would constitute a major aspect of the WHO reform process.

The representative of SRI LANKA welcomed the proposed criteria. However, his Government recommended that a new factor should be included in Criteria A and B, namely "A proposal that has been adopted by more than two regional committees for regional agendas". While supporting the proposal to simplify the relative weighting ranges made by the representative of Thailand, he said if the ranges were to be applied without change, he suggested that his recommended additional factor should receive a rating of up to 15 points.

The representative of ZIMBABWE¹ supported measures for time-bound reform and renewal, which must be considered separately from the Organization's ability to implement the minor changes required for effective and efficient operational performance. Additional factors could include: integration with existing major thematic areas, such as tuberculosis and malaria; and the impact of responsible referral of items to the regional committees.

The representative of SPAIN¹ said that his Government supported the draft decision. However, noting that the proposed criteria and factors would inevitably need to be refined, he said that any revision should take place as soon as possible.

The representative of GERMANY¹ said that her Government supported the criteria proposed in Annex 2 and the timely adoption of the decision. She encouraged the Board to try the new system before discussing it again, although she agreed that a review would be required. The new tool would enable the Secretariat to work more efficiently and ensure greater accountability and transparency. Her Government also supported the proposal made by the representative of the Netherlands. An analysis of the current rules of procedure was both timely and necessary.

The representative of the RUSSIAN FEDERATION¹ said that the proposed approach to prioritization would enhance the effectiveness of WHO's work and expressed his support for the draft decision. He agreed with the proposal made by the representative of the Netherlands regarding electronic voting.

The representative of NORWAY¹ expressed his support for the proposal made by the representative of the Netherlands.

The representative of the OFFICE OF THE LEGAL COUNSEL recalled that the Officers of the Board had assessed the existing criteria for the prioritization of agenda items and had decided that by reducing the number of criteria and providing definitions for each criterion, they could make the prioritization tool more objective and transparent. Following discussions during the 140th session of

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

the Board, two further criteria had been added. He stressed that both the tool and the scoring system would be widely disseminated.

The Board could choose either to keep the existing system or to develop further the prioritization tool on a trial basis. The trial period originally proposed by the Officers of the Board would culminate in a report submitted to the Board at its 146th session in 2020. However, if the Board wished, feedback could be provided sooner.

The aim was to implement the system in time for the 142nd session of the Board in January 2018, so that an initial assessment of the tool could be made during that session.

With regard to the relative weighting, the criteria had been graded according to their importance and awarded a corresponding number of points, adding up to a possible total of 200 points. The weighting system aimed to provide an objective method of comparing proposals, thereby making the prioritization and selection process more transparent.

Several speakers had proposed expanding the scope of the Secretariat's work to cover matters such as electronic voting, written submissions and the accreditation process. The Secretariat was prepared to comply with that request by the 142nd session of the Board in January 2018.

The representative of BRAZIL said that his Government had reservations about endorsing the proposed criteria in their current form, and suggested that the words "to endorse" at the start of paragraph (1) of the draft decision be amended to read, "to apply on a trial basis for the next Executive Board session with a view to further developing the criteria". Furthermore, he asked the Secretariat to explain exactly which decisions the Board had before it under the current item.

The representative of the OFFICE OF THE LEGAL COUNSEL said that there were two separate proposals before the Board. The first was the draft decision, contained in document EB141/5, relating to the proposed new criteria and factors and the prioritization tool. Several speakers had suggested that the tool could initially be used on a trial basis, and that a performance evaluation report could be submitted to the Board at its session in January 2018. Should the Board wish to adopt that approach, the draft decision would need to be amended. The Secretariat could prepare a revised draft decision later in the meeting.

The second proposal concerned expanding the scope of the Secretariat's analysis of the rules of procedure of the Board and the Health Assembly relating to agenda management, in order to cover additional issues such as electronic voting, written statements and accreditation. As there seemed to be support for that proposal, the Chairman suggested putting it forward for adoption.

The representative of MEXICO recalled that the current report had been the result of an open and honest dialogue on governance reform between Member States in 2015. Regrettably, not all the points raised during that dialogue had been fully considered. Several comments had been made during the current meeting, which implied that benefit could be obtained from concluding that dialogue. He therefore proposed reopening that dialogue on governance reform measures, particularly in light of the positive outcomes seen thus far.

The representative of ALGERIA agreed with the proposal made by the representative of Mexico and reiterated his earlier request for clarification regarding the relative weighting ranges.

The DIRECTOR-GENERAL recalled that the report had been primarily prepared by the Officers of the Executive Board to consider issues relating to agenda management, and noted that it enjoyed wide support. From the comments made, she understood that the Board was prepared to test the criteria and prioritization tool in order to have a basis for further considerations. The Board was not being asked to endorse the Annexes at the current time. Furthermore, the Board seemed prepared to accept the proposal made by the representative of the Netherlands to expand the scope of the Secretariat's report and its subsequent deliberation by the Board.

However, the proposal made by the representative of Mexico was much broader and would require significant preparation by the Secretariat and Member States if the discussion was to be reopened. Therefore, a decision would not be taken on that proposal at the current meeting.

The representative of BRAZIL thanked the Director-General and the Secretariat for addressing the concerns of Member States and formulating a way forward. He asked who would apply the proposed criteria.

The DIRECTOR-GENERAL recalled that on a regular basis, the Secretariat organized a meeting of the members of the Officers of the Executive Board. It was the Officers who would apply the criteria in Annexes 1 and 2; however the Secretariat would provide administrative support once the relative weighting for each proposal had been decided.

The CHAIRMAN said that discussion of the current agenda item would be suspended in order for the Secretariat to revise the draft decision.

The representative of MEXICO thanked the Director-General for her clarifications and said that he would provide a more concrete proposal regarding reopening the wider discussion on governance reform at the 142nd session of the Executive Board.

Evaluation of the election of the Director-General of the World Health Organization: Item 7.2 of the agenda (document EB141/6)

The CHAIRMAN drew the Board's attention to the draft decision contained in document EB141/6.

The representative of the PHILIPPINES applauded the inclusivity of the recent election of the Director-General. He also appreciated that the presentation of candidates had been open to representatives of Member States not represented on the Board. Although generally, the election process had been efficient, the laborious process of manually casting and counting votes should be improved by using electronic voting. He noted that some international organizations conducted their elections using electronic voting without concerns about security or the validity of the results. The Secretariat should conduct further studies on electronic voting including discussions with other international organizations that had relevant experience.

The representative of the NETHERLANDS noted that the evaluation of the election process would be discussed in an open meeting, in accordance with resolution WHA65.15 (2012). Given that the evaluation was not an issue relating to the candidates, but one of governance, he said that the matter should be discussed in a public meeting. He asked the Legal Counsel to explain the rationale for addressing it in an open meeting. He supported the proposal to establish an evaluation management group and looked forward to discussing the results of the evaluation at the 142nd session of the Board.

The representative of SWEDEN said that the election process could be improved in terms of the appropriate length of campaigns, the rules regarding transparency, and the funding level of campaigns, to allow all Member States to nominate candidates on equal terms. He welcomed the proposal to present the results of an online survey to the 142nd session of the Board, together with additional feedback from the Chairman of the 140th session of the Board, the Secretariat and the six candidates.

