



WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD

118th SESSION

GENEVA, 29-31 MAY 2006

**RESOLUTIONS AND DECISIONS
ANNEXES**

SUMMARY RECORDS

**GENEVA
2006**

PREFACE

The 118th session of the Executive Board was held at WHO headquarters, Geneva, from 29 to 31 May 2006.

The Fifty-ninth World Health Assembly elected 12 Member States to be entitled to designate a person to serve on the Executive Board in place of those whose term of office had expired,¹ giving the following new composition of the Board:

Designating country	Unexpired term of office ²	Designating country	Unexpired term of office ²
Afghanistan.....	3 years	Liberia.....	2 years
Australia	1 year	Libyan Arab Jamahiriya.....	1 year
Azerbaijan.....	2 years	Luxembourg.....	1 year
Bahrain	1 year	Madagascar	2 years
Bhutan.....	2 years	Mali	3 years
Bolivia	1 year	Mexico	2 years
Brazil	1 year	Namibia.....	2 years
China.....	3 years	Portugal.....	2 years
Denmark	3 years	Romania	1 year
Djibouti.....	3 years	Rwanda	2 years
El Salvador	3 years	Singapore	3 years
Iraq.....	2 years	Slovenia	3 years
Jamaica	1 year	Sri Lanka.....	3 years
Japan.....	2 years	Thailand	1 year
Kenya.....	1 year	Tonga.	1 year
Latvia.....	3 years	Turkey	3 years
Lesotho	1 year	United States of America.....	3 years

Details regarding members designated by the above Member States will be found in the list of members and other participants.

¹ By decision WHA59(8). The retiring members were those designated by Canada, Czech Republic, Ecuador, France, Guinea-Bissau, Iceland, Nepal, Pakistan, Sudan, and Viet Nam.

² At the time of the closure of the Fifty-fifth World Health Assembly.

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AGENDA¹

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3. Outcome of the Fifty-ninth World Health Assembly
4. Report of the Programme, Budget and Administration Committee of the Executive Board
5. Technical and health matters
 - 5.1 Control of leishmaniasis
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 - 5.3 Rational use of medicines: progress in implementing the WHO medicines strategy
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¹ As adopted by the Board at its first meeting.

9. Consideration of the acceleration of the procedure to elect the next Director-General of the World Health Organization
 10. Deputy Director-General of the World Health Organization
 11. Closure of the session
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LIST OF DOCUMENTS

EB118/1(annotated)	Provisional agenda (annotated)
EB118/1 Rev.1	Agenda ¹
EB118/2	Outcome of the Fifty-ninth World Health Assembly
EB118/3	Report of the Programme, Budget and Administration Committee of the Executive Board
EB118/4	Control of leishmaniasis
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¹ See page 57.

² See Annex 2.

EB118/11	Confirmation of amendments to the Staff Rules ¹
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EB118/13	Expert committees and study groups
EB118/14	Arsenic mitigation for safe groundwater
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EB118/16	Health information systems in support of the Millennium Development Goals
EB118/17	Proposal for a supplementary agenda item
EB118/18	Proposal for a supplementary agenda item
EB118/19	Deputy Director-General of the World Health Organization
EB118/20 and EB118/20 Add.1	Consideration of the acceleration of the procedure to elect the next Director-General of the World Health Organization

Information documents

EB118/INF.DOC./1	Statement by representative of the WHO staff associations
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Diverse

EB118/DIV/1 Rev.1	List of members and other participants
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EB118/DIV/3	Decisions and list of resolutions
EB118/DIV/4	List of documents

¹ See Annex 1.

² See Annex 2.

PART I
RESOLUTIONS AND DECISIONS
ANNEXES

RESOLUTIONS

EB118.R1 Thalassaemia and other haemoglobinopathies¹

The Executive Board,

Having considered the report on thalassaemia and other haemoglobinopathies;²

Recalling resolution WHA57.13 on genomics and world health, resolution EB117.R3 on sickle-cell anaemia, and the recognition by the Executive Board at its 116th session of the role of genetic services in improving health globally and in reducing the global health divide;³

Concerned at the impact of genetic diseases, and of haemoglobinopathies (thalassaemia and sickle-cell anaemia) in particular, on global mortality and morbidity, especially in developing countries, and by the suffering of patients and families affected by the disease;

Recognizing that the prevalence of thalassaemia varies between communities, and that insufficient epidemiological data may hamper effective and equitable management;

Deeply concerned that thalassaemia and other haemoglobinopathies are not recognized as priorities in public health;

Deploring the current worldwide lack of access to safe and appropriate genetic services;

Aware that effective programmes for thalassaemia must be sensitive to cultural practices and appropriate for the given social context;

Recognizing that the management of haemoglobinopathies, particularly prenatal screening, raises specific ethical, legal and social issues that require appropriate consideration,

1. **URGES Member States:**

(1) to design, implement and reinforce in a systematic, equitable and effective manner, comprehensive national, integrated programmes for prevention and management of thalassaemia and other haemoglobinopathies, including surveillance, dissemination of information, awareness-raising and screening, such programmes being tailored to specific socioeconomic and cultural contexts and aimed at reducing the incidence, morbidity and mortality associated with these diseases;

¹ See Annex 2 for the administrative and financial implications for the Secretariat of this resolution.

² Document EB118/5.

³ See document EB116/2005/REC/1, summary record of the first meeting, section 4.

- (2) to develop their capacity to monitor thalassaemia and other haemoglobinopathies and to evaluate the impact of national programmes;
- (3) to intensify the training of all health professionals in high-prevalence areas;
- (4) to develop and strengthen medical services, within existing primary health-care systems, in partnership with parent or patient organizations;
- (5) to promote relevant community education, including health counselling and ethical, legal and social issues associated with haemoglobinopathies;
- (6) to promote international cooperation in combating haemoglobinopathies;
- (7) to provide support for basic and applied research on thalassaemia, in collaboration with international organizations;

2. REQUESTS the Director-General:

- (1) to raise awareness of the international community of the global burden of thalassaemia and other haemoglobinopathies, and to promote equitable access to health services and medicines for prevention and management of these diseases;
- (2) to provide technical support and advice to Member States in framing of national policies and strategies for prevention and management of thalassaemia and other haemoglobinopathies;
- (3) to promote intercountry collaboration in order to expand the training and expertise of personnel, and to provide support for the further transfer of affordable technologies and expertise to developing countries;
- (4) to continue WHO's normative functions by drafting guidelines on prevention and management of thalassaemia and other haemoglobinopathies;
- (5) to promote research on thalassaemia and other haemoglobinopathies in order to improve the duration and quality of life of those affected by such disorders;
- (6) to consider setting the theme of haemoglobinopathy diseases such as thalassaemia and sickle-cell anaemia for a World Health Day in the near future.

(Second meeting, 29 May 2006)

EB118.R2 Consideration of the acceleration of the procedure to elect the next Director-General of the World Health Organization

The Executive Board,

Noting decision EBSS(2) taken by the Board at its special session held on 23 May 2006, by which the Board requested the Secretariat "to submit to the Board at its 118th session options for its consideration concerning the acceleration of the procedure to elect the next Director-General of the World Health Organization";

Having considered the reports by the Secretariat in response to the Board's request,¹

1. DECIDES, in accordance with Rule 53 of the Rules of Procedure of the Executive Board, to suspend Rule 52 with regard to the deadlines set out in paragraphs 1 to 3 of the latter Rule, in order to accelerate the process of nomination of the next Director-General;
2. DECIDES that, for the purpose of nominating the next Director-General, the following deadlines will apply in lieu of those provided for under Rule 52:
 - (a) notification of Acting Director-General to Member States that they may propose persons for nomination to the post of Director-General: 1 June 2006;
 - (b) final date for receipt by WHO of proposals for nomination: 5 September 2006;
 - (c) date of dispatch of proposals, curricula vitae and supporting information to Member States: 5 October 2006;
3. DECIDES, in accordance with Rule 5 of its Rules of Procedure, to convene a session of the Board, which will be held from 6 to 8 November 2006 at the headquarters of the World Health Organization;
4. FURTHER DECIDES that the only item on the provisional agenda of the session of the Board referred to in the preceding paragraph will be entitled "Director-General" and will comprise two subitems entitled respectively "nomination for the post" and "draft contract";
5. REQUESTS the Acting Director-General to consider placing officers and staff members who are candidates for the election referred to in the present resolution on temporary leave of absence with pay from their current posts during the period from 5 September 2006 until the Health Assembly's appointment of a new Director-General;
6. REQUESTS the Acting Director-General, in accordance with Rule 2 of the Rules of Procedure of the World Health Assembly, to convene a special session of the Health Assembly on 9 November 2006 in Geneva, and to include on the provisional agenda of the special session only one item entitled "Director-General", comprising two subitems entitled respectively "appointment" and "approval of contract";
7. RECOMMENDS that the Health Assembly at its special session should suspend Rule 108 of its Rules of Procedure with regard to the term of office of the next Director-General and set his or her term of office so that it terminates shortly after closure of a Health Assembly.

