EXECUTIVE BOARD
146th session

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PROVISIONAL SUMMARY RECORD OF THE FOURTH MEETING

WHO headquarters, Geneva
Tuesday, 4 February 2020, scheduled at 14:30

Chair: Dr H. Nakatani (Japan)

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FOURTH MEETING

Tuesday, 4 February 2020, at 14:30

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PILLAR 4: MORE EFFECTIVE AND EFFICIENT WHO PROVIDING BETTER SUPPORT TO COUNTRIES (continued)

1. STAFFING MATTERS: Item 25 of the agenda (continued)

Human resources: update: Item 25.5 of the agenda (document EB146/48 Rev.1) (continued)

The DIRECTOR (Human Resources Management), referring to issues raised during the earlier discussion of the agenda item, said that the need for additional efforts to improve geographical representation among job applicants and WHO staff had been noted and that steps would be taken to address concerns about the reputational risk to the Organization and the need for greater due diligence when individuals were recruited – locally or internationally – on the basis of agreements for performance of work or as consultants. Turning to the question of interns, who from 2020 onwards would be paid a living allowance, she said that the estimated cost of US$ 3 million per year (for 600 interns) was borne by the technical divisions as part of their work to implement the Thirteenth General Programme of Work, 2019–2023.

The ASSISTANT DIRECTOR-GENERAL (Business Operations) highlighted the progress made towards gender equality among the heads of country offices, where there had been an increase of 6 percentage points in female representation. He noted the lively discussion in the Programme, Budget and Administration Committee of the Executive Board, where the three regional offices that were struggling to achieve gender parity had expressed their difficulty in overcoming the challenge and had explained the decisions made to tackle the issue. He assured Member States that WHO was closely examining the United Nations strategy on disability inclusion and looking at how to integrate the strategy into human resources policies when it came, for example, to testing candidates. He would report back at the next Programme, Budget and Administration Committee meeting on that issue. Geographical representation had become a key performance indicator as part of the compacts to be signed by senior members of the management team, which would be published. He hoped to report significant improvement in the future.

The DIRECTOR-GENERAL noted that gender parity had already been achieved at senior management level and that efforts would be made to achieve gender parity at all levels. Concerning geographical representation, all regions were represented at the senior management level and representation from the global south had increased by 36.7% at the director level; the Secretariat nevertheless intended to do more to make WHO a truly global organization. Diversity was not being pursued for its own sake but to make WHO better and stronger, as talent would be attracted from all over the world by changing recruitment guidelines.

The Board noted the report contained in document EB146/48 Rev.1 and concurred with the Committee's guidance in respect of human resources.

Amendments to the Staff Regulations and Staff Rules: Item 25.6 of the agenda (documents EB146/49 Rev.1 and EB146/49 Rev.1 Add.1)

The CHAIR drew attention to the two draft resolutions, on the remuneration of staff in the professional and higher categories, and on the remuneration of staff in ungraded positions and the Director-General, contained in paragraph 10 of document EB146/49 Rev.1, with their financial implications, contained in document EB146/49 Rev.1 Add.1.

The representative of GERMANY, speaking in his capacity as Chair of the Programme, Budget and Administration Committee of the Executive Board, said that the proposed amendments reflected changes to common system salaries recently adopted by the United Nations General Assembly. In response to a request from the Committee, the Secretariat had promised to include a more detailed introduction to the changes and an explanation of the implications for WHO in future reports on the subject. It had stressed that WHO was part of the United Nations common system and that the proposed changes in remuneration had been made on a no-loss, no-gain basis. Those relating to the remuneration of staff in ungraded positions and of the Director-General required the approval of the Health Assembly. The Committee had recommended that the Board adopt the two draft resolutions.

The representative of BENIN, speaking on behalf of the Member States of the African Region, expressed support for the two draft resolutions. The proposed amendments aimed to ensure better working conditions for all WHO staff on an equal basis, as they applied to all professional categories. The new unified salary scale for the professional and higher categories would reduce disparities between the categories.