The representative of CANADA was pleased with the recent transparent election process, but said that fine-tuning was needed. She supported the establishment of the evaluation management group and looked forward to participating in the evaluation process.

The representative of VIET NAM appreciated that the election had been well organized and transparent. She agreed with establishing an evaluation management group, and steps to enhance fairness and transparency among Member States and seek their informed opinions.

The representative of ZAMBIA, speaking on behalf of the Member States of the African Region, said that independent feedback on the election process should be sought from the non-State actors that had attended the Seventieth World Health Assembly. He asked who would receive the specific questionnaires and be chosen for the key informant interviews referred to in paragraph 7 of document EB141/6. He also agreed with the proposed timeline for the evaluation and the establishment of an evaluation management group.

The representative of FRANCE said that the election process had been democratic and transparent, and that it should serve as a model for future elections at WHO and other international organizations. However, there was still room for improvement, and she welcomed the Secretariat's proposals, particularly the creation of an evaluation management group.

The representative of MEXICO said that the election had been a step forward in terms of transparency, and the positive process should be replicated by other entities of the United Nations system. He supported the draft decision and agreed that, in addition to establishing an evaluation management group, the opinions of Member States should be gathered through online surveys. However, following the initial evaluation of the election, a more in-depth review of the election process as a whole should be undertaken to determine its efficacy.

The representative of THAILAND thanked the Secretariat for facilitating the inclusive and transparent election process. As improvements could always be made, she supported the draft decision.

The representative of BRAZIL appreciated the transparency of the recent election, particularly the many opportunities for dialogue with the candidates and time allotted for their campaigns. The length of campaigning should be further assessed to ensure that it was cost-effective and fair to all candidates. The election process had met Member States' expectations and had added to the legitimacy and efficiency of health multilateralism. He agreed with the proposal to undertake a more in-depth assessment, as proposed by the representative of Mexico, which should provide an opportunity for broad consultation with Member States.

The representative of NEW ZEALAND expressed concern regarding the duration of the election process, which was too long; the potential disruptive impact on elections at the end of the five-year term if that term remained unchanged; and the cost for candidates and their countries. Voting should take place through an open process, and consideration should be given to changing the term of office of the Director-General and the length of the transition process, which was too short. A cap in election expenses should also be considered. The review process must take into account the opinions of a balance of large and small Member States with a wide geographical distribution.

The representative of SRI LANKA appreciated that all Member States had been able to vote in the election. He agreed with the need to evaluate the election process. He asked whether the Director-General elect would have to step down and appoint an interim Director-General for the duration of the election process if he wished to be re-elected at the end of his current mandate.

The representative of JAPAN requested that terms of reference should be prepared for the evaluation management group, so that its work could be focused and effective. He also asked how the independence of the evaluation management group would be ensured. He noted that most of the Officers of the Board who had been elected were not fully aware of the heavy workload of their positions, and should be able to give informed consent when asked to serve.

The representative of MONACO¹ said that some points regarding the organization of the election still needed to be fine-tuned. The date on which a new Director-General took up office should be reviewed, to allow for a longer transition period with the outgoing team. Transparency and efficiency during the election process could also be improved, in particular during the vote itself, including the use of electronic voting. Her delegation fully supported the establishment of an evaluation management group, and was prepared to participate in any consultations.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND¹ welcomed the open and transparent election process, which had increased the focus on WHO and the priorities of its Member States, and had given a clear mandate to the Director-General elect.

The representative of ZIMBABWE¹ agreed that there was an urgent need to evaluate the election process as a whole, and the conduct of the Secretariat during that process. The integrity and neutrality of the Secretariat were critical to ensure the trust of Member States and that WHO remained effective. Therefore, those principles should be added to the factors already proposed for the evaluation. External independent evaluations should be conducted alongside the internal evaluation process.

The representative of the REPUBLIC OF KOREA¹ said that she supported the decision to seek feedback from Member States, with a view to increasing fairness and transparency in future elections. However, the Secretariat should introduce an efficient and user-friendly electronic voting system for the next election. She looked forward to participating in the online survey.

The representative of NORWAY¹ agreed that the evaluation of the election process was a governance issue, and asked the Secretariat to explain why it had proposed restricting discussions on the evaluation to an open meeting of the Board.

The representative of the UNITED STATES OF AMERICA¹ welcomed the proposal to establish an evaluation management group, and said that she looked forward to its results. The fact that the election campaign was long and the transition period was short presented challenges. She supported the proposal to consider a single non-renewable term of office for the Director-General that would be longer than five years.

The CHAIRMAN said that he wished to relinquish his position as chairman of the proposed evaluation management group, in order to ensure transparency and manage conflict of interest, given that Pakistan (his country) presented a candidate for the recent election. Therefore, he requested that the first Vice-Chairman should lead the proposed evaluation management group, and that a Board member from the Eastern Mediterranean Region should be selected to represent that Region. If the members of the Board agreed, the wording of the draft decision would need to be amended accordingly.

The representative OF THE DIRECTOR-GENERAL (Evaluation and Organizational Learning) confirmed that the online survey would be sent to all Member States and that additional feedback on the election process would be sought through key informant interviews with the Chairman of the 140th session of the Board, the six candidates and members of the Secretariat who had been involved in the election process. The Evaluation Office would develop the survey and interviews in consultation with the evaluation management group. Once completed, the Evaluation Office would share the findings of

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

the process with the evaluation management group. Member States and the evaluation management group could make a decision on whether to include non-State actors in official relations with WHO in the evaluation process, which could be done through a specific online survey. A proposal for the process and timeline for the online survey and interviews would be prepared shortly with the evaluation management group, taking into account the new composition of that group. Member States would be presented with the findings of the evaluation for discussion at the 142nd session of the Board.

The LEGAL COUNSEL said that the Secretariat had not proposed carrying out the evaluation in an open meeting; the Health Assembly had made that decision in resolution WHA65.15 (2012). However, although the discussion would take place in an open meeting, the aforementioned resolution required that no Member State should be excluded.

The CHAIRMAN took it that the Board wished to suspend the discussion pending further consultations on the draft decision.

It was so agreed.

Evaluation: annual report: Item 7.3 of the agenda (document EB141/7)

The CHAIRMAN drew the Board's attention to paragraph 14 of the report of the twenty-sixth meeting of the Programme, Budget and Administration Committee of the Executive Board, contained in document EB141/2, which outlined the opinion of that Committee regarding the annual report on evaluation.

The representative of ZAMBIA, speaking on behalf of the Member States of the African Region, noted with satisfaction the evaluation of the Secretariat's contribution to the health-related Millennium Development Goals. Such evaluations would enable WHO to improve continuously its performance and its service to Member States, provided that they were carried out regularly, and that the resulting recommendations were implemented. Evaluations should also be carried out in regional and country offices, and not only at headquarters. All results should be disseminated to stakeholders, including staff, to facilitate the improvement of performance.