(Third meeting, 30 May 2006)

¹ Documents EB118/20 and EB118/20 Add.1, which includes the costing.

EB118.R3 Control of leishmaniasis

The Executive Board,

Having considered the report on control of leishmaniasis,¹

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:²

The Sixtieth World Health Assembly,

Having considered the report on control of leishmaniasis;

Recognizing that leishmaniasis is one of the most neglected tropical diseases, and that more than 12 million people worldwide are currently infected, with two million new cases each year;

Noting with concern that 350 million people are considered at risk and the number of new cases is on the increase;

Recognizing the lack of accurate information on the epidemiology of the disease for better understanding of the disease and its control;

Noting with concern that the disease affects the poorest populations in 88 countries, placing a heavy economic burden on families, communities and countries, particularly developing countries;

Noting the burden that treatment can place on families;

Bearing in mind that malnutrition and food insecurity are often identified as major causes of disposition to, and severity of, leishmaniasis;

Acknowledging the significant support extended by Member States and other partners and appreciating their continuing cooperation,

1. URGES Member States where leishmaniasis is a substantial public-health problem:

(1) to reinforce efforts to set up national control programmes that would draw up guidelines and establish systems for surveillance, data collection and analysis;

(2) to strengthen prevention, active detection and treatment of cases of both cutaneous and visceral leishmaniasis in order to decrease the disease burden;

(3) to strengthen the capacity of peripheral health centres so that they provide appropriate affordable diagnosis and treatment and act as sentinel surveillance sites;

(4) to conduct epidemiological assessments in order to map foci, and to calculate the real impact of leishmaniasis through accurate studies of prevalence and incidence,

¹ Document EB118/4.

² See Annex 2 for the administrative and financial implications for the Secretariat of this resolution.

socioeconomic impact and access to prevention and care, and the extent of the disease in those affected by malnutrition and HIV;

(5) to establish a decentralized structure in areas with major foci of disease, strengthening collaboration between countries that share common foci, increasing the number of WHO collaborating centres for leishmaniasis and giving them a greater role, and relying on initiatives taken by the various actors;

2. FURTHER URGES Member States:

(1) to advocate high quality and affordable medicines, and appropriate national drug policies;

(2) to encourage research on leishmaniasis control in order:

(a) to identify appropriate and effective methods of vector control;

(b) to find alternative safe, effective and affordable medicines for oral, parenteral or topical administration involving shorter treatment cycles, less toxicity, and new drug combinations, and to define appropriate doses and duration of therapy schedules for these medicines;

(c) to determine mechanisms to facilitate access to existing control measures, including socioeconomic studies and health-sector reform in some developing countries;

(d) to evaluate and improve sensitivity and specificity of serological diagnostic methods for canine and human visceral leishmaniasis, including assessment of standardization and effectiveness;

(e) to evaluate effectiveness of alternative control measures such as use of bednets impregnated with long-lasting insecticide;

3. CALLS ON partner bodies to maintain and expand their support for national leishmaniasis prevention and control programmes and, as appropriate, to accelerate research on, and development of, leishmaniasis vaccine;

4. REQUESTS the Director-General:

(1) to raise awareness of the global burden of leishmaniasis, and to promote equitable access to health services for prevention and disease management;

(2) to draft guidelines on prevention and management of leishmaniasis, with emphasis on updating the report of WHO's Expert Committee on Leishmaniasis,¹ with a view to elaborating regional plans and fostering the establishment of regional groups of experts;

¹ *Control of leishmaniasis. Report of a WHO Expert Committee.* Geneva, World Health Organization, 1990 (WHO Technical Report Series, No. 793).

- (3) to strengthen collaborative efforts among multisectoral stakeholders, interested organizations and other bodies in order to support the development and implementation of leishmaniasis control programmes;
- (4) to frame a policy for leishmaniasis control, with the technical support of WHO's Expert Advisory Panel on Leishmaniasis;
- (5) to promote research pertaining to leishmaniasis control and dissemination of the findings of that research;
- (6) to monitor progress in the control of leishmaniasis in collaboration with international partners;
- (7) to report to the Sixty-third World Health Assembly on progress achieved, problems encountered and further actions proposed in the implementation of leishmaniasis control programmes.

(Fourth meeting, 30 May 2006)

EB118.R4 Strengthening of health information systems

The Executive Board,

Having considered the report on health information systems in support of the Millennium Development Goals,¹

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:²

The Sixtieth World Health Assembly,

Recalling resolution WHA58.30 on achieving internationally agreed health-related development goals, including those contained in the Millennium Declaration;

Noting resolution WHA58.28 on eHealth, and mindful of resolution WHA58.34 on the Ministerial Summit on Health Research;

Acknowledging that sound information is critical in framing evidence-based health policy and making decisions, and fundamental for monitoring progress towards internationally agreed health-related development goals, including those contained in the United Nations Millennium Declaration;

Recognizing that health information systems in most developing countries are weak, fragmented, understaffed, and inadequately resourced;

¹ Document EB118/16.

² See Annex 2 for the administrative and financial implications for the Secretariat of this resolution.

Convinced of the importance of health information, disaggregated by gender, age and key socioeconomic factors, to inform decisions on delivery of interventions to those who need them most;

Acknowledging that health information and research are complementary as foundations for strengthening health systems and health policy;

Mindful of the key role of national statistics offices in developing and implementing national statistical strategies and contributing to population health information;

Noting the constitutional normative mandates of WHO in health information and epidemiological reporting, and reaffirming the Organization's role as a founding partner of, and hosting secretariat for, the Health Metrics Network which has determined core standards for health information systems,

1. URGES Member States to mobilize the necessary scientific, technical, social, political, human and financial resources in order:

(1) to develop, implement, consolidate and assess plans to strengthen their health information systems through collaboration between health and statistics sectors and other partners;

(2) to bring together technical and development partners around a coherent and coordinated country-led strategy and plan for strengthening health information systems that is fully integrated in the mainstream of national health programmes and plans;

(3) to strengthen the capacity of planners and managers at various levels of the health system to synthesize, analyse, disseminate and utilize health information for evidence-based decision-making and for raising public awareness;

(4) to strengthen the capacity of health workers to collect accurate and relevant health information;

(5) to link strengthening of health information systems to policies and programmes for building of statistical capacity in general;

2. CALLS UPON the health information and statistical communities, other international organizations, including global health initiatives and funds, the private sector, civil society and other concerned stakeholders, to provide strong, sustained support for strengthening of information systems, including use of the standards and guiding principles set out in the framework of the Health Metrics Network, and covering the spectrum of health statistics, including health determinants; health resources, expenditures and system functioning; service access, coverage and quality; and health outcomes and status, and according particular attention to information on poverty and inequity in health;

3. REQUESTS the Director-General:

(1) to strengthen the information and evidence culture of the Organization and to ensure the use of accurate and timely health statistics in order to generate evidence for major policy decisions and recommendations within WHO;

- (2) to increase WHO's activities in health statistics at global, regional and country levels and provide support to Member States to build capacities for development of health information systems and generation, analysis, dissemination and use of data;
- (3) to promote better access to health statistics, encourage information dissemination to all stakeholders in appropriate and accessible formats, and foster transparency in data analysis, synthesis and evaluation, including peer review;
- (4) to promote improved alignment, harmonization and coordination of health information activities, bearing in mind the Paris Declaration on Aid Effectiveness: Ownership, Harmonization, Alignment, Results and Mutual Accountability (2005) and the Best Practice Principles for Global Health Partnership Activities at Country Level;¹
- (5) to undertake regular reviews of country experiences, to provide support for updating the framework of the Health Metrics Network in line with lessons learnt and evolving methodologies, and to report on progress as from the Sixty-second World Health Assembly.

(Fourth meeting, 30 May 2006)

EB118.R5 Confirmation of amendments to the Staff Rules²

The Executive Board,

Having considered the report on amendments to the Staff Rules,³

1. CONFIRMS, in accordance with Staff Regulation 12.2, the amendments to the Staff Rules that have been made by the Director-General with effect from 1 January 2007 concerning the application of the Staff Rules, effective date, salary determination, net base salary on promotion to a higher grade, net base salary on reduction in grade, temporary assumption of responsibilities of a post of a higher grade, payment of net base salary to temporary staff in the professional and higher categories, dependants' allowances, special education grant for disabled children, mobility and hardship allowance, assignment grant, service allowance, appointment policies, reinstatement upon re-employment, interorganization transfers, end of probation, within-grade increase, promotion, reassignment, annual leave, home leave, leave for military training or service, accident and illness insurance, sick leave, maternity and paternity leave, grant in case of death, travel of spouse and children, special education grant travel, termination for reasons of health, completion of appointments, termination of temporary appointments, abolition of post, terminal remuneration, unsatisfactory performance or unsuitability for international civil service, notice of termination, mobility and hardship allowance for staff in posts subject to local recruitment, conference and other short-term service staff, consultants, and national professional officers; such amendments being subject to transitional measures determined by the Director-General;

¹ Best Practice Principles for Global Health Partnership Activities at Country Level. Report of the Working Group on Global Health Partnerships. Paris, High-level Forum on the Health MDGs, 14-15 November 2005.