The two resolutions were adopted.[1]

Report of the International Civil Service Commission: Item 25.7 of the agenda (document EB146/50)

The representative of GERMANY, speaking in his capacity as Chair of the Programme, Budget and Administration Committee of the Executive Board, said that the Committee had drawn attention to United Nations General Assembly resolution 74/255 A–B, which had reiterated a call to all United Nations common system organizations to cooperate with the International Civil Service Commission on matters relating to salaries, allowances and conditions of service. In particular, the General Assembly had noted that not all decisions had been applied consistently. The Committee had expressed overall support for the Commission's work and urged the Secretariat to ensure that WHO policy and practice complied with the Commission's decisions. It had recommended that the Board note the report.

The representative of BENIN, speaking on behalf of the Member States of the African Region, noted that the Commission's recommendations and the resolutions and decisions adopted at the seventy-third session of the United Nations General Assembly were intended to ensure better working conditions for all categories of WHO staff.

The Board noted the report.

[1] Resolutions EB146.R4 and EB146.R5.

2. COMMITTEES OF THE EXECUTIVE BOARD: Item 24 of the agenda (continued)

Membership of the Independent Expert Oversight Advisory Committee: Item 24.1 of the agenda (documents EB146/42 and EB146/42 Add.1)

The representative of the UNITED REPUBLIC OF TANZANIA, speaking on behalf of the Member States of the African Region, expressed appreciation for the work of the outgoing members of the Independent Expert Oversight Advisory Committee, Dr Jeya Wilson (South Africa and New Zealand) and Mr Leonardo P. Gomes Pereira (Brazil), and endorsed the proposal to appoint Ms Vanessa Huang (Malaysia) and Mr Bert Keuppens (Belgium) in their stead. The many applications received for the two vacancies demonstrated that there was great interest in working for WHO and that its work was valued.

The Board noted the reports.

The CHAIR took it that the Board wished to appoint Ms Vanessa Huang (Malaysia) and Mr Bert Keuppens (Belgium) as members of the Committee for a four-year non-renewable term starting on 1 May 2020.

It was so agreed.[1]

Participation in the Programme Budget and Administration Committee: Item 24.2 of the agenda (document EB146/43)

The CHAIR invited the Board to note the report contained in document EB146/43 and drew attention to a draft decision on participation in the Programme, Budget and Administration Committee of the Executive Board, proposed by himself in his capacity as Chair, which read as follows:

> The Executive Board, having considered the report on participation in the Programme, Budget and Administration Committee,[2] decided:
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> (PP1) to amend the terms of reference of the Programme, Budget and Administration Committee, with effect from the closure of its 146th session, as follows (new text appears in bold character),
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> 1. The Programme, Budget and Administration Committee shall be composed of 14 members, two from each region, selected from among Executive Board members, as well as the Chairman and a Vice-Chairman of the Board, ex officio.
>
> **1 bis. The following observers may attend meetings of the Programme, Budget and Administration Committee without the right to vote, subject to the conditions set out in paragraph 1 ter below;**
>
> **the set of Observers mentioned in paragraph 3 of Document EB 146/43, namely, the Holy See, Palestine, Gavi, Order of Malta, International Committee of the Red Cross, International Federation of Red Cross and Red Crescent Societies, Inter-Parliamentary Union, Global Fund to Fight AIDS, Tuberculosis and Malaria; the United Nations and other intergovernmental organizations with which WHO has**

[1] Decision EB146(4).

[2] Document EB146/43.

established effective relations under article 70 of the Constitution; and the European Union.

1 ter. The Chair, subject to any relevant decision of the Board, may, if circumstances require, close the meeting of the Committee, or parts thereof, to observers. Regarding speaking by observers, observers are requested to make interventions at the Board and not to do so at the Committee for the purpose of efficient and effective conduct of Committee business. In an exceptional case where the Chair determines that the efficient and effective conduct of Committee business will not be affected in any way, the Chair may, as appropriate, invite observers to make interventions with respect to items on the agenda that are of particular concern to them or relevant to their mandate.

(PP2) that additional observers may be added to the list provided in paragraph 1 bis of the Terms of reference of the PBAC, as amended, if so decided by the Board;

(PP3) to request that the Director-General report to Executive Board at its 150th session on the implementation of this decision.

Both the representative of TUNISIA and the representative of SUDAN, the latter speaking on behalf of the Member States of the Eastern Mediterranean Region, expressed support for the draft decision.

The Board noted the report and adopted the decision.[1]

The CHAIR informed the Board that the decision would apply from the end of the current session.