The representative of the NETHERLANDS encouraged the Secretariat to continue implementing the framework for strengthening evaluation and organizational learning. The Director-General elect should keep evaluation high on his agenda. The Organization's three-level and technical structure posed challenges to the establishment of systematic and strongly independent evaluations. Information should be provided on the role of the headquarters evaluation function in relation to other oversight functions and the decentralized evaluation activities of the regions and technical departments. The decision to protect the evaluation function from budget cuts under category 6, which had been made in the Programme budget 2018–2019, was welcome, and should be maintained throughout the biennium.

The representative of BURUNDI, emphasizing the importance of the evaluation function, agreed that evaluations should also be conducted at the regional level. He encouraged the Secretariat to disseminate the results of such evaluations.

The representative of MEXICO said that it was vital to strengthen the evaluation function, alongside governance and predictability in administrative matters. He looked forward to the results of the evaluation of the Secretariat's contribution to the health-related Millennium Development Goals, which would inform work towards attaining the Sustainable Development Goals. Enhanced communication and feedback, and support for Member States, would improve strategic programmes and projects at country level. He welcomed the recommendation to encourage the active participation

of WHO representatives in country offices, as a means of contributing to the achievement of outcomes under the general programme of work. However, such participation must respect local management processes and be in line with national priorities. Evaluations, audits and general performance reports should serve to implement preventive and remedial action to improve the functioning of WHO.

The representative of IRAQ agreed that evaluations should also be carried out at the regional and country levels, and in the area of human resources, using quality management approaches. Standards should be reviewed periodically, in accordance with epidemiological variables. Finally, evaluations should remain closely linked to WHO reform.

The representative of the UNITED STATES OF AMERICA¹ said that evaluations were invaluable tools for organizational learning when fully integrated into planning processes and when used to inform strategic decision-making. The Secretariat should continue to place an emphasis on organizational learning in its evaluation framework, and maximize the dissemination of results and the implementation of recommendations.

The representative OF THE DIRECTOR-GENERAL (Evaluation and Organizational Learning) said that evaluations were carried out across the three levels of WHO through collective evaluation workplans. The 2016–2017 biennial workplan addressed the evaluations to be conducted at all levels in that period, and the evaluation annual report contained updates in that regard. The Evaluation Office was working to produce a document that would contain a more comprehensive consolidation of all the evaluations that were under way.

The Evaluation Office at headquarters worked closely with the decentralized evaluation functions through a global network on evaluation, with focal points in the clusters at headquarters and in the regional offices. The focal points ensured that evaluation at all levels was being conducted in line with evaluation policy, and the role of the central function was to provide technical backstopping and quality assurance. The reports of any corporate evaluations were transmitted to the Director-General and Member States, and were published on the WHO website, together with the response from the Management. Reports were also sent to the regional directors and assistant directors-general, to be forwarded to all staff. A newsletter was published on a quarterly basis with information on ongoing evaluations. Organizational learning was always a challenge, and the Evaluation Office was looking at how to manage better the recommendations issued as a result of the many different evaluations and facilitate their implementation. The Management's responses to and annual updates on evaluations were also provided to Member States during governing bodies meetings.

The Board noted the report.

Evaluation of the election of the Director-General of the World Health Organization: Item 7.2 of the agenda (document EB141/6) (resumed)

At the invitation of the CHAIRMAN, the SECRETARY read out the amended draft decision:

The Executive Board, having considered the report on the evaluation of the election of the Director-General of the World Health Organization, decided to establish an evaluation management group, to be composed of the Vice-Chairmen and Rapporteur of the 141st session of the Executive Board, in addition to a member of the Executive Board from the Eastern

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

Mediterranean Region, to take forward the work; and to be chaired by the first Vice-Chairman, with support from the WHO Evaluation Office.

The decision, as amended, was adopted.¹

Membership of the Independent Expert Oversight Advisory Committee: Item 7.4 of the agenda (document EB141/14)

The CHAIRMAN introduced the report containing the proposed members for the Independent Expert Oversight Advisory Committee. It was proposed that Mr Christoph Gabriel Maetze and Mr Jayant Karia should replace Mr Steve Tinton and Mr Mukesh Arya in January 2018, and that Mr Christopher Mihm should replace Mr Robert Samels in January 2019. The full curriculums vitae of the candidates were available for consultation.

The representative of the UNITED REPUBLIC OF TANZANIA, speaking on behalf of the Member States of the African Region, commended the work done by the Independent Expert Oversight Advisory Committee and its outgoing experts. The large number of applications received from diverse regions and from people with diverse backgrounds reflected the growing interest in serving on the Committee. He supported the appointment of the three new members and the proposal that the term of the current Chairman of the Committee be extended by one year, to January 2019. He emphasized the continued need to ensure gender balance within the Committee.

The CHAIRMAN asked whether the Board was prepared to note the report and appoint the three new members to the Independent Expert Oversight Advisory Committee.

It was so decided.²

Hosted partnerships: Item 7.5 of the agenda

- **Report on hosted partnerships** (document EB141/8)
- **Review of hosted partnerships** (document EB141/9)

The CHAIRMAN drew the attention of the Board to paragraph 15 of the report of the Programme, Budget and Administration Committee of the Executive Board, contained in document EB141/2, which outlined the discussion on hosted partnerships by that Committee.

The representative of ZIMBABWE³ expressed serious concern regarding health partnerships hosted by WHO and other United Nations agencies. Such partnerships, supported by Member States and their development agencies, ran parallel to the support of WHO and undermined its role as a global public health leader. They also undermined WHO's ability to prioritize, respond rapidly, coordinate, and act as the global health platform in priority areas. He requested the Secretariat to take into account the importance of a single unified health platform at the global level, to support a single regional health platform in each region, and then a single national health platform in each country. The involvement of all stakeholders in a single platform would reduce health transaction and inflation costs and would have an impact on efforts towards universal health coverage.

¹ Decision EB141(1).

² Decision EB141(2).

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

The DIRECTOR-GENERAL said that she recognized the concern expressed by the representative of Zimbabwe. Member States had provided the Secretariat with sound guidance on the partnership policy, which was being implemented. Overall, partnerships were good for the Organization. Some partnerships were excellent while others were problematic and required sound management.

The Board noted the reports.

Committees of the Executive Board: filling of vacancies: Item 7.6 of the agenda (documents EB141/10 and EB141/10 Add.1)

The CHAIRMAN said that there were seven vacancies to be filled on the Programme, Budget and Administration Committee, which was composed of 14 members: two members from each region, selected from among the members of the Board; plus the Chairman and a Vice-Chairman of the Board, as ex officio members. He asked whether the Board approved the proposals contained in paragraph 2 of document EB141/10 Add.1.

It was so decided.¹

The CHAIRMAN said that there was one vacancy to be filled on the Foundation Committees, and asked whether the Board approved the proposal contained in paragraph 2 of document EB141/10 Add.1.

It was so decided.²

The CHAIRMAN proposed that the Board should be represented at the Seventy-first World Health Assembly by the Chairman and the first three Vice-Chairmen. If any of them were not able to attend the Health Assembly, the other Vice-Chairman and the Rapporteur could be asked to represent the Board. In the absence of any objections, he took it that the Board wished to approve that proposal.