² See Annex 1.

³ Document EB118/11.

2. DECIDES that this confirmation of amendments to the Staff Rules is subject to endorsement by the United Nations General Assembly of the general framework recommended by the International Civil Service Commission;
3. REQUESTS the Director-General to submit to the Executive Board at its 120th session, through the Programme, Budget and Administration Committee, a full report on implementation and cost of these amendments.

(Fifth meeting, 31 May 2006)

DECISIONS

EB118(1) Membership of the Executive Board's Standing Committee on Nongovernmental Organizations

The Executive Board appointed Dr P.M. Buss (Brazil), Dr Ren Minghui (China), Dr R.R. Jean Louis (Madagascar), and Dr Suwit Wibulpolprasert (Thailand) as members of its Standing Committee on Nongovernmental Organizations for the duration of their term of office on the Executive Board, in addition to Mr O.K. Shiraliyev (Azerbaijan), already a member of the Committee. It was understood that if any member of the Committee was unable to attend, his or her successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Committee.

(Fourth meeting, 30 May 2006)

EB118(2) Membership of the Programme, Budget and Administration Committee of the Executive Board

The Executive Board appointed as members of the Programme, Budget and Administration Committee Dr F. Kakar (Afghanistan), Ms J. Halton (Australia), Dr J.K. Gøtrik (Denmark), Dr W.T. Gwenigale (Liberia), Mr N.S. de Silva (Sri Lanka) and Dr J. Agwunobi (United States of America) for a two-year period or until expiry of their membership on the Board, whichever occurs first, in addition to Dr Jigmi Singay (Bhutan), Dr A.H.I. Al-Shamari (Iraq), Dr B. Wint (Jamaica), Professor J. Pereira Miguel (Portugal), Dr J.D. Ntawukuliryayo (Rwanda) and Dr V. Tangi (Tonga), already members of the Committee, and Dr F. Antezana Aranibar (Bolivia), Chairman of the Board, member ex officio, and Dr J. Nyikal (Kenya), Vice-Chairman of the Board, member ex officio. It was understood that if any member of the Committee was unable to attend, his or her successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Committee.

(Fourth meeting, 30 May 2006)

EB118(3) Appointment of representatives of the Executive Board at the Sixtieth World Health Assembly

The Executive Board, in accordance with paragraph 1 of resolution EB59.R7, appointed its Chairman, Dr F. Antezana Aranibar (Bolivia), and its first three Vice-Chairmen, Mr O.K. Shiraliyev (Azerbaijan), Dr B. Sadasivan (Singapore) and Dr Suwit Wibulpolprasert (Thailand), to represent the Board at the Sixtieth World Health Assembly. It was understood that if any of those members were not available for the Health Assembly, the other Vice-Chairman, Dr J. Nyikal (Kenya), and the Rapporteur, Dr A.H. Saheli (Libyan Arab Jamahiriya), could be asked to represent the Board.

(Fourth meeting, 30 May 2006)

EB118(4) Date, place and duration of the 119th and 120th sessions of the Executive Board

The Executive Board decided that its 119th session should be convened on Monday, 6 November 2006, at WHO headquarters, Geneva, and should close no later than Wednesday, 8 November 2006. It further decided that its 120th session should be convened on Monday, 22 January 2007, at WHO headquarters, Geneva, and should close no later than Tuesday, 30 January 2007.

(Fourth meeting, 30 May 2006)

EB118(5) Place, date and duration of the Sixtieth World Health Assembly

The Executive Board decided that the Sixtieth World Health Assembly should be held at the Palais des Nations, Geneva, opening on 14 May 2007, and that it should close no later than Wednesday, 23 May 2007.

(Fourth meeting, 30 May 2006)

ANNEX 1

Confirmation of amendments to the Staff Rules¹

Report by the Secretariat

[EB118/11 – 18 May 2006]

1. Amendments to the Staff Rules made by the Director-General are submitted for confirmation by the Executive Board in accordance with Staff Regulation 12.2.²

2. The amendments described in this document stem from the decisions expected to be taken by the United Nations General Assembly at its resumed sixtieth session, on the basis of the recommendations made by the International Civil Service Commission in its annual report for 2005.³ At its sixtieth session, the United Nations General Assembly endorsed only one of the Commission's recommendations, namely that relating to the staff assessment scale; consideration of the Commission's other recommendations was deferred to the resumed sixtieth session, which opened in March 2006. A decision is expected in May 2006.

3. The amendments described hereafter also take into account the Organization's proposals on the reform of WHO's framework of contractual arrangements.

...

5. The text of the amended Staff Rules is contained in the Appendix.

PROPOSED FRAMEWORK OF CONTRACTUAL ARRANGEMENTS: BACKGROUND TO GOALS AND OBJECTIVES

6. In order to bolster its capacity to respond to ever-increasing needs in a complex health and development environment, the Organization has identified and implemented reform initiatives in key areas of programmes and operations, including the introduction of results-based management. Furthermore, reform strategies in management functions that facilitate technical programmes, such as human resources, finance and information technology, have been designed to improve support for programme delivery.

¹ See resolution EB118.R5.

² *Basic documents*, 45th ed., Geneva, World Health Organization, 2005.

³ Document A/60/30.

7. The call for effective reform is being heeded across the United Nations common system, particularly in the area of human resources management. Improved and more responsive contractual arrangements and conditions of service are central to the successful delivery of WHO's programmes. The Organization's current challenges call for contractual arrangements that make it possible to recruit and retain talented staff at all levels who are capable of handling large and complex programmes and of performing both as specialists in their fields and as multi-skilled, versatile and mobile individuals whose activities may span occupational groups and geographical regions. The present contract forms – which are bureaucratic and lacking in coherence – are not adapted to WHO's needs; they therefore represent an impediment to the Organization's ability to respond to changing needs and requirements.

8. Consequently, the goal of contract reform is to ensure that contractual arrangements serve WHO's programme and operational needs by maintaining and developing a strong workforce of the highest quality through the introduction of greater fairness and equity among staff with regard to the administration of conditions of service. With this in mind, the proposed framework of contractual arrangements has targeted an overall increase in effectiveness, productivity and performance for both the Organization and its staff, together with lower administrative and transactional costs, balancing these improvements against the potential direct costs associated with greater equity in pay and benefits.

9. The objectives of the proposed reform of contractual arrangements are to: (a) ensure that contractual arrangements respond better to the Organization's programmatic and operational needs; (b) ensure that contractual arrangements facilitate performance, competency development and accountability for the Organization and its staff; (c) ensure that contractual arrangements encourage staff mobility and career development; (d) align contract types closely with the resources foreseen in human-resources plans, as approved, and with the nature and duration of the functions concerned; (e) unlink conditions of service, entitlements and benefits from the nature of the post and base these – more appropriately – on length of service, staff performance and duration of the assignment; (f) ensure that contracts are streamlined and easy to administer; and (g) put in place contracts and related conditions of service that are fair and transparent, rooted in the principle of equal pay for equal work, and that, as a result, recognize equally and equitably the value of the work and contributions of all staff, whether on contracts of a continuing, fixed-term or temporary nature.

10. The proposed framework of contractual arrangements has made use of the experience gained and lessons learnt from the reforms introduced in 2002. It has also taken into consideration the contract reform recommendations made by the International Civil Service Commission to the United Nations General Assembly, and the United Nations Secretary-General's report of 7 March 2006 "Investing in the United Nations: for a stronger Organization worldwide".¹ It is the result of an Organization-wide process of consultation that culminated in an extraordinary meeting of the WHO Global Staff/Management Council on 3 and 4 April 2006.

11. At present, large numbers of fixed-term staff remain whose appointment status does not reflect their contribution to the Organization over time – a situation that represents a significant barrier to succession management, mobility, rotation and career development. As a result, the Organization's efforts to attract, retain and further develop competent and motivated international civil servants will also be hampered.

12. Staff members holding the two existing types of temporary contracts (short-term and term-limited) face similar difficulties. Planning and monitoring of the need for temporary staff have been less than adequate, leading to high levels of dissatisfaction on the part of managers and staff alike.

¹ Document A/60/692.

Although intended to bring simplicity and ease of administration, the implementation of temporary contracts has proven to be highly cumbersome and time consuming. In addition, although temporary staff are expected to meet the same high standards of performance as colleagues with long-term contracts, and despite the fact that they are increasingly serving in difficult, high-risk and hardship locations in proportionally higher numbers than longer term staff, such temporary staff do not enjoy the same conditions of service as fixed-term staff. This is in contrast with the conditions of service offered by other organizations in the United Nations common system, particularly those with high numbers of field staff.