PILLAR 1: ONE BILLION MORE PEOPLE BENEFITING FROM UNIVERSAL HEALTH COVERAGE (continued)

PILLAR 4: MORE EFFECTIVE AND EFFICIENT WHO PROVIDING BETTER SUPPORT TO COUNTRIES (resumed)

3. PRIMARY HEALTH CARE: Item 6 of the agenda (document EB146/5) (continued from the second meeting, section 5)

MANAGEMENT MATTERS: Item 23 of the agenda (continued)

Evaluation: update and proposed workplan for 2020–2021: Item 23.1 of the agenda (document EB146/38 Add.1) (continued from the third meeting, section 3)

The CHAIR drew attention to a draft decision on the draft operational framework on primary health care, proposed by Botswana and Tajikistan, which read:

The Executive Board, recalling resolution WHA72.2 (2019) on primary health care, which welcomed the Declaration of Astana and requested the Director-General, inter alia, to develop, in

[1] Decision EB146(5).

consultation with Member States, an operational framework for primary health care for consideration by the Seventy-third World Health Assembly; and recalling the United Nations General Assembly resolutions 74/2 (2019) and 74/20 (2019), and taking note of the report by the Director-General,[1] decided:

(1) to emphasize the importance of strengthening health systems in the provision of primary health care to ensure the availability of comprehensive, quality, accessible and affordable first-level health services, which are fundamental to achieving Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages) in particular, target 3.8 on achieving universal health coverage, and other health-related Sustainable Development Goals;

(2) to support the Secretariat's efforts to expand capacity to support Member States globally in improving primary health care through dedicated programmes and offices, as appropriate;

(3) to request the Director-General to finalize, in consultation with Member States, for consideration by the Seventy-third World Health Assembly, an operational framework on strengthening primary health care, taking into account WHO's health system model and its six building blocks, and taking into account, as appropriate, the WHO-UNICEF document, A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals.[2]

The representative of TUNISIA, outlining the steps taken to strengthen primary health care in his country, stressed that effective and high-quality primary health care services led to fewer complications from serious illness and therefore better management of available resources within health systems.

The representative of TONGA said that all frameworks endorsed by the Board must be practical and relevant at the country level, and that the needs and challenges of small island developing States should be taken into account. It was important to ensure that primary health care systems were equipped not only to respond to communicable diseases but also to prevent and treat noncommunicable diseases. In her country and the rest of the Pacific, nurses formed the backbone of any strong primary health care system, often serving as the only health care providers for the most vulnerable people and those living in remote communities. Their role should not be forgotten in 2020, the Year of the Nurse and the Midwife.

The representative of TAJIKISTAN said that present-day health care challenges required stronger primary health care systems. The strength of the draft operational framework lay in its core strategic and operational levers, which were relevant and timely, but the specific features of certain countries would still have to be taken into consideration. It might be appropriate to add to the strategic and operational levers listed in the draft framework a further lever on interaction with international organizations, development partners and donors, as such interaction was particularly important for countries with lower levels of economic development. The narrative descriptions of the levers should be expanded to contain real-life examples that illustrated how the use of a specific lever had helped a particular country.

The representative of ESWATINI said that universal health coverage based on strong primary health care could not be achieved until economic, regional and political inequities in health were

[1] Document EB146/5.

[2] WHO and UNICEF. A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/handle/10665/328065, accessed 3 February 2020).

addressed. He expressed support for the draft operational framework and called upon all Member States to promote strong, cross-boundary partnerships and collaboration at all levels to accelerate its implementation.

The representative of DJIBOUTI outlined his country's primary health care policy and expressed support for the draft operational framework, which should guide the Member States' actions as they worked to ensure health for all.

The representative of CHINA expressed support for the draft operational framework and said that her country was willing to share its experience and best practice in terms of primary health care. When mobilizing resources and strengthening their health systems, governments should place greater emphasis on promoting primary health care and strengthening the primary-level health workforce; improving health insurance coverage to provide more effective protection from financial hardship; focusing more intensely on preventive care; and improving public health services and management so that people became ill less often and later in life.

The representative of the UNITED STATES OF AMERICA expressed support for the draft operational framework, as it would help countries to uphold the Declaration of Alma-Ata. Investment in primary health care systems was key to building health care that was accountable, affordable, accessible and reliable. Strong, sustainable primary health care services also helped to safeguard national and global security. She supported all forms of high-performing health institutions, be they public, private or non-profit; there was no single optimal path forward, and governments, civil society and the private sector in each country had to choose their own solutions.