It was so decided.³

3. STAFFING MATTERS: Item 8 of the agenda

Statement by the representative of the WHO staff associations: Item 8.1 of the agenda (document EB141/INF./1)

The CHAIRMAN drew the Board's attention to the report of the WHO staff associations contained in document EB141/INF./1, but said that the item would be postponed until the representative of the staff associations could be present.

¹ Decision EB141(3).

² Decision EB141(4).

³ Decision EB141(5).

Amendments to the Staff Regulations and Staff Rules: Item 8.2 of the agenda (documents EB141/11 and EB141/11 Add.1)

The CHAIRMAN said that paragraph 21 of document EB141/11 contained two possible draft resolutions and the Board was invited to adopt one of those. Additionally, he drew the Board's attention to paragraph 16 of the report of the Programme, Budget and Administration Committee of the Executive Board, contained in document EB141/2. The Committee had recommended that the Board should adopt draft resolution 1, which would confirm that the amendments to the Staff Rules would come into effect from 1 January 2018, and not from 1 January 2020. The financial and administrative implications of the resolutions, should one be adopted, were set out in document EB141/11 Add.1.

The representative of CANADA said that it was essential to harmonize practices and maintain consistency and coherency across the United Nations system. She noted the concerns raised by the Secretariat related to the costs and liabilities of extending the mandatory age of separation to 65 and the proposed implementation date of 1 January 2018. Nevertheless, there should be no delay in implementing that change, and the complete, international civil service package should be implemented universally, as endorsed by the United Nations General Assembly. She encouraged WHO to work with other agencies to learn from best practices. She understood that the WHO staff associations supported the 1 January 2018 date and expressed the concern that unnecessary legal challenges could result from deviation from the United Nations common system. Moreover, PAHO had already voted to implement the change from that date. WHO should not rely on the unrelated policy area of implementation of the mandatory age of separation to solve gender and diversity issues. She supported draft resolution 1.

The representative of COLOMBIA said that his Government supported draft resolution 2: the implementation of the amendments to the Staff Rules with effect from 1 January 2020. That option could allow WHO to save US\$ 10 million and avoid unbudgeted costs related to reassignments and relocations. The Director-General elect would also require time for administrative analysis and decision-making, in particular for staff decisions.

The representative of the NETHERLANDS said that matters related to raising the mandatory age of separation had already been discussed on multiple occasions, and welcomed the ample information provided on the consequences of the two draft resolutions. He continued to support draft resolution 1.

The representative of SWAZILAND, speaking on behalf of the Member States of the African Region, said that draft resolution 1 was unfavourable as it would increase the cost of the projected poliomyelitis liabilities to US\$ 3–4 million and delay progress in achieving gender and diversity targets. The detailed work of the Secretariat and the advice of the Independent Expert Oversight Advisory Committee to the Programme, Budget and Administration Committee indicated that WHO would not benefit from draft resolution 1. That was particularly true for the African Region, where the gender imbalance was most pronounced and a greater percentage of international professionals were expected to retire in comparison with the global average. While he recognized that the staff associations had expressed support for draft resolution 1, he supported draft resolution 2, as it addressed financial concerns and posed no legal challenges.

The representative of SWEDEN, noting the concerns outlined by the Secretariat, said that the decision of when to implement the amendments should not be reduced to the issue of gender parity. Measures to achieve gender balance should be both short- and long-term, and extend to policies beyond recruitment, including fostering a work environment conducive to both men and women. Her Government supported the uniform implementation of the new mandatory age of separation for staff across all agencies, and expressed regret that some international organizations had chosen to delay the

implementation of that change. Further discrepancies in the terms of employment within the United Nations common system should be avoided to prevent competition in recruitment of personnel and to facilitate inter-agency mobility. She supported draft resolution 1.

The representative of JAPAN said his country preferred draft resolution 2. Deferment of the implementation date would accelerate improvement in the Organization's gender balance and geographical representation. There was also a financial consideration; it would also allow WHO to avoid approximately US\$ 10 million in liabilities. Several United Nations agencies had decided to defer in the light of their specific contexts. WHO had its own specific needs, as an organization that was undergoing a reform process and had now elected a new Director-General. Deferment of implementation would be prudent as WHO was undertaking significant reforms that required ample financial resources and was transitioning to new leadership.

The representative of BRAZIL supported the adoption of draft resolution 1. He recalled that United Nations General Assembly resolution 70/244 had been adopted by consensus and the date for entry into force of the new mandatory age of separation contained therein must be respected. The Subcommittee on Program, Budget and Administration of PAHO's Executive Committee, at its eleventh session, had approved implementation of the new policy by 1 January 2018 at the regional level. Consistency in staff working conditions within WHO and across the United Nations system was important.

The representative of FRANCE agreed that as the United Nations General Assembly resolution had been adopted by consensus, her Government supported the adoption of draft resolution 1.

The representative of THAILAND noted the desire for a common policy across the United Nations system, but said that different United Nations agencies had different fiscal contexts. The cost of implementing the new mandatory age of separation from 1 January 2018 amounted to a considerable portion of the 3% increase in assessed contributions agreed for the biennium 2018–2019. While recognizing that the decision to defer implementation of the new mandatory age of separation would have an impact on some staff members due to retire in 2018 or 2019, he said that adopting draft resolution 2 would ensure efficiency in WHO's work.

The representative of BURUNDI said that more time was needed to prepare for the changes. Given the financial implications of early implementation, his delegation was in favour of draft resolution 2.

The representative of MEXICO supported the adoption of draft resolution 1. Harmonization across the United Nations systems and respect for decisions adopted by the United Nations General Assembly were important. He agreed with others that gender balance and geographical representation should be promoted through appropriate short- and long-term policies and practices.

The representative of NEW ZEALAND said that deferring the implementation of the United Nations General Assembly resolution was not a good example of good-faith bargaining for staff. In the report, the Secretariat seemed to focus on health care liabilities, which were increasing, rather than pension costs. Additionally, there was no guarantee that the costs incurred by the implementation of the new mandatory age of separation would not be even greater in two years' time. Similarly, postponing the policy change would enhance gender balance and geographical representation only if all positions that became vacant were filled to that effect. In order to take an informed decision, Member States needed information on the financial implications of deferral, which had not been provided. Given those uncertainties, his delegation supported draft resolution 1.

The representative of ALGERIA supported draft resolution 2, echoing the concerns expressed by the representatives of Swaziland, Japan and Thailand.

The representative of NORWAY,¹ supporting draft resolution 1, said that the United Nations General Assembly resolution was just that, a resolution, and not a recommendation. He shared the concerns expressed by the representative of New Zealand regarding the unknown financial implications of postponing implementation. He also agreed that a positive impact on gender balance in the Organization could not be guaranteed.

While thanking the Office of the Legal Counsel for its contribution to the report, he said that the possibility of staff members challenging a decision to defer implementation before the ILO Administrative Tribunal could not be ruled out. If so, the Tribunal might adopt a different view from that reflected in paragraph 20 of document EB141/11. Any such ruling could incur financial liabilities for the Organization.