13. In line with the goals and objectives mentioned above, the proposed framework of contractual arrangements comprises three types of appointments:

- **continuing appointment:** this is an appointment without a time limit, which will be granted after a minimum of five years' uninterrupted, active service on fixed-term appointments and certified satisfactory performance. The continuation of service on such appointments will be subject to such factors as continuing need for the function and availability of funding;
- **fixed-term appointment:** this is a time-limited appointment of one year or more. It may be extended provided that the total duration of service under consecutive fixed-term appointments does not exceed five years. Exceptionally, service on such appointments may be further extended for up to one additional year. During that time, the staff member's performance and competencies will be assessed with a view to conversion to a continuing appointment;
- **temporary appointment:** this is a time-limited appointment of up to two years to meet short-term needs, such as peak workloads and other specific time-limited requirements. If the temporary appointment is of less than two years it may be extended, provided that the total duration of uninterrupted service under consecutive temporary appointments does not exceed two years. A staff member who has completed the maximum duration of uninterrupted service on one or more temporary appointments may not be employed by the Organization unless more than 30 calendar days have elapsed since his or her separation from service.

14. The introduction of the fixed-term appointment leading to conversion to a continuing appointment will bring about greater fairness and equity in appointment status among long-term staff. It will also allow for greater transparency, openness, and accountability in the management of the performance of staff members. Further improvements in the performance-management system will promote objectivity and fairness in decisions related to conversions of fixed-term appointments into continuing appointments. Extensions of fixed-term appointments will remain subject to availability of funding, the needs of the Organization and certification of satisfactory performance.

15. Planning and monitoring of temporary needs and functions will be significantly strengthened under the proposed temporary appointment. In accordance with the principles of managerial accountability and responsibility for programme delivery, managers are expected to take considered, informed decisions on both the duration and the nature of the functions required to meet the Organization's needs. Contracts will be simpler to administer and the efficiency of programme delivery will be improved by removing the requirement of a break in service irrespective of programme need. Staff members will benefit from reliable information on available temporary opportunities as indicated in plans for the management of human resources, and increased certainty regarding the duration of their employment. This will allow staff members both to manage their personal and professional lives better, and enjoy increased fairness and equity in conditions of service. At the same time, the Organization's competitiveness and its capacity to attract competent and experienced staff members to meet temporary needs will be significantly increased, particularly at field level, where other agencies offer more attractive and secure contractual arrangements.

16. The proposed framework of contractual arrangements has a number of significant features:

- the nature and duration of contracts will be linked directly to plans for the management of human resources
- entitlements will vary according to the duration of the assignment and the length of continuous service, rather than the nature of the contract
- conditions of service have been reviewed with the aim of bringing about greater equity and fairness, simplicity and ease of administration, and adoption of the best human-resources practices, including in the area of a supportive work environment
- career or service appointments have been discontinued and replaced by continuing appointments
- the first year on a fixed-term appointment will continue to be probationary
- the maximum duration of any temporary function will be a continuous period of two years. If the function is required beyond this period, the manager must request creation of a fixed-term position through the established processes for planning and budgeting to meet programme needs before expiration of the two-year period
- the maximum duration of a temporary appointment will be an uninterrupted period of two years
- consultants will no longer have the status of staff members.

AMENDMENTS TO THE STAFF RULES

Introductory section

Application

17. Staff Rule 030 has been amended so that the Director-General may make temporary appointments of 60 days or less with terms of service different from those provided in the Staff Rules; the aim was also to align Rule 030 with amended Rule 1320 on conference service and other short-term staff members.

Effective date

18. Staff Rule 040 has been amended to reflect the effective date of implementation of the amended Staff Rules.

Section 3 – Salary, post adjustment, allowances and grants

Salary determination

19. Staff Rule 320.1 has been amended to apply equal conditions to all staff members in determination of salary.

20. Staff Rules 320.2, 320.2.1 and 320.2.2 have been deleted to reflect the fact that Staff Rule 320.1 now covers the salary determination of temporary staff. Staff Rules 320.3, 320.4, 320.4.1, 320.4.2 and 320.5 have been renumbered accordingly.

Net base salary on promotion to a higher grade

21. Staff Rule 320.3 has been further amended to indicate that it is applicable only to staff holding continuing or fixed-term appointments.

Net base salary on reduction in grade

22. Staff Rule 320.4 has been further amended to indicate that it is applicable only to staff holding continuing or fixed-term appointments.

Temporary assumption of responsibilities of a post of a higher grade

23. Staff Rule 320.5 has been further amended to indicate that it is applicable only to staff holding continuing or fixed-term appointments.

Payment of net base salary to temporary staff in the professional and higher categories

24. Staff Rule 330.3 has been deleted in light of the equal conditions to be applied to staff members holding continuing, fixed-term or temporary appointments.

Dependants' allowances

25. Staff Rule 340 has been amended to apply equal conditions for the granting of dependants' allowances to all staff in the professional and higher categories.

Special education grant for disabled children

26. Staff Rule 355.1 has been amended to apply equal conditions to all staff for eligibility for such a grant. The reference to consultants has also been removed.

Mobility and hardship allowance

27. Staff Rule 360.1 has been amended and reworked text from this Rule has been used to create Staff Rules 360.1.1 and 360.2. Former Staff Rules 360.1.1, 360.1.2, 360.1.3, 360.1.4, and 360.2 have been deleted. In addition, new Staff Rule 360.1.2 has been introduced to reflect the applicability of the mobility and hardship allowance both to staff who are assigned or transferred to an official station for a period of one year or longer, and to staff who are assigned or transferred to an official station for an initial period of less than one year, and whose assignment or transfer is subsequently extended so that the uninterrupted period of service at that official station is one year or longer.

28. The above-mentioned amendments have also been made to reflect the recommendations of the International Civil Service Commission to the United Nations General Assembly on the revised mobility and hardship scheme. Furthermore, the provisions concerned have been considerably edited in the interests of simplicity and clarity, and in order to ensure that the content is focused on normative rather than procedural requirements.

29. The last sentence of Staff Rule 360.3, on the categorization of official stations, was previously found in Staff Rule 360.1.

Assignment grant

30. Staff Rule 365.1 has been slightly amended and text transferred to Staff Rule 365.1.1; new Staff Rule 365.1.2 has also been introduced. The aim of these changes is to indicate that the assignment grant will be paid upon appointment or reassignment to an official station for a period of at least one year, or upon extension of an initial appointment or reassignment to an official station of less than one year resulting in an uninterrupted period of service at that official station of one year or longer.

31. Text previously found in Staff Rule 365.1 on the amounts of the assignment grant has been used to create Staff Rule 365.2 and Staff Rules 365.1.1 and 365.1.2 have been renumbered accordingly.

32. Staff Rule 365.3 has been deleted and new Staff Rule 365.3 introduced to reflect the recommendations of the International Civil Service Commission to the United Nations General Assembly on the assignment grant. These amendments have also been made in the interests of simplification and clarity. New Staff Rule 365.3 sets out the normative criteria and requirements applying to the increase of the assignment grant by one or more lump sums.

33. Following the above-mentioned amendments, Staff Rules 365.2, 365.4 and 365.5 have been renumbered.

Service allowance

34. Staff Rule 367 providing for the payment of a service allowance for staff holding temporary appointments has been deleted as such an allowance is no longer appropriate in the light of the greater equity in benefits and entitlements and other emoluments being granted to staff holding temporary appointments under the amended Staff Rules.

Section 4 – Recruitment and appointment

Appointment policies

35. Staff Rule 420 has been amended to reflect the new appointment system.

36. New Staff Rule 420.1 has been added listing the new types of appointment.

37. Staff Rules 420.1, 420.2 and 420.3 have been renumbered and amended to reflect the definitions of continuing, fixed-term and temporary appointments, respectively.

38. Staff Rules 420.4 and 420.5 have been renumbered, and the cross-references in Staff Rule 420.5 to Staff Rules 420.2 and 420.3 corrected to indicate Staff Rules 420.3 and 420.4, respectively.

39. Staff Rule 420.6 has been renumbered and amended to indicate that it applies to fixed-term staff only.

Reinstatement upon re-employment

40. Staff Rule 470 has been amended in the interests of clarity by adding the term “reinstatement”, as this Rule deals with reinstatement upon re-employment. In addition, the cross-reference to Staff

Rule 420.3 has been corrected to indicate Staff Rule 420.4. The reference to consultants has also been deleted.

Interorganization transfers

41 Staff Rule 480.1.3 has been amended to correct the cross-reference to Staff Rule 420.5, which has been renumbered as Staff Rule 420.6.

Section 5 – Performance and change of status

End of probation

42. Staff Rule 540.1 has been amended to correct the cross-reference to Staff Rule 420.6, which has been renumbered 420.7.

Within-grade increase

43. Staff Rule 550.1 has been amended to reflect its application to all staff, and to clarify that the sentence indicating that the “date of entitlement shall not be earlier than the date of confirmation of the appointment” applies only to staff members holding fixed-term appointments subject to a probationary period. Staff Rule 550.3 has been amended to replace the words “linguistic staff” with a reference to “conference and other short-term service staff” appointed under amended Staff Rule 1320.