The representative of ISRAEL, pointing out that it would have been helpful if the draft operational framework had been distributed earlier, said that he particularly welcomed the inclusion of the "Monitoring and evaluation" operational lever, which, in addition to information systems and reliable data, should also emphasize concrete and measurable indicators with which to assess progress. While technological advances such as digital health tools had benefited health systems in recent years, their integration should be well planned and take into account local health system capacity; a rushed or improper roll-out could lead to ineffective or even negative results. He looked forward to publication of the monitoring and evaluation framework.

The representative of JAPAN said that unwavering political commitment would be needed to advance the primary health care agenda, including building on the momentum of at the high-level meeting of the United Nations General Assembly on universal health coverage and its translation into concrete action. The draft operational framework should serve as a guide for promoting a whole-of-government, whole-of-society approach to universal health coverage. The Secretariat, in collaboration with other United Nations organizations, should help Member States with its application.

The representative of AUSTRALIA agreed that primary health care was the foundation for universal health coverage. Practical action should be guided by the Declaration of Astana on primary health care, the Political Declaration of the high-level meeting on universal health coverage and the 2030 Agenda for Sustainable Development. It was particularly important to expand access to sexual and reproductive health services, and all efforts to strengthen primary health care must be adapted to countries' individual contexts and be aligned with, and integrated into, existing country-led initiatives. The draft operational framework was welcome, and she looked forward to considering it in further detail ahead of the Seventy-third World Health Assembly.

The representative of AUSTRIA expressed full support for the draft operational framework. Outlining reforms introduced in his country, he stressed that high-income economies did not necessarily have well-developed primary health care systems, citing Austria's ageing health workforce as one challenge that his Government was working to overcome. Austria's plans were considered best practice within the European Union, and his delegation would happily exchange knowledge with other Member States.

The representative of BANGLADESH welcomed the draft operational framework. Indeed, even though it was broadly agreed that strengthening primary health care was a sustainable approach to achieving universal health coverage, countries were facing challenges in translating that vision into action. It would be difficult to measure progress, however, without good indicators, which would need to be provided in the forthcoming monitoring and evaluation framework. In addition, the draft framework should be supplemented with concrete guidance on integrating nutrition into primary health care. She commended the Secretariat for supporting Member State efforts to achieve universal health coverage.

The representative of BRAZIL agreed that strong, sustainable and people-centred primary health care was essential to achieving universal health coverage and safeguarding health and national security. He expressed support for the draft operational framework, especially its core strategic levers, and for the draft decision, to which he stood ready to contribute with a view to building consensus on it.

The representative of ARGENTINA expressed support for the draft operational framework, adding that most health care systems, including hospitals, overemphasized biology to the detriment of the sociocultural determinants of health. Only by placing health care in the social domain would it be possible to eliminate health inequities and reach the most vulnerable populations. Health care systems should be locally based and community-centred, with services provided by interdisciplinary teams and a sense of solidarity being felt at all levels. Strengthening primary health care must also be a priority.

The representative of CHILE expressed support for the draft operational framework and outlined some of the health system reforms adopted by his Government.

The representative of SUDAN called for stronger integration and harmonization between the Thirteenth General Programme of Work, 2019–2023, the Global Action Plan for Healthy Lives and Well-being for All, the WHO Framework on integrated people-centred health services and the WHO framework for action for strengthening health systems to improve health outcomes.

His Government welcomed the draft operational framework and supported its implementation. The Secretariat should further clarify the actions and interventions to be undertaken in respect of each lever at country level. It should engage in further capacity-building efforts and dialogue with national authorities and civil society, to ensure that the levers were properly integrated into national health policies and strategies. Social accountability and community engagement were also important.

The representative of INDIA[1] said that his Government's strategy for primary health care was based on a number of factors, such as expanding the service delivery package, ensuring a continuum of care and extending community outreach. WHO should create regional and global mechanisms to enable governments to exchange experiences on models of primary health care.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND[1] said that the levers outlined in the draft operational framework captured critical elements of

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

primary health care that must be addressed urgently. For example, the draft framework would help WHO to prioritize actions and allocate resources. However, it was disappointing that there was not a stronger focus on nutrition. She urged the Secretariat to focus efforts on implementing the framework without delay. Primary health care must be joined up with wider efforts to strengthen the whole of the health system. It should not become another vertical initiative.