The representative of the UNITED STATES OF AMERICA¹ recognized the specific implications of the new mandatory age of separation for WHO. She shared the concerns expressed by the representative of Norway regarding the potential risk to the Organization if the decision was deferred. There was a responsibility inherent in participation in the United Nations system to abide by decisions of the International Civil Service Commission and the United Nations General Assembly, which ensured consistency in staff benefits and compensation across the United Nations.

The representative of FINLAND,¹ supporting adoption of draft resolution 1, said that he did not believe that draft resolution 2 would be risk free, from a legal point of view.

The representative of SWITZERLAND¹ expressed support for coherence across the United Nations system with regard to human resources policy. The increase in the mandatory age of separation was based on a long-term perspective, taking into account the demographics of the organizations. She therefore supported adoption of draft resolution 1.

The representative of SPAIN,¹ expressing his Government's full commitment to the optimal use of human and financial resources across the United Nations system, reiterated that the amendment to implement the new mandatory age of separation of 65 would have to enter into force either in 2018 or 2020, as WHO had not expressed any intention to withdraw from the United Nations system. The question was whether WHO would adjust the timeline to its specific needs, and potentially save US\$ 10–15 million. The United Nations General Assembly resolution carried no direct legal implications for WHO, otherwise the discussion on amending the Staff Rules and Staff Regulations would not be taking place.

During the Seventieth World Health Assembly, many Member States' representatives had underlined the importance of ensuring that WHO had the resources it needed to implement its mandate. Many representatives had also expressed their willingness to make an exception to the zero real growth policy maintained for budgets of other United Nations agencies, accepting an increase in the budget in the light of WHO's financial situation and the importance of its work. However, there was little coherence between that position and the current prevailing focus on the seemingly mechanical implementation of United Nations General Assembly resolution 70/244.

His delegation favoured adoption of draft resolution 2, but given the diversity of views among members, he proposed that the Board could consider a compromise solution, in which the amendments related to the new mandatory age of separation would enter into force on 1 January 2019.

The representative of AUSTRALIA¹ aligned himself with those who supported draft resolution 1, recalling the consensus agreement on the timeline across the United Nations system. Any other issues raised in the report, such as the impact on poliomyelitis transition planning, gender

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

balance and geographical representation, should be considered separately to the decision on the mandatory age of separation, in a comprehensive, Organization-wide response to human resources. He also echoed the concerns expressed by the representative of New Zealand that a cost deferred was still a cost.

The representative of the REPUBLIC OF KOREA¹ said that some United Nations agencies had already shown flexibility in implementing the United Nations General Assembly resolution. She urged WHO to take account of the need to improve gender balance and geographical distribution and manage funding and budgets efficiently. Her delegation therefore supported the adoption of draft resolution 2.

The representative of MONACO¹ fully supported the statements made by the representatives of Norway and Switzerland. She supported the adoption of draft resolution 1, given the importance of coherence in the mandatory age of separation across the United Nations system.

The representative of ANGOLA¹ joined other representatives in supporting the adoption of draft resolution 2.

The representative of the CONGO,¹ while noting the importance of coherence with other United Nations organizations, said that Congo supported draft resolution 2.

The ASSISTANT DIRECTOR-GENERAL (General Management) recognized the diversity of views within the Board. With regard to the future unknown costs of deferring the entry into force of the amendments relating to the mandatory age of separation, he recalled that the estimated short-term cost would amount to US\$ 10–15 million, and that there would be an additional increase in costs for poliomyelitis transition planning of US\$ 4 million. Having consulted representatives of the United Nations Joint Staff Pension Fund, he informed the Board that the implementation of the new mandatory age of separation on 1 January 2018 would incur a cost for WHO. WHO's contribution to that Pension Fund represented a fixed percentage of a given salary, which was considerably higher for staff aged 62 and due to retire than it would be for newly recruited staff. Thus, WHO's contributions to the Pension Fund would be higher than the pension payments it would be required to make. There would be no financial implications for the Organization in terms of health insurance contributions.

The DIRECTOR-GENERAL said that some United Nations agencies had decided to delay implementation of the resolution, others were refraining from its implementation altogether. WHO would not leave the United Nations system and would continue to do its utmost to honour the decisions and recommendations of the International Civil Service Commission. However, taking evidence-based policy decisions required looking at the different draft resolutions before the Board and their financial implications for the Organization. Implications for gender balance and geographical representation were also important to consider. Given that Member States were deeply divided on the issue, she asked whether they might be willing to entertain the compromise solution of deferring implementation to 1 January 2019, as proposed by the representative of Spain. That solution would give the Director-General elect some flexibility to prepare for the implementation of United Nations General Assembly resolution 70/244.

The representative of JAPAN supported the compromise proposal.

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

The representative of BRAZIL, noting that consideration of agenda item 8.1, statement by the representative of the WHO staff associations, had been suspended, asked whether the Board could hear the views of WHO's staff members prior to making a decision.

Statement by the representative of the WHO staff associations: Item 8.1 of the agenda (document EB141/INF./1) (resumed)

The representative of the WHO STAFF ASSOCIATIONS, speaking on behalf of the staff associations of WHO, PAHO, IARC and UNAIDS, paid tribute to the outgoing Director-General, Dr Margaret Chan, for maintaining good relations between management and staff. He also congratulated the incoming Director-General, Dr Tedros Adhanom Ghebreyesus, on his election. The staff associations looked forward to engaging constructively with the new administration on staff-related issues, which had a direct impact on the overall performance of the Organization.

He expressed his full support for the implementation of the extension of the mandatory age of separation to 65 by 1 January 2018, as requested in United Nations General Assembly resolution 70/244. The measure was fully aligned with WHO's public health policy on ageing and he urged the Organization to adhere to the recommended timeline.

Harassment continued to remain a challenge at all levels of the Organization, often with undesirable consequences for the health of staff members. It was a specialized area, which should be managed by experts in that domain. The staff associations therefore supported the establishment of an independent office to handle all cases of harassment in the workplace.

Unfortunately, staff working conditions at WHO had deteriorated. In order for the Organization to enjoy the full benefit of motivated and functional staff, it must invest in them. A global vision was needed to integrate changes such as geographical mobility, career development and modern working methods into the culture of the Organization. The newly established WHO Health Emergencies Programme comprised many new functions and posts around the world and provided a good opportunity to pilot new working methods and update skills and tools. In that regard, Member States must ensure dedicated and predictable funding.

The representative of ZAMBIA, speaking on behalf of the Member States of the African Region, said that the staff associations, in their report, had expressed concern that important contributions made by the staff associations in the mutual interests of the Organization and its staff were often not incorporated by the Administration. He made particular reference to the request to reinstate the practice of sharing vacancy notices with the headquarters Staff Association prior to publication. He asked which platforms existed to engage with the staff associations, and recommended that they should be used properly for the benefit of the Organization.

The staff associations had also raised concern over the proposal to postpone implementation of United Nations General Assembly resolution 70/244. However, the Member States of the Region supported deferring the application of the extended mandatory age of separation, since the implementation of the new rules would have significant financial implications for the Region.