Promotion

44. Staff Rules 560.1, 560.2, 560.3 and 560.4 have been amended to indicate that they apply to staff members holding continuing and fixed-term appointments only. In addition, the cross-reference in Staff Rule 560.3 to Staff Rule 320.5 has been corrected to indicate Staff Rule 320.4.

Reassignment

45. Staff Rules 565.1, 565.2, 565.3 and 565.4 have been amended to indicate that the term “reassignment” as defined in Staff Rule 565.1 applies to staff holding continuing and fixed-term appointments only. In addition, the cross-reference in Staff Rule 565.4 to Staff Rule 320.5 has been corrected to indicate Staff Rule 320.4.

Section 6 – Attendance and leave

Annual leave

46. Staff Rule 630.3.1 has been amended to delete the reference to staff employed on a “when actually employed” basis as these arrangements have been discontinued in light of the reform of contractual arrangements.

47. Staff Rule 630.3.2 has been renumbered and further amended to delete the reference to staff holding temporary appointments. This Staff Rule has been further amended to introduce a reference to conference and other short-term service staff appointed under amended Staff Rule 1320.

48. Staff Rule 630.3.3 has been deleted to remove the reference to consultants.

49. As a result of these amendments, Staff Rules 630.3.4 and 630.3.5 have been renumbered.

Home leave

50. Staff Rule 640.3.3 has been amended to indicate that home leave applies to temporary staff and to specify that it does not apply to national professional officers appointed under Staff Rule 1330.

Leave for military training or service

51. Staff Rule 660.1 has been amended to correct the reference to Staff Rule 420.3, which has been renumbered Staff Rule 420.4, and to remove the reference to consultants.

Section 7 – Social security**Accident and illness insurance**

52. Staff Rule 720.1.1 on staff health insurance and Staff Rule 720.2.1 on accident and illness insurance have been amended so that they apply equally to all staff. Staff Rule 720.2.2 has been deleted accordingly.

Sick leave

53. Staff Rule 740.1 has been amended to remove the reference to staff engaged on a “when actually employed” basis as this form of employment has been discontinued under the proposed framework of contractual arrangements. The reference to Staff Rule 1330 on consultants has also been removed.

Maternity and paternity leave

54. Staff Rule 760.1 has been amended to reflect that staff members are entitled to maternity and paternity leave, subject to conditions established by the Director-General.

55. Staff Rule 760.2 has been amended and Staff Rule 760.3 deleted to indicate that maternity leave applies equally to all staff members (not including those appointed under Staff Rule 1320). Staff Rules 760.4, 760.5 and 760.6 have been renumbered accordingly.

56. Staff Rule 760.6 has been amended to indicate that paternity leave applies equally to all staff members.

Grant in case of death

57. Staff Rule 770.1 has been amended to apply the right to a grant in case of death equally to all staff members, and to remove the reference to Staff Rule 1330 on consultants.

Section 8 – Travel and transportation**Travel of spouse and children**

58. Staff Rules 820.2 and 820.2.1 have been amended to grant the right to reimbursement for travel expenses of a spouse and children equally to all staff members upon appointment for a period of not less than one year, and upon the extension of an initial appointment of less than one year resulting in an uninterrupted period of service of one year or longer.

Special education grant travel

59. Staff Rule 825 on special education grant travel has been amended so that it may apply to staff holding temporary appointments. It has been further amended to indicate that it does not apply to national professional officers under Staff Rule 1330, as renumbered. The reference to consultants has also been removed.

Section 10 – Separation from service

Termination for reasons of health

60. Staff Rule 1030.2.2 has been amended to indicate that reassignment possibilities prior to termination for reasons of health will be explored only for staff holding continuing and fixed-term appointments.

61. Staff Rule 1030.3.1 has been amended to specify that in the case of termination for reasons of health, staff members holding continuing and fixed-term appointments will receive three months' notice, and staff members holding temporary appointments will receive one month's notice.

Completion of appointments

62. Staff Rule 1040 has been amended to add the requirement that, where it has been decided not to offer an extension of appointment to a staff member holding a temporary appointment, the staff member shall be notified thereof normally no less than one month before the expiry of the appointment. The Staff Rule has been further amended to specify that no such notice will be required in the case of a staff member holding a temporary appointment who has reached the maximum duration of uninterrupted service under consecutive temporary appointments.

Termination of temporary appointments

63. New Staff Rule 1045 has been introduced to specify that a temporary appointment may be terminated on the grounds specified in Staff Rule 1030 (termination for reasons of health), Staff Rule 1075 (termination for misconduct) and Staff Rule 1080 (termination for abandonment of post). It has also been introduced to specify the requirements, including notice and termination indemnity, applying to the termination of temporary appointments for the following reasons: because the temporary function is discontinued, because the staff member's performance is considered unsatisfactory, or because the staff member proves unsuited to his or her work or to international civil service.

Abolition of post

64. Staff Rule 1050.2 has been amended so that it refers to "continuing appointments" rather than "service appointments".

65. Staff Rule 1050.3 has been amended so that it refers to "continuing appointments" rather than "service appointments".

Terminal remuneration

66. Staff Rule 1050.4 has been amended so that it may accommodate the payment of indemnities to staff holding temporary appointments, and whose function is discontinued under new Staff Rule 1045.

Unsatisfactory performance or unsuitability for international civil service

67. Staff Rules 1070.1, 1070.2, 1070.3, and 1070.4 have been amended to specify that these Staff Rules apply only to staff members holding continuing and fixed-term appointments.

Notice of termination

68. Staff Rule 1083 has been amended to indicate that notice of termination under new Staff Rule 1045 may not be served to a staff member on maternity leave.

Section 13 – Special employment conditions**Mobility and hardship allowance for staff in posts subject to local recruitment**

69. Staff Rule 1310.5 has been amended to add the words “in the United Nations common system” after the reference to “international organizations” in relation to staff recruited outside the area for posts subject to local recruitment.

Conference and other short-term service staff

70. Staff Rule 1320 has been re-titled “Conference and other short-term service staff”, thus removing the reference to “temporary appointments”. The Rule has been further amended to align it with the amendments made to Staff Rule 030.

Consultants

71. Staff Rule 1330 on consultants has been deleted.

National professional officers

72. Staff Rule 1340.1 has been renumbered and the term “posts” replaced by the term “appointments”. Staff Rule 1340.2 has also been renumbered and the cross-reference to Staff Rule 1340.1 corrected to Staff Rule 1330.1, as renumbered.

ACTION BY THE EXECUTIVE BOARD

73. [This paragraph contained a draft resolution which was adopted at the fifth meeting as resolution EB118.R5].

Appendix

TEXT OF AMENDED STAFF RULES

030. APPLICATION

The Staff Rules shall apply to all staff members of the World Health Organization, except as specifically provided in any particular Rule herein. Nothing in the present Rules shall be interpreted as preventing the Director-General from making temporary appointments of 60 days or less with terms of service different from those provided in the present Rules, where he or she considers that the interests of the service so require.

040. EFFECTIVE DATE

These Staff Rules are effective as from 1 January 2007 and supersede all Rules in force before that date. All subsequent modifications shall become effective as from the date shown thereon.

.....
320. SALARY DETERMINATION

320.1 On appointment, the net base salary of staff members shall normally be fixed at step 1 of the grade of the post or function to be occupied; however, in accordance with guidelines established by the Director-General, it may be fixed at a higher step in the grade in order to take into account a staff member's qualifications, skills and experience in relation to the requirements of the post or function.

320.2 On promotion of a staff member with a continuing or fixed-term appointment to a higher grade, the net base salary of a staff member shall be fixed at the lowest step in the new grade that will provide an increase in net base salary for promotion within the same salary scale or total net remuneration for promotion from the general service to the professional category, at least equal to that which would have resulted from the granting of two steps within the staff member's present grade. However, on restoration to a higher grade formerly held, the staff member's net base salary shall not exceed that which would have been attained had the staff member remained in the higher grade.

320.3 On reduction in grade of a staff member with a continuing or fixed-term appointment:

320.3.1 due to reasons other than unsatisfactory performance, unsuitability for international service, or misconduct, the net base salary of a staff member shall be fixed at that step in the lower grade that corresponds to his current net base salary, or at the step nearest below if there is no exactly corresponding step;

320.3.2 due to unsatisfactory performance, unsuitability for international service, or misconduct, the net base salary may be fixed at a lower step in the lower grade.

320.4 A staff member with a continuing or fixed-term appointment may be officially required to assume temporarily the responsibilities of an established post of a higher grade than that

which he occupies; such temporary arrangements shall not be continued for more than 12 months, unless otherwise decided by the Director-General. As from the beginning of the fourth consecutive month of such service, the staff member shall be granted non-pensionable extra pay normally equal to, but not exceeding, the difference between his current pay, consisting of net base salary, post adjustment and allowances, and that which he would receive if promoted to the post of higher grade.

.....

340. DEPENDANTS' ALLOWANCES

Staff members appointed to the professional or higher categories, are entitled to a dependant's allowance for dependants as defined in Rule 310.5, as follows:

...