The representative of GHANA[1] welcomed the fact that the draft operational framework centred on national action and that it would be reflected in WHO general programmes of work and programme budgets.

Effective primary health care service delivery reduced the pressure on higher-level facilities and hence the financial pressure on governments. It also helped to reduce health care inequalities that affected deprived and vulnerable populations in particular. Most primary health facilities in Ghana faced challenges such as inadequate resources and infrastructure. It was against that background that Ghana welcomed the draft operational framework.

The representative of KAZAKHSTAN[1] said that the draft operational framework would serve to implement declarations on primary health care in accordance with the needs and priorities of Member States. She proposed that consultations should be held during the present session of the Executive Board to finalize the draft decision, as a number of minor issues remained to be resolved.

The CHAIR said that a proposal to reopen discussion of the draft decision would have to be endorsed by a member of the Executive Board.

The representative of TAJIKISTAN endorsed the proposal to hold further consultations on the draft decision.

The representative of BOTSWANA[1] expressed support for the draft operational framework, which would enable governments to strengthen their health systems and respond to people's needs along the continuum of care. The Secretariat should nevertheless continue to provide technical and financial support to countries in respect of primary health care.

The representative of THAILAND[1] said that the four main strategies deployed by her Government in respect of primary health care – intersectoral collaboration, community engagement, appropriate technologies, and strong and equitable basic health care systems – should be embedded in the draft operational framework.

WHO country offices should work with policy entrepreneurs to drive the primary health care agenda. Evidence showed that policy entrepreneurs were the primary movers of health sector reform in low- and middle-income countries.

The representative of the ISLAMIC REPUBLIC OF IRAN[1] expressed support for the draft operational framework and noted that, despite significant advances in health outcomes, unequal access to primary health care remained a problem, especially in developing countries. Challenges affecting primary health care coverage in his country included noncommunicable diseases, road traffic injuries, ageing and urbanization.

The representative of the RUSSIAN FEDERATION[1] commended the draft operational framework as a science-based and practical tool for advancing primary health care. The Secretariat should provide more specific recommendations regarding the indicators for monitoring primary health

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care, and the draft framework itself should contain a clearer definition of primary health care, understanding of which was currently too broad.

The representative of ECUADOR[1] expressed support for the draft operational framework, implementation of which must go hand in hand with work on universal health coverage and on the social, environmental and economic determinants of health.

The representative of NICARAGUA[1] said that community engagement was key to any effective health care system and indeed lay at the centre of the health care system in his country.

The representative of FRANCE[1] said that her Government had prioritized the strengthening of primary health care during its presidency of the G7. It was important to share experience of and knowledge on primary health care, with a view to improving political decision-making.

The representative of the PLURINATIONAL STATE OF BOLIVIA[1] said that, despite challenges to the implementation of universal health coverage over the past 14 years, his country had made great progress and introduced significant changes in that regard.

The representative of MONTENEGRO[1] said that it was crucial to place primary health care at the centre of efforts to achieve healthy lives. She endorsed the Secretariat's coordination role, including in respect of the Global Action Plan on Healthy Lives and Well-being for All. Implementation of the 2030 Agenda for Sustainable Development would require bold action – incremental changes would not suffice.

The representative of SPAIN[1] said that health system excellence was predicated on the delivery of primary health care services that were effective, safe, efficient, sustainable and based on the best scientific evidence available. Without strong primary health care, which was the driver for achieving universal health coverage, no health system was sustainable in the long term.

The representative of MYANMAR[1] assumed that the levers set out in the draft operational framework, which should be implemented in the light of each country's national circumstances, would transform the commitments in the Declaration of Astana into actions. As a developing country, Myanmar continued to require technical and financial support to improve primary health care with a view to achieving universal health coverage. She encouraged the Secretariat to help design options for developing strategies to implement the framework and meeting the commitments of the Declaration of Astana and the Political Declaration of the high-level meeting on universal health coverage.

The representative of the BOLIVARIAN REPUBLIC OF VENEZUELA[1] described the health services provided in her country despite the constraints under which the health system was currently operating. She thanked partners, including PAHO, for their assistance in reinforcing HIV, malaria and tuberculosis treatment and in conducting a measles immunization campaign.