Given the persistent gender disparity within WHO, long-standing recruitment and career development practices needed to be improved. The Board should receive regular updates on progress made in that regard. The newly established WHO Health Emergencies Programme needed to be fully resourced; technical assistance and capacity-building should be provided and Member State investment increased.

The representative of FRANCE supported the staff associations' request to adhere to the 1 January 2018 timeline for the implementation of the amendments to the Staff Rules. Her delegation also supported the staff associations' suggestions concerning the promotion of teleworking, the handling of harassment cases by an independent office, incentives to encourage geographical mobility, and the strengthening of gender equity within the Organization.

The representative of ZIMBABWE¹ expressed concern about the reports of harassment at all levels of the Organization. The reported failure to handle cases expeditiously and impartially, and their subsequent referral to the ILO Administrative Tribunal, undermined the integrity of WHO and needed to be addressed quickly.

The DIRECTOR-GENERAL thanked the staff associations for their support in the implementation of WHO reforms over the past decade. Although it had not always been easy to reach agreement, dialogue between management and staff had been constructive and had produced good results in areas such as the promotion of a respectful workplace and the introduction of flexible workplace policies and geographical mobility. She requested the representative of the staff associations to convey her appreciation to all staff members of the Organization.

The ASSISTANT DIRECTOR-GENERAL (General Management) said that all vacancy notices were shared with the staff associations prior to publication. WHO's staff members were its greatest asset and dialogue with the staff associations would continue. WHO was implementing the Respectful Workplace initiative and currently revising its harassment policy in order to address and prevent harassment. In addition, a teleworking policy had been put in place. Closing the gender gap had been made a priority and management reported regularly on the progress made.

The Board noted the report.

Amendments to the Staff Regulations and Staff Rules: Item 8.2 of the agenda (documents EB141/11 and EB141/11 Add.1) (resumed)

The representative of THAILAND asked whether the US\$ 10 million referred to in the report included the pension fund implications outlined by the Assistant Director-General. He also requested clarification from the Legal Counsel on whether staff members were likely to take legal action if implementation of the resolution was deferred, and the potential financial implications of any such action. Since WHO had its own Constitution and managed its own finances, he was unconvinced by the argument that United Nations-wide coherence was at stake. The main concern should be to ensure that the actions agreed by the Health Assembly and the Board were adequately funded. In his opinion, the positive impact of deferring the implementation of the amendments to the Staff Rules was overwhelming.

The representative of the UNITED REPUBLIC OF TANZANIA, taking into account the comments made by the Director-General, was prepared to support the compromise proposal made by the representative of Spain.

The representative of CANADA supported the adoption of draft resolution 1 and explained that her Government had consulted the International Civil Service Commission to understand the financial implications of the two draft resolutions. Expeditious implementation of United Nations General Assembly resolution 70/244 was in keeping with current labour market and life expectancy trends. She enquired whether the US\$ 10 million estimate was based on the assumption that all 359 staff would retire.

The representative of BURUNDI thanked the Director-General for her clarifications and said he would be prepared to support the compromise proposal if a consensus was reached in that regard. Otherwise, he would support draft resolution 2.

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

The representative of ALGERIA said that there was general agreement that WHO needed to be coherent with the wider United Nations system, and with its own policies. There was also a shared interest in improving gender balance and geographical representation, as well as making financial savings. While his Government preferred draft resolution 2, if consensus was to be reached on the compromise proposal of entry into force on 1 January 2019, Member States needed to know more about the financial implications of that option.

The observer of the RUSSIAN FEDERATION¹ said that his delegation supported draft resolution 1, which was in line with United Nations principles. However, he would not object to the compromise proposal put forward by the representative of Spain.

The ASSISTANT DIRECTOR-GENERAL (General Management) said that the Secretariat's calculations had been based on the assumption that all staff affected by the change in the mandatory age of separation would choose to retire at 65 and the financial implications mentioned did include those who were expected to retire. However, staff could leave whenever they chose, which made it difficult to plan from a human resources perspective. By implementing a system whereby each post would be reviewed on retirement and downgraded if justified, some savings could be made that had not been taken into account in the cost estimate. The financial implications of postponement until 1 January 2019 would need to be calculated, but could be expected to amount roughly to half the cost of implementation in 2018.

In response to the comments made by the representative of Canada, he said that the International Civil Service Commission was not responsible for the United Nations Joint Staff Pension Fund, and had only considered the long-term implications of the decision. Actuaries working for the Pension Fund had clearly stated that the impact of the decision on the Pension Fund would be marginal. He reiterated that WHO would be implementing the new mandatory age of separation, it was just a question of when.

He also said it was difficult to learn from the experiences of other United Nations agencies as the staffing profiles varied, and the savings and cost implications would therefore not be the same.

The LEGAL COUNSEL, responding to the concerns raised regarding the legal risks of adopting draft resolution 2 or the compromise proposal, said that Article 36 of the WHO Constitution provided that the conditions of service of the staff of the Organization should conform as far as possible with those of other United Nations organizations. That did not mean, however, that WHO had no discretion as to how to implement decisions of the United Nations General Assembly; and that it was reasonable to regard that discretion as extending to the date of implementation. There could be no certainty that staff would not seek to challenge such a decision, or that the view of the ILO Administrative Tribunal might differ from that of WHO. However, there were reasonable legal arguments to defend a decision to defer, should the Board decide to take that course of action.

The representative of THAILAND noted that the two draft resolutions had similar levels of support, but said that many members of the Board had not yet expressed their opinions. The Board was responsible for making an objective decision that would benefit the Organization as a whole, and he recognized the importance of WHO's staff as its greatest asset. In his opinion, deferring implementation to 2020 would lead to benefits in terms of gender equity, geographical representation and cost savings.

The CHAIRMAN encouraged members of the Board who had not yet expressed their opinions to do so.

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

The representative of the DOMINICAN REPUBLIC said that he supported the compromise proposal put forward by the representative of Spain.

The representative of ITALY said that if labour market trends were to be followed, the changes should be implemented immediately. However, draft resolution 1 had a serious financial implication and in a time of financial crisis he supported draft resolution 2.

The representative of FIJI said that he was unwilling to express a preference for either draft resolution. The solution proposed by the representative of Spain was a compromise, but might ultimately provide a sensible middle ground. It was worth noting that the current gender and geographical imbalance reflected previous recruitment practices, and that it would be naive to assume that the whole recruitment system could be transformed by the introduction of a new staff policy. He expressed the hope that steps would be taken to ensure that recruitment practices were based on the principles of gender balance and geographical representation.

The representative of JAMAICA said that he supported the adoption of draft resolution 2.

The representative of TURKEY said that his Government would abstain from a decision on the issue.

The representative of the PHILIPPINES said that, given the importance of budgetary matters, she would support deferring implementation of the amendments to the Staff Rules until 2020.

The representative of LIBYA said that, although his Government had initially favoured draft resolution 1, it supported the compromise proposal. Deferring the discussion until January 2018 was out of the question.

The representative of BHUTAN said that while she favoured the middle ground, she would support the majority decision.

The representative of KAZAKHSTAN said that his Government supported the compromise proposal.

The representative of VIET NAM said that she supported draft resolution 2.