.....

355. SPECIAL EDUCATION GRANT FOR DISABLED CHILDREN

- 355.1 Staff members are entitled to a special education grant in respect of any physically or mentally disabled child, recognized as dependant under Rule 310.5.2, up to the end of the year in which such child reaches the age of 28, under conditions established by the Director-General. In cases where an education grant is payable under Rule 350, the total of the amounts payable under Rules 350 and 355 shall not exceed the applicable maximum.
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360. MOBILITY AND HARDSHIP ALLOWANCE

- 360.1 The following staff members shall receive a non-pensionable mobility and hardship allowance designed to recognize varying degrees of hardship at different official stations and provide incentives for mobility, in accordance with conditions established by the Director-General:

360.1.1 staff members, except those appointed under Rules 1310 and 1330, who are assigned or transferred to an official station for a period of one year or longer; and

360.1.2 staff members, except those appointed under Rules 1310 and 1330, who are assigned or transferred to an official station for an initial period of less than one year, and whose assignment or transfer is subsequently extended so that the uninterrupted period of service at that official station is one year or longer.

- 360.2 The allowance is composed of three elements: mobility, hardship and non-removal, and shall be paid as determined by the Director-General on the basis of conditions and procedures agreed among the international organizations in the United Nation's common system.

- 360.3 Official stations shall be categorized according to conditions of life and work and on the basis of criteria agreed among the international organizations in the common system for classifying official stations. Headquarters, North American and European official stations and similar designated locations shall be categorized H official stations, whereas all other official stations shall be categorized from A to E.
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365. ASSIGNMENT GRANT

- 365.1 A staff member whose travel is authorized shall be paid an assignment grant:
- 365.1.1 upon appointment or upon reassignment to an official station for a period of at least one year; or
 - 365.1.2 upon extension of an initial appointment or reassignment to an official station of less than one year, resulting in an uninterrupted period of service at that official station of one year or longer.
- 365.2 The amount of the assignment grant shall be the equivalent of:
- 365.2.1 travel per diem in respect of himself for a period of 30 days from his arrival;
 - 365.2.2 travel per diem, in respect of each family member accompanying or joining him at the Organization's expense under Rule 820, except for children eligible for travel under Rule 820.1.4, for 30 days at half the rate after their arrival.
- 365.3 Subject to conditions established by the Director-General on the basis of conditions and procedures agreed among international organizations in the United Nations common system, the assignment grant shall be increased by one or more lump sums, depending on the category of the official station, whether the staff member is entitled to removal under Rule 855.1, and the duration or expected duration of the assignment at that official station. The lump sum shall be calculated and payable on the basis of the staff member's net base salary and, as applicable, the post adjustment at the official station to which the staff member is assigned at his grade and step, and rates determined by the Director-General.
- 365.4 No assignment grant shall be paid for children born, or for any other dependant acquired, after the arrival of the staff member at the official station.
- 365.5 If a staff member resigns from the Organization within six months of the date of his appointment or reassignment, any assignment grant paid under Rules 365.2 and 365.3 is recoverable proportionately under conditions established by the Director-General.
- 365.6 If both spouses are staff members of international organizations applying the common system of salaries and allowances at the same official station, the grant under Rule 365.2.1 shall be payable to each staff member. The amount under Rule 365.2.2 shall be payable to the staff member in respect of whom the child is recognized as a dependant, whereas the amount under Rule 365.3 shall be payable to the spouse whose entitlement yields the higher amount.

420. APPOINTMENT POLICIES¹

- 420.1 Staff members may be granted continuing, fixed-term or temporary appointments as defined below.
- 420.2 A “continuing appointment” is an appointment without specified time-limit. A continuing appointment shall be granted after a minimum of five years’ uninterrupted, active service on fixed-term appointments and certified satisfactory performance.
- 420.3 A “fixed-term appointment” is a time-limited appointment of one year or more. A fixed-term appointment may be extended, provided that the total duration of service under consecutive fixed-term appointments does not exceed five years. Exceptionally, service on such appointments may be further extended, for up to one additional year, in accordance with conditions determined by the Director-General.
- 420.4 A “temporary appointment” is a time-limited appointment of up to two years. If the temporary appointment is of less than two years, it may be extended, provided that the total duration of uninterrupted service under consecutive temporary appointments does not exceed two years. A staff member who has completed the maximum period of uninterrupted service on one or more temporary appointments may not be employed by the Organization unless more than 30 calendar days have elapsed since his separation from service. Any future employment is subject to conditions established by the Director-General.
- 420.5 Appointments may be on a full-time or part-time basis.
- 420.6 All staff, including staff members seconded to the Organization, shall be appointed initially on fixed-term appointments as defined in Rule 420.3, or on temporary appointments as defined in Rule 420.4.
- 420.7 Any fixed-term appointment of one year or more shall be subject to a period of probation, which shall be at least one year and may be extended up to two years when necessary for adequate evaluation of the staff member’s performance, conduct and suitability to international service.

470. REINSTATEMENT UPON RE-EMPLOYMENT

- 470.1 Staff members, except those holding temporary appointments as defined in Rule 420.4, who are re-employed within one year of the termination of their appointment, may, at the option of the Organization, be reinstated. In such cases they shall have restored to them the status which they held upon termination, and the intervening absence shall be charged to annual leave and leave without pay as necessary. They shall refund to the Organization all separation payments made to them.

¹ Staff members holding career-service and service appointments on 1 January 2007, shall have such appointments automatically converted to continuing appointments.

480. INTERORGANIZATION TRANSFERS

...

- 480.1.3 shall be appointed on a fixed-term appointment in accordance with Staff Rule 420.6, and serve the same probationary period as a newly appointed staff member, except for appointees transferred from the Pan American Health Organization;

540. END OF PROBATION

- 540.1 A performance evaluation report (see Rule 530.2) shall be made before the end of the normal probationary period (see Rule 420.7). On the basis of this report a decision shall be taken, and notified to the staff member, that the:

- 540.1.1 appointment is confirmed;
- 540.1.2 probationary period is extended for a specified period;
- 540.1.3 appointment is not confirmed and is to be terminated.

550. WITHIN-GRADE INCREASE

- 550.1 Staff members whose performance has been certified by the supervisors as being satisfactory shall be entitled to a within-grade salary increase of one step upon completion of each unit of service time as defined in Rule 550.2. For staff members holding fixed-term appointments subject to a period of probation, the date of entitlement shall not be earlier than the date of confirmation of the appointment except as provided in Rule 480. The effective date for a within-grade increase shall be the first of the month nearest the date of satisfactory completion of the service requirement. Increases may be granted up to the maximum for the staff member's grade except that, if either Rule 555.2 or Rule 1310.9 applies, the normal maximum may be exceeded accordingly.

...

- 550.3 The unit of service time shall be reduced to ten months under Rule 550.2.1 and to twenty months under Rule 550.2.2 in the case of staff members who have demonstrated, by passing a prescribed test, proficiency of a second official language of the Organization. Staff members whose mother tongue is one of the official languages of the Organization must demonstrate proficiency in a second official language. This Rule applies to staff members in the professional and higher categories except for conference and other short-term service staff appointed under Rule 1320, e.g., translators, editors, revisers and interpreters.
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560. PROMOTION (see Staff Regulation 4.4)

560.1 Promotion is the advancement of a staff member with a continuing or fixed-term appointment to a post of higher grade, as a result either of the reclassification of the post he occupies or of reassignment to a different post.

560.2 Subject to Rule 560.3, a staff member with a continuing or fixed-term appointment shall be entitled to the promotion resulting from a reclassification of the post he or she occupies if he or she has the necessary qualifications and his or her performance has been satisfactory.

560.3 If an occupied post is reclassified from the general service category to the professional category or by more than one grade within a category, the post shall be announced to the staff and selection for that post shall be on a competitive basis, subject to conditions to be determined by the Director-General. In such cases, the staff member with a continuing or fixed-term appointment occupying the advertised post may be granted extra pay as from the fourth consecutive month of the effective date of the reclassification calculated in accordance with the provisions of, and with due regard to, the period specified in Rule 320.4.

560.4 A staff member with a continuing or fixed-term appointment whose performance has been satisfactory, may at any time be considered for reassignment to a post of higher grade for which he or she has the qualifications.

.....

565. REASSIGNMENT

565.1 A reassignment is any formal movement of a staff member with a continuing or fixed-term appointment from one post to another. It may involve a change in title, grade, duties, salary, post adjustment or official station, or a combination of these changes.

565.2 A staff member with a continuing or fixed-term appointment may be reassigned whenever it is in the interest of the Organization to do so. A staff member with a continuing or fixed-term appointment may at any time request consideration for a reassignment in his own interest.

565.3 So far as practicable, vacancies in posts in the professional category and above shall be filled by the reassignment of staff members with continuing or fixed-term appointments between the different activities and offices of the Organization in the interest of developing a versatile career staff. In accepting appointment, a staff member with a continuing or fixed-term appointment accepts the applicability of this policy to himself.