The representative of TURKEY[1] expressed support for the draft operational framework, the core strategic and operational levers of which would assist Member States with implementation, but said that it could be enhanced by a stronger emphasis on vulnerable populations. She looked forward to receiving the monitoring and evaluation framework, and requested the Secretariat to provide detailed information, before the Seventy-third World Health Assembly, on the selection criteria for indicators and on how the

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

Member States' selection of levers and indicators would be harmonized and implemented during the monitoring process.

The representative of CANADA[1] underscored the role of primary health care in achieving universal health coverage, which must be complemented with effective intersectoral and multisectoral collaboration. She also underscored the importance of taking into account gender and other drivers of inequality, including by effectively integrating sexual and reproductive health services and rights into essential primary health care and universal health coverage service packages. Both were key enablers of good health, reducing extreme poverty, advancing gender equality and empowering women. She welcomed the draft operational framework and looked forward to receiving more information on the support WHO would lend countries under its special programme on primary health care.

The representative of MEXICO[1] said that accountability mechanisms, multisectoral action and coordination should exist at all levels of government, so as to ensure that direct action was taken for those most in need and that funds intended for health care were not diverted elsewhere. To that end, the draft operational framework should include a core strategic lever on transparency and accountability, in order to help interested States establish robust mechanisms for ensuring transparency and preventing misappropriation. It was also crucial to strengthen data collection systems with a view to obtaining clear and sufficient data.

The representative of SENEGAL[1] said that the draft operational framework would be a major factor in achievement of the commitments set out in the Declaration of Alma-Ata, the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa, the Declaration of Astana and the health-related Sustainable Development Goals. Improved primary health care delivery required the participation and empowerment of people and communities, and called for concerted partnerships, in particular with civil society, the private sector and development partners. He encouraged the Secretariat to continue supporting Member State efforts to deliver primary health care, notably by strengthening their national health systems and developing evaluation tools.

The representative of PERU[1] expressed support for the draft operational framework. Primary health care was the most effective means of guaranteeing universal health coverage, and health promotion and primary health care had to be seen as complimentary strategies for reinforcing health care systems, with a view to obtaining equitable results for all. The health sector had to ensure more relevant and concrete health promotion; it had to work with communities to create healthy living conditions based on primary health care. Health for all would only be achieved if the social determinants of health were addressed using intersectoral measures that encompassed social, political and technical action.

The representative of GUATEMALA[1] said that his country was relying on cooperation with WHO/PAHO, development cooperation agencies and donor countries to improve the population's health. He thanked Taiwan,[2] in particular, for its invaluable support for three major projects.

The representative of LIBYA[1] said that her Government, while committed to strengthening the country's health care system, was experiencing difficulties in that regard compounded by the ongoing conflict. She welcomed the draft operational framework, but hoped that categorizing Member States into economic groups would not have a negative impact on vulnerable countries that might miss opportunities as a result, particularly in the Eastern Mediterranean Region, where economic status had

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

[2] World Health Organization terminology refers to "Taiwan, China".

become fluid. She also hoped that accountability measures would go hand in hand with implementation strategies. She emphasized the importance of the Global Action Plan for Healthy Lives and Well-being for All – countries with fragmented health systems unfortunately tended to attract fragmented assistance from international organizations – and commended the Secretariat for its leadership in that regard.

The representative of ETHIOPIA[1] expressed support for the draft operational framework. He underlined the importance of community engagement, political will and commitment, and regional and global collaboration to advance primary health care. He encouraged the Secretariat to work closely with Member States and relevant stakeholders to establish and strengthen regional centres of excellence that could help Member States apply the draft framework.

The representative of ZIMBABWE[1] said that the Declaration of Astana had the potential to extend efforts relating to primary health care. She expressed support for the draft operational framework, in particular its core strategic levers, and welcomed the accompanying training manual, which would further enhance the skills of health care workers.

The representative of JAMAICA[1] welcomed the draft operational framework and its four core strategic levers, and noted with appreciation that the report acknowledged that many countries would continue to need technical and financial support to improve primary health care. Primary health care could only be strengthened through partnerships, and his Government looked forward to working with its regional and international partners to that end.