The representative of ALGERIA said that, given the fact that the Board sought to achieve consensus, it was important to give consideration to the compromise proposal put forward by the representative of Spain. He stressed that the matter should not be deferred until the 142nd session of the Board.

The representative of SRI LANKA said that cost was a major issue, and expressed support for draft resolution 2. However, he would also be willing to accept a compromise.

The representative of SWEDEN expressed concerns regarding the compromise proposal put forward by the representative of Spain, which still deviated from the United Nations General Assembly resolution, without any of the financial benefits of draft resolution 2.

In order to provide a more acceptable compromise solution, he proposed amending draft resolution 2, to read:

“CONFIRMS, in accordance with Staff Regulation 12.2, the amendments to Staff Rules 410 and 1020 that have been made by the Director-General with effect, as soon as possible but no later than from January 2020”.

The representative of IRAQ said that certain issues, especially those relating to funding, remained unclear. He supported the compromise proposal. In meantime, efforts could be made to cut expenditure and reduce the budgetary implications of introducing the new mandatory age of separation.

The representative of the NETHERLANDS said that the proposal made by Spain did not represent a successful compromise. He therefore supported the proposal made by the representative of Sweden.

The representative of FRANCE said that she favoured draft decision 1. Unfortunately, the solution proposed by the representative of Spain did not provide a satisfactory solution, either in terms of funding or in providing a response to the concerns of Member States that supported the uniform application of staff policy throughout the United Nations system. However, she was prepared to support the amendment to draft resolution 2 proposed by the representative of Sweden.

The representative of the UNITED REPUBLIC OF TANZANIA expressed the concern that the discussion had begun to focus on semantic detail. He encouraged the members of the Board to select one of the two original proposals for a draft resolution without delay. If that was not possible, the matter could either be deferred to the 142nd session of the Board for a full discussion, thereby losing the opportunity to take advantage of the first draft decision, or the Board could follow the suggestion made by the Director-General, namely to consider the proposal made by the representative of Spain.

The representative of BRAZIL said that WHO should not postpone a decision on the matter since clarity was needed. Although there was no specific reason for the Board to choose to implement the changes to the Staff Rules on 1 January 2019, it made sense politically. However, the decision was a difficult one since there was still much uncertainty concerning the figure of US\$ 10 million contained in the report, the number of people who would retire and whether there would be any legal challenges. It was also important for the Board to consider aligning WHO with the rest of the United Nations common system and to take into account the positions of the staff of the Organization who wished to implement the amendments sooner rather than later. He encouraged the Board to be flexible, and said that he respected the view of the Director-General that entry into force in 2019 could be a compromise. However, he was not in favour of adding imprecise language as proposed by the representative of Sweden.

The representative of THAILAND asked the Legal Counsel to clarify whether implementing the amendments on 2 January 2020 would be in violation of draft resolution 2 if it were amended as proposed by the representative of Sweden. Summarizing the views expressed so far, he concluded that the choice was between the amendment proposed by the representative of Sweden and the compromise proposed by the representative of Spain.

The representative of MEXICO said that he would not agree to postpone a decision on the amendments to the Staff Rules. He expressed the belief that the solution proposed by the representative of Sweden added ambiguity to the text and asked the Legal Counsel for his advice in that regard. In the spirit of compromise, he supported the proposal put forward by the representative of Spain.

The DIRECTOR-GENERAL said that it was vital that the Staff Regulations and the Staff Rules remained specific and not open to interpretation. Any ambiguity would leave the Director-General open to challenges from staff. In her opinion, the amendment proposed by the representative of Sweden would do just that. She therefore advised the Board to adopt resolution 1, resolution 2 or the compromise solution proposed by the representative of Spain.

The representative of NORWAY¹ reiterated that the solution proposed by the representative of Spain was not a compromise. It did not improve the basic problems associated with draft resolution 2: it was still inconsistent with United Nations General Assembly resolution 70/244 and it still left WHO at risk of legal challenge. Moreover, it would have fewer short-term benefits than draft resolution 2.

He considered the amendment proposed by the representative of Sweden to be of considerable merit since it reflected the original motive behind providing a second draft resolution: the need for flexibility. However, he understood the concerns expressed by the Director-General regarding the ambiguity and risks that the amendment could introduce and asked the Legal Counsel to propose some alternative wording, for example adding “when deemed to be in the best interests of the Organization” to the end of draft resolution 2. That draft resolution should also be amended to explain the reasoning behind the decision. Postponing a decision on the matter was not a solution.

The representative of FIJI said that he agreed with the Director-General on the need for a clear date for the implementation of the new mandatory age of separation. When a decision had to be made, often a solution that pleased no one was the right one, and he therefore suggested that the Board consider the compromise proposed by the representative of Spain.

The LEGAL COUNSEL said that by adopting the proposed amendment to draft resolution 2, the Board would empower the Director-General to decide when to make the amendments to the Staff Rules effective, within a final deadline. If that amendment was adopted, it would not be possible for the amendments to the Staff Rules to enter into force on 2 January 2020. However, until 1 January 2020, the Director-General would have flexibility on when to implement them.

It was true that the proposal made by the representative of Sweden added more uncertainty and therefore more legal risk. In order to mitigate that risk, the words “as soon as possible” could be removed so that the phrase would read: “with effect no later than 1 January 2020”. It would also be possible to add a preambular paragraph such as the following: “bearing in mind the specific circumstances of WHO”.

The representative of MONACO¹ recalled that during the 140th session of the Board, broad agreement had already been reached on implementing the United Nations General Assembly resolution without delay. Therefore, a decision needed to be taken immediately. The proposal made by the representative of Sweden, although it introduced some ambiguity, might allow the two sides to be reconciled.

The representative of the UNITED STATES OF AMERICA¹ agreed with the Director-General and said that there must be no ambiguity in the Staff Regulations and Staff Rules. The proposal made by the representative of Sweden would increase ambiguity and legal risk, which was unnecessary and should be avoided at all costs.

The representative of NEW ZEALAND recalled that the Programme, Budget and Administration Committee had recommended that the Board should adopt draft resolution 1. It was not appropriate to argue that WHO was being incoherent in terms of its financial policies. Additionally, the compromise proposal implied that the Organization could spend an additional US\$ 5 million rather than US\$ 10 million, when in reality it could afford neither. It was important to take into account the level of dissatisfaction among the Organization’s staff. The Board was responsible for the performance of the Organization, including its staff, and the staff associations had expressed a preference for draft resolution 1.

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

The CHAIRMAN said that it was clear that a consensus could not be reached on either of the two original draft resolutions contained in document EB141/11. Agreement would only be possible through the compromise proposal: implementation of the amendments to the Staff Rules with effect from 1 January 2019, which many members had said they would accept. It would be preferable to reach a consensus rather than proceed by vote.

The representative of ZIMBABWE¹ asked the Legal Counsel how much flexibility was available to WHO as an independent, specialized health agency within the United Nations system.

The representative of JAPAN, while expressing a preference for draft resolution 2, said that a decision by consensus would be preferable and that the compromise proposal put forward by the representative of Spain could be a solution.