565.4 A staff member with a continuing or fixed-term appointment may be required, without formal reassignment and in the interests of the Organization, to perform duties of a post other than his own, due regard being given to the provisions of Rule 320.4. Any such arrangement shall not exceed twelve months, unless otherwise decided by the Director-General.

.....

630. ANNUAL LEAVE

...

630.3 Annual leave accrues to all staff members except:

630.3.1 to conference and other short-term service staff appointed under Rule 1320 engaged on a daily basis;

630.3.2 to those on leave without pay under Rule 655.1 in excess of 30 days;

630.3.3 to those on special leave under insurance coverage in excess of 30 days.

640. HOME LEAVE

...

640.3.3 they are not locally recruited under Rules 1310 and 1330; and

660. LEAVE FOR MILITARY TRAINING OR SERVICE

660.1 Upon application, staff members, except those holding temporary appointments as defined in Rule 420.4, may be granted leave of absence for military training or service required by their government for a period not exceeding one year in the first instance but subject to extension on request. At the staff members' option, such absence shall be charged as either leave without pay or as annual leave to the extent accrued and thereafter to leave without pay. During any period of leave without pay for this purpose the provisions of Rule 655.2 shall apply.

720. ACCIDENT AND ILLNESS INSURANCE

720.1 Staff Health Insurance:

720.1.1 Staff members shall participate in the Organization's Staff Health Insurance, and their spouse and eligible dependants shall also be covered by it, in accordance with rules established by the Director-General in consultation with the staff. Staff members shall contribute to the cost.

720.2 Accident and Illness Insurance:

720.2.1 Staff members shall be insured against the risk of disability or accidental death to the extent provided for in the Organization's accident and illness insurance policy relating to them. Staff members shall contribute to the cost.

740. SICK LEAVE

- 740.1 Staff members, except those excluded by the Director-General under the provisions of Rule 1320 who are unable to perform their duties because of illness or injury, or whose attendance is prevented by public health requirements, may be granted sick leave with pay in the following amounts:

...

740.1.4 a staff member appointed for a period of less than one year, and paid on a monthly basis may be granted sick leave proportionate to the duration of the appointment.

760. MATERNITY AND PATERNITY LEAVE

- 760.1 Staff members shall be entitled to maternity leave and paternity leave, subject to conditions established by the Director-General.
- 760.2 Maternity leave shall commence six weeks before the expected date of birth upon submission of a certificate from a duly qualified medical practitioner or midwife indicating the expected due date. At the request of the staff member and on medical advice, the Director-General may permit the maternity leave to commence less than six weeks but not less than two weeks before the expected due date. Maternity leave shall extend for a period of 16 weeks from the time it is granted, except that in no case shall it terminate less than 10 weeks after the actual date of birth. The leave is paid with full salary and allowances.
- 760.3 A nursing mother shall be allowed additional maternity leave of sufficient time each day to nurse her child.
- 760.4 Where both parents of a new-born child are staff members of the World Health Organization, any unused portion of maternity leave to which the mother would otherwise have been entitled under Rule 760.2 may be used by the father of the child, under conditions established by the Director-General.
- 760.5 Subject to conditions established by the Director-General, and upon presentation of satisfactory evidence of the birth of his child, a staff member, shall be entitled to paternity leave for a total period of up to four weeks or, in the case of internationally recruited staff members serving at a non-family duty station, up to eight weeks. In exceptional circumstances, leave shall be granted for a total period of up to eight weeks. Paternity leave must be exhausted within 12 months from the date of the child's birth.
-

770. GRANT IN CASE OF DEATH

- 770.1 On the death of a staff member whose death does not result in any indemnity payment from the Organization's accident and illness insurance policy, a payment shall be made to:
-

820. TRAVEL OF SPOUSE AND CHILDREN

...

820.2 The Organization shall pay the travel expenses of a staff member's spouse and dependent children, as defined in Rule 820.1, under the following circumstances:

820.2.1 on appointment for a period of not less than one year, or upon extension of an initial appointment of less than one year resulting in an uninterrupted period of service of one year or longer, from the recognized place of residence or, at the option of the Organization, the place of recruitment, to the official station, or from some other place, provided that the cost to the Organization does not exceed that for the travel from the recognized place of residence, and subject to the requirement that in any case the spouse and dependent children are expected to remain at the official station at least six months;

825. SPECIAL EDUCATION GRANT TRAVEL

The Organization shall, in accordance with terms and conditions determined by the Director-General, pay travel expenses of dependent children in respect of whom staff members are entitled to the special education grant under Rule 355. In this case, the provisions for education grant travel under Rule 820.2.5 shall not apply, except for the round trips under Rules 820.2.5.2 and 820.2.5.3. The provisions of this Rule shall apply to professional and higher category staff not serving in the country of their recognized place of residence, and to staff referred to in Rule 1310.4 recruited outside the local area as well as outside the country of the official station. They shall not apply to other staff referred to in Rules 1310 and 1330.

1030. TERMINATION FOR REASONS OF HEALTH

1030.1 When, for reasons of health and on the advice of the Staff Physician, it is determined that a staff member is incapable of performing his current duties, his appointment shall be terminated.

1030.2 Prior to such termination the following conditions must be fulfilled:

1030.2.1 the medical condition must be assessed as of long duration or likely to recur frequently;

1030.2.2 reassignment possibilities for staff members holding continuing or fixed-term appointments shall be explored and an offer made if this is feasible;

1030.2.3 participants in the Pension Fund shall have their pension rights determined.

1030.3 A staff member whose appointment is terminated under this Rule:

- 1030.3.2 may be entitled to disability benefit in accordance with the rules of the Pension Fund;
- 1030.3.3 may be entitled to a disability payment in accordance with the terms of the insurance coverage provided for in Rule 720.2;
- 1030.3.4 shall receive a termination payment at the rates set out in Rule 1050.4, provided that the amount due under that Rule, together with any periodic disability benefits due in the 12 months following termination and payable by virtue of the provisions of Section 7, shall not exceed one year's terminal remuneration;
- 1030.3.5 shall always have the option of resigning.

1040. COMPLETION OF APPOINTMENTS

In the absence of any offer and acceptance of extension, fixed-term and temporary appointments shall terminate automatically on the completion of the agreed period of service. Where it has been decided not to offer an extension of appointment to a staff member holding a fixed-term appointment, the staff member shall be notified thereof no less than three months before the expiry of the appointment. Where it has been decided not to offer an extension of appointment to a staff member holding a temporary appointment, the staff member shall be notified thereof normally no less than one month before the expiry of the appointment. Such notice shall not be required in the case of a staff member holding a temporary appointment who has reached the maximum duration of uninterrupted service under consecutive temporary appointments, as defined in Rule 420.4. Eligible staff members who do not wish to be considered for reappointment shall also give that period of notice of their intention.

1045. TERMINATION OF TEMPORARY APPOINTMENTS

- 1045.1 In addition to the grounds for termination set out in Rules 1030, 1075, and 1080, a temporary appointment may be terminated prior to its expiration date if:
 - 1045.1.1 the function the staff member performs is discontinued, or;
 - 1045.1.2 the staff member's performance is deemed to be unsatisfactory, or if the staff member proves unsuited to his work or to international service. It shall be considered unsatisfactory performance if the staff member does not or cannot perform the temporary functions to which he is assigned, and unsuitability for international service if he fails to establish satisfactory working relationships with other staff members or with nationals of other nations with whom he is working.
- 1045.2 When a temporary appointment is terminated due to discontinuation of the function, the staff member will be given at least one month's notice and will be paid a termination indemnity in accordance with the schedule set out in Rule 1050.4.
- 1045.3 When a temporary appointment is terminated for unsatisfactory performance or because the staff member proves unsuited to his work or to international civil service, the staff member shall normally be given at least one month's notice. In addition, the staff member may, at the discretion of the Director-General, be paid an indemnity not exceeding one-

half of the amount to which he would have been entitled if his appointment had been terminated under Rule 1045.2.

1050. ABOLITION OF POST

1050.1 The fixed-term appointment of a staff member with less than five years of service may be terminated prior to its expiration date if the post he occupies is abolished.

1050.2 When a post held by a staff member with a continuing appointment, or by a staff member who has served on a fixed-term appointment for a continuous and uninterrupted period of five years or more, is abolished or comes to an end, reasonable efforts shall be

made to reassign the staff member occupying that post, in accordance with procedures established by the Director-General, and based upon the following principles:

...

1050.3 Termination under this Rule shall require giving at least three months' notice to a staff member holding a continuing appointment or a non-probationary fixed-term appointment, and at least one month's notice to any other staff member.