The representative of BARBADOS[1] encouraged WHO to continue taking action on primary health care, which, because it emphasized promotion and prevention, the determinants of health and a people-centred approach, had proven to be highly effective and efficient at addressing the main health risk factors.

The observer of GAVI, THE VACCINE ALLIANCE said that children who were not receiving vaccines were being left behind, unable to access the benefits of primary health care and universal health coverage. Primary health care should be strengthened through routine immunization services. His organization looked forward to working with partners to mobilize adequate and sustainable resources for health.

The representative of the INTERNATIONAL SOCIETY OF NEPHROLOGY, speaking at the invitation of the CHAIR, called on Member States to deliver quality primary health care encompassing comprehensive and integrated service delivery. Interventions must address the burden of co-morbidities and empower individuals, families and communities through a people-centred approach.

The representative of the INTERNATIONAL PHARMACEUTICAL FEDERATION, speaking at the invitation of the CHAIR, highlighted the commitment to action on primary health care made by pharmacy leaders at a conference held for the European Region and urged Member States to implement the vision and commitments of the Declaration of Astana.

The representative of the WORLD MEDICAL ASSOCIATION, INC., speaking at the invitation of the CHAIR, welcomed the draft operational framework, in particular the focus on supporting the health workforce. Primary health care should be delivered by physician-led, multidisciplinary teams employing a comprehensive, integrated approach to health promotion, disease prevention, specialized care and rehabilitation. He supported WHO's advocacy for greater investment in human resources for

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

health and called on Member States to ensure decent working conditions to attract and retain health professionals, especially in rural areas.

The representative of the INTERNATIONAL PHARMACEUTICAL STUDENTS' FEDERATION, speaking at the invitation of the CHAIR, said that primary health care was the most equitable, efficient and effective approach to improving health, with pharmacists playing a key role that should receive greater recognition. She called for intersectoral engagement in health system strengthening, good governance and health reforms in support of primary health care; the active integration of community pharmacists; and the inclusion of young people in primary health care activities.

The representative of the INTERNATIONAL COUNCIL OF NURSES, speaking at the invitation of the CHAIR, said that nurses were often the first or only health care professionals in communities and were therefore central to high-quality, people-centred primary health care models. She supported the implementation of the special programme on primary health care in accordance with country needs; called on governments to prioritize investment in nursing education and long-term workforce planning; and encouraged Member States to actively involve nurses in the integration of primary health care into national activities.

The representative of the INTERNATIONAL ASSOCIATION FOR HOSPICE AND PALLIATIVE CARE, INC., speaking at the invitation of the CHAIR, highlighted the need to improve global access to palliative care and medicines in the scope of health system strengthening and to support the translation of the primary health care vision into action. The Secretariat was already helping several Member States to conduct research and pilot programmes on the integration of palliative care into primary health care; indicators should be developed to monitor those efforts, starting with an assessment of the implementation of mechanisms identifying patients requiring palliative care.

The representative of the INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS, speaking at the invitation of the CHAIR, said that strengthening primary health care in all health systems in order to achieve universal health coverage would require political will, sustainable investments, the creation of a multidisciplinary working environment and initiatives for the future health workforce. He congratulated the global health community on the Declaration of Astana but lamented the omission of a reference to young people in the draft operational framework, given their role as future health leaders.

The representative of MEDICUS MUNDI INTERNATIONAL, speaking at the invitation of the CHAIR, welcomed WHO's renewed commitment to primary health care and urged Member States to support the draft operational framework. She called on Member States to integrate community empowerment into the operational levers to ensure that communities, in particular the most vulnerable groups, would be involved in planning, review and monitoring systems. Partnerships with private sector providers should not jeopardize equity in health; they should therefore be well-regulated and the Secretariat should strengthen Member State capacities to create appropriate accountability and patient rights protection mechanisms, to avoid prioritizing commercial interests over health needs.

The representative of the UNION FOR INTERNATIONAL CANCER CONTROL, speaking at the invitation of the CHAIR, congratulated the Secretariat on the draft operational framework and called on Member States to include sufficient, affordable and tailored promotive, preventive, curative, rehabilitative and palliative health services; link primary health care to strong secondary and tertiary health care; ensure the meaningful engagement of people living with noncommunicable diseases and carers in primary health care strengthening; and integrate the expertise of those interacting most closely

with health systems in monitoring and evaluation frameworks, employing independent accountability mechanisms to track progress.