The LEGAL COUNSEL, in response to the question asked by the representative of Zimbabwe, reiterated his earlier comments that the conditions of service of the staff should conform as far as possible with those of other United Nations organizations. The proposals under discussion did not call into question whether the decision of the United Nations General Assembly would be implemented, but rather posed the question of how the amendments would be implemented. As a specialized agency, WHO had a certain discretion as to how such decisions were implemented, and it was reasonable to regard this discretion as including the precise date of implementation of the new mandatory age of separation. However, there was a legal risk involved in choosing any option other than to implement the amendments to the Staff Rules with effect from 1 January 2018.

The CHAIRMAN asked whether the Board was ready to adopt the compromise proposal put forward by the representative of Spain, which endorsed the implementation of the amendments to the Staff Rules relating to extending the mandatory age of separation with effect from 1 January 2019.

The resolution, as amended, was adopted.²

The meeting was suspended at 18:55 and resumed at 19:05.

4. MATTERS FOR INFORMATION: REPORT ON MEETINGS OF EXPERT COMMITTEES AND STUDY GROUPS: Item 10 of the agenda (document EB141/12)

The CHAIRMAN invited the Board to comment on the sixty-seventh report of the Expert Committee on Biological Standardization.

The representative of NEW ZEALAND said that the report clearly showed that the work undertaken by expert committees was important to WHO, regulators and ultimately the general public, as it facilitated access to safe, high-quality medicines.

The DIRECTOR (Essential Medicines and Health Products) thanked the representative of New Zealand and the members of the Expert Committee for their support for the work of the Secretariat and the expert committees.

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

² Resolution EB141.R2.

The CHAIRMAN invited the Board to comment on the thirty-eighth report of the Expert Committee on Drug Dependence.

The representative of JAMAICA welcomed the work carried out by the Expert Committee on Drug Dependence towards conducting a pre-review of cannabis, which was important for those considering the use of cannabis for medical purposes. His Government intended to contribute scientific and other pertinent information to the Expert Committee to facilitate that review. Continued efforts should be made to broaden participation in the Expert Committee to include experts from countries such as those in his subregion. His Government was actively involved in developing regulations for a new medicinal cannabis industry.

The representative of MEXICO said that the Expert Committee on Drug Dependence played a key role in the WHO's mandate on drug policy. The recommendation to hold a specific meeting of the Expert Committee, dedicated to cannabis and its component substances, was a sign of recognition of the paradigm shift demonstrated in the final document of the Special session of the General Assembly on the world drug problem. In Mexico, that shift had resulted in a fruitful debate and the adoption of legislation by a federal legislative body on cannabis for medicinal use. She reiterated the call for open and candid discussions based on evidence, in order to develop and implement drug policies that had a strong focus on public health.

The DIRECTOR (Essential Medicines and Health Products) said that the Expert Committee on Drug Dependence would report on the progress made on the pre-reviews of cannabis and other substances, over the course of 2018.

The CHAIRMAN requested the Secretariat to convey the gratitude of the Board to the experts for their contributions and to follow up on their recommendations as appropriate.

The Board noted the report.

5. FUTURE SESSIONS OF THE EXECUTIVE BOARD AND THE HEALTH ASSEMBLY:
Item 11 of the agenda (document EB141/13)

The CHAIRMAN took it that the Board wished to adopt the two draft decisions contained in document EB141/13.

It was so decided.¹

6. MANAGEMENT AND GOVERNANCE MATTERS: Item 7 of the agenda (resumed)

Governance reform: follow-up to decision WHA69(8) (2016): Item 7.1 of the agenda (document EB141/5) (resumed)

The CHAIRMAN requested the SECRETARY to read out the amended draft decision, with a view to its adoption by the Board.

¹ Decisions EB141(6) and EB141(7).

The SECRETARY read out the amended draft decision:

“The Executive Board, having considered the report on governance reform: follow-up to decision WHA69(8), decided:

- (1) to request the Officers of the Board to apply, on a trial basis, the set of criteria and factors, and the tool for the prioritization of proposals set out in Annexes 1 and 2 to document EB141/5 for the preparation of the provisional agenda of the 142nd session of the Executive Board (January 2018), and to report thereon at that session;
- (2) with a view to ensuring transparency, to request that the report under paragraph 1 include the scores resulting from the application of the tool for prioritization; and
- (3) to request that the Secretariat’s analysis of the rules of procedure for additional, supplementary and urgent items to be prepared in accordance with decision WHA69(8) also address other ambiguities and gaps in the rules of procedure of the governing bodies”.

The representative of THAILAND requested that the draft decision should contain a reference to providing the set of criteria and factors to Member States who wished to submit an additional agenda item.

The SECRETARY said that the Secretariat would provide Member States with that information.

The DIRECTOR-GENERAL agreed that it was important for Member States to have the criteria prior to their decision to propose an additional agenda item. She proposed that the criteria and factors for future additional agenda items could be circulated to all Member States when the provisional draft agenda was sent out for their consideration.

The representative of FIJI suggested replacing the words “ambiguities and gaps” in the third paragraph of the amended draft decision with the words “ambiguities, gaps and other shortcomings,” to avoid any undue constraints.

The CHAIRMAN took it that the Board was ready to adopt the decision as amended.

The decision, as amended, was adopted.¹

7. CLOSURE OF THE SESSION: Item 12 of the agenda

The representative of AUSTRALIA, speaking on behalf of all the Member States, expressed profound respect for the Director-General’s leadership over the previous decade. She recalled all that had been said about the Director-General’s achievements in global health, which had been carried out with wisdom, courage, good humour, patience and tireless dedication.

The Board paid tribute to the Director-General, Dr Margaret Chan, through the medium of song.

¹ Decision EB141(8).

The DIRECTOR-GENERAL thanked Member States – institutions, experts and non-State actors – for supporting WHO in its work, including through its diverse networks and expert groups. The contribution of Member States to the Organization was not just financial; it was the talent of their people, which was the beauty of multilateralism. Also commendable was WHO reform, which would improve transparency and accountability. Thanks to their guidance and support, Member States had elected the next Director-General in a very democratic process for the first time in WHO history.

She thanked the Chairman for his efficient and diligent leadership of the Board. His discussions had always been in a spirit of friendship, collaboration and compromise. The Board was a place for true deliberation and placed great importance on the experiences of Member States, and the representatives of those Member States were able to learn from each other.

Her term of office as Director-General had been a learning experience, which was a privilege and honour. She looked forward to continuing her work in global public health as Director-General Emeritus. All her colleagues at WHO were committed and dedicated and she appreciated having had the opportunity to serve with them. She thanked those countries that had provided her with an education, which had made her a better person and able to serve the Organization. Her education had also taught her about the importance of efficiency, effectiveness and judicious financial management.

She had been grateful for her opportunity to join WHO and expressed her fondness for the Organization. She looked forward to seeing her colleagues in the future to discuss how WHO could go forward as a stronger Organization of which Member States could be proud.

The Board gave the Director-General a standing ovation.

After the customary exchange of courtesies, the CHAIRMAN declared the 141st session of the Board closed.

The meeting rose at 19:40.