The representative of PUBLIC SERVICES INTERNATIONAL, speaking at the invitation of the CHAIR, said that the draft operational framework should set clear parameters regulating private profit-seeking interests in and action on the commercial determinants of health; take an anti-austerity approach to funding and resource allocation; emphasize equity in models of care; explicitly define engagement with private providers to avoid downplaying the primacy of governments as duty-bearers; and ensure the inclusion of all relevant stakeholders in monitoring and evaluation activities. He welcomed the commitment to ensuring that primary health care workers were well remunerated and adequate in number and stressed that improved working conditions and social dialogue were inherent to the concept of decent work.

The representative of IOGT INTERNATIONAL, speaking at the invitation of the CHAIR, welcomed the integrated approach of the draft operational framework. Taxation of health-harmful products had been proven to reduce the overall health burden, raise resources and promote healthy environments; it should therefore be better reflected in the "Funding and resource allocation" lever. Health workers often lacked the capacities to identify cross-cutting health risk factors such as alcohol abuse and to address related co-morbidities; harnessing the potential of the primary health care system to identify such conditions could improve the health of the individuals affected and their communities.

The representative of the INTERNATIONAL PLANNED PARENTHOOD FEDERATION, speaking at the invitation of the CHAIR, welcomed the draft operational framework. The "Engagement of communities and other stakeholders" lever should envisage opportunities for communities to hold their governments to account and enhance the delivery of quality, culturally appropriate primary health care services; a gender-sensitive and responsive approach to the work of community leaders would be crucial to that end. He applauded the focus on country leadership when it came to aligning interventions with partners in primary health care and urged WHO to include that concept in its reform agenda while ensuring the meaningful involvement of non-State actors in governance at the country and regional levels.

The DEPUTY DIRECTOR-GENERAL said that the unprecedented political commitment to primary health care demonstrated in the Declaration of Astana and at the high-level meeting on universal health coverage should now be translated into meaningful interventions and accelerated progress based on all 14 operational levers outlined in the draft operational framework, which countries should incorporate into their national policies and strategies. The draft operational framework incorporated points raised by Member States and echoed in the Declaration of Astana, such as multisectoral action and community and stakeholder involvement.

Primary health care should be integrated into the six building blocks of health systems and be positioned as the first level of entry into the health network. It should integrate public health functions, such as immunization surveillance, prevention, promotion and protection, address all health determinants and be relevant to each country's specific disease burden. The Secretariat would provide increased support for implementation through the special programme for primary health care, a truly three-level and cross-divisional programme, in accordance with country contexts and needs, prioritizing those with the most fragile health systems; however, Member States should also redouble their efforts to develop primary health care capacities. A coordination mechanism had been implemented to bring together stakeholders within and outside the United Nations system, as envisaged in the Global Action Plan for Healthy Lives and Well-being for All, which included primary health care as an accelerator. The Secretariat had also compiled a compendium of case studies for the information of Member States, and was in the process of reviewing the indicators in the forthcoming monitoring and evaluation framework to avoid overburdening Member States.

The DIRECTOR-GENERAL said that country-led primary health care interventions adapted to national realities would be pivotal to the achievement of universal health coverage; he therefore called on governments to reaffirm and maintain their commitment to primary health care, which was often neglected in favour of grander and more visible interventions such as hospital-building.

The CHAIR took it that the Board wished to note the reports contained in documents EB146/5 and EB146/38(Add.1).

The Board noted the reports.

The CHAIR took it that the Board wished to defer adoption of the draft decision proposed by Botswana and Tajikistan pending consultations during its current session.

It was so agreed.

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

The representative of CHINA, speaking in exercise of the right of reply, reiterated that there was broad consensus in the international community that the Taiwan region[1] was part of China and asked the Chair to remind countries to refrain from discussing the internal affairs of Member States.

The CHAIR urged all speakers to ensure that their statements focused on the topic at hand.

The representative of GUATEMALA,[2] speaking in exercise of the right of reply, said that his earlier statement had been relevant to the discussion as it had concerned an issue of international health. In addition, the administration of Taiwan[1] was an important health partner of his Government.

The meeting rose at 17:15.

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[1] World Health Organization terminology refers to “Taiwan, China”.

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