1050.4 Staff members whose appointments are terminated under this Rule shall be paid an indemnity in accordance with the following schedule and with due regard to Rule 380.2:

Indemnity

(Terminal remuneration)

Years of service	Staff holding continuing appointments	Staff holding other types of appointments
Less than 1))
1))
2))
3))
4))
5))
6	6 months	5 months
7	7 months	6 months
8	8 months	7 months
9	9 months	9 months
10	9.5 months	9.5 months
11	10 months	10 months
12	10.5 months	10.5 months
13	11 months	11 months
14	11.5 months	11.5 months
15 or more	12 months	12 months

1070. UNSATISFACTORY PERFORMANCE OR UNSUITABILITY FOR
INTERNATIONAL SERVICE

1070.1 A staff member's continuing or fixed-term appointment may be terminated if his performance is unsatisfactory or if he proves unsuited to his work or to international service. It shall be considered unsatisfactory performance if the staff member with a continuing or fixed-term appointment does not or cannot perform the functions of the post to which he is assigned, and unsuitability for international service if he fails to establish satisfactory working relationships with other staff members or with nationals of other nations with whom he is working.

1070.2 Prior to termination action, a staff member with a continuing or fixed-term appointment shall be given a written warning and a reasonable time to improve. If there is reason to believe that the unsatisfactory performance results from assignment to duties and responsibilities beyond the capacity of the staff member, consideration shall be given to reassignment to a post more suited to his abilities.

1070.3 A staff member with a continuing or fixed-term appointment whose appointment is terminated under this Rule shall be entitled to a notice period equivalent to that specified in Rule 1050.3.

1070.4 A staff member whose continuing or fixed-term appointment is terminated under this Rule may, at the discretion of the Director-General, be paid an indemnity not exceeding one-half of the amount to which he would have been entitled if terminated under Rule 1050.

.....

1083. NOTICE OF TERMINATION

Notice of termination under Staff Rules 1030, 1045, 1050, 1060, 1070 and 1080 shall not be served to a staff member on maternity leave.

.....

1310. STAFF IN POSTS SUBJECT TO LOCAL RECRUITMENT

...

1310.5 At designated official stations, a mobility and hardship allowance may be payable to staff members described in Rule 1310.4 in accordance with the conditions defined under Rule 360 and at the rates payable to staff in grades P.1 to P.3. The Director-General shall establish, on the basis of procedures agreed among the international organizations in the United Nations common system, the criteria under which the mobility and hardship allowance may be payable.

.....

1320. CONFERENCE AND OTHER SHORT-TERM SERVICE STAFF

The Director-General may establish conditions of service for conference and other short-term service staff holding temporary appointments of 60 days or less without regard to

the provisions of other Staff Rules, including Staff Rules 340, 640, 710, 760, 770, 820, and 825.

1330. NATIONAL PROFESSIONAL OFFICERS

- 1330.1 The Director-General may appoint National Professional Officers to perform work at the professional level without regard to the provisions of other sections of the Rules. All appointments in the National Professional Officer category are subject to local recruitment.
- 1330.2 With respect to Rule 1330.1 the Director-General shall establish employment conditions for staff engaged in the local area, including the fixing of rates of pay and allowances in terms of the best prevailing practices in the local area.
-

ANNEX 2

Administrative and financial implications for the Secretariat of resolutions adopted by the Executive Board

1. Resolution EB118.R1 Thalassaemia and other haemoglobinopathies ¹	
2. Linkage to programme budget	
Area of work	Expected result
Surveillance, prevention and management of chronic, noncommunicable diseases	1. Support provided to countries for framing policies and strategies for prevention and management of chronic, noncommunicable diseases at national level, including integration of primary and secondary prevention into health systems.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
The resolution will provide a framework for achieving the expected result with regard to the prevention and management of thalassaemia and other haemoglobinopathies.	
3. Financial implications	
(a) Total estimated cost for implementation over the “life-cycle” of the resolution (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 2 740 000, excluding the staff costs of US\$ 2 440 440 detailed in the report on administrative and financial implications of resolution EB117.R3.	
(b) Estimated cost for the biennium 2006-2007 (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 1 390 000	
(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities? Not applicable (no funds allocated except those under the regular budget in respect of the Programme Manager, an estimated 50% of whose work time will be needed for implementation of the resolution).	
4. Administrative implications	
(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken and identify the specific regions where relevant)	
Selected countries, five regional offices (the regional offices for the Americas, South-East Asia, Europe, the Eastern Mediterranean and the Western Pacific) and headquarters.	
(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile)	
Please see the report on administration and financial implications of the resolution EB117.R3.	
(c) Time frames (indicate broad time frames for implementation and evaluation)	
The lifespan of the global initiative is four years from 2006. The monitoring committee is to meet every two years.	

[EB118/5 Add.1 – 27 May 2006]

¹ As sickle-cell anaemia is a common haemoglobinopathy kindly see also the administrative and financial implications of resolution EB117.R3 (document EB117/2006/REC/1, Annex 4).

1. Resolution EB118.R3 Control of leishmaniasis	
2. Linkage to programme budget	
Area of work	Expected result
Communicable disease prevention and control	1. Strengthen national capacity to make substantial progress in the intensified control or elimination of targeted endemic tropical diseases.
<p>(Briefly indicate the linkage with expected results, indicators, targets, baseline)</p> <p>Linkage with the following indicators for this expected result: number of countries that have updated national programmes for the prevention and control of major zoonoses; number of countries facing emergencies provided with effective support for applying appropriate prevention and control measures for communicable diseases.</p>	
3. Financial implications	
<p>(a) Total estimated cost for implementation over the “life-cycle” of the resolution (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 3 million will be required over three years</p> <p>(b) Estimated cost for the biennium 2006-2007 (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 1.8 million</p> <p>(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities? US\$ 1.4 million have been already donated by the Government of Spain to the leishmaniasis control programme for the biennium. Additional funding of US\$ 400 000 is needed, and negotiations with potential donors are in process</p>	
4. Administrative implications	
<p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken and identify the specific regions where relevant) Mainly at country level to support the WHO Representatives’ offices in order to strengthen peripheral health centres; some additional capacity will however be required by the control programme at headquarters to help in structuring the global task force, organizing mapping activities, updating the relevant WHO Technical Reports, and supporting activities in countries. Emphasis will be placed on the principal areas in which the disease is endemic in the African Region, the Region of the Americas and the South-East Asia and Eastern Mediterranean regions, and on areas for which information is lacking.</p> <p>(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile) At headquarters one staff member is required with the following profile: an excellent knowledge of leishmaniasis, operational planning skills and a background in infectious diseases and public health.</p> <p>(c) Time frames (indicate broad time frames for implementation and evaluation) Implementation in a limited number of countries would begin in the current biennium (Afghanistan, Bangladesh, Ethiopia, India, Nepal and Sudan); the activities should be extended in the years following the biennium.</p>	

1. Resolution EB118.R4 Strengthening of health information systems	
2. Linkage to programme budget	
Area of work	Expected result
Health information, evidence and research policy	1. Strengthened and reformed country health-information systems that provide and use quality and timely information for local health problems and programmes and for monitoring of major international goals.
<p>(Briefly indicate the linkage with expected results, indicators, targets, baseline)</p> <p>The resolution is consistent with the expected result through its focus on strengthening country health-information systems in keeping with international standards defined in the Health Metrics Network, together with the priority given by WHO to evidence-based decision-making. It is in line with indicators and targets concerning both a WHO database of core health indicators with metadata, focusing on the health-related Millennium Development Goals, and the development and implementation by countries of norms and standards, such as the <i>International statistical classification of diseases and related health problems</i> and the <i>International classification of functioning, disability and health</i>, and reviews of health status and health-systems metrics.</p>	
3. Financial implications	
<p>(a) Total estimated cost for implementation over the “life-cycle” of the resolution (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 40 million (does not include the budget for the Health Metrics Network)</p> <p>(b) Estimated cost for the biennium 2006-2007 (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 11 million (does not include the budget for the Health Metrics Network)</p> <p>(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities? About US\$ 7 million of the proposed expenditure for the current biennium can be absorbed under existing programmed activities. Additional funding of US\$ 4 million is required to enable WHO to play a lead role at global, regional and country levels and continue to be a key player in the Health Metrics Network.</p>	
4. Administrative implications	
<p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken and identify the specific regions where relevant)</p> <p>Headquarters, in collaboration with the regional offices, will continue to develop and test tools and methods and set normative guidance. Globally, the Secretariat will continue to serve as the repository of sound health statistics and evidence. Normative guidance and implementation of plans to strengthen health information systems will be adapted at country level, with strong regional office support.</p> <p>(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile)</p> <p>Seven full-time equivalent professional staff are required to enable the regional offices to provide strong support to country implementation (one in each region, with two in the Regional Office for Africa). The staff concerned require skills in statistics, epidemiology, planning and monitoring and evaluation.</p> <p>Limited additional staffing is required at headquarters (two full-time equivalent professional staff) in order to ensure high-quality technical work on health statistics at global level and adherence to agreed standards. The staff concerned require skills in statistics, epidemiology, biostatistics, demography and health economics.</p>	

(c) Time frames (indicate broad time frames for implementation and evaluation)

Implementation of normative work and support to regions and countries will start immediately, in collaboration with activities of the Health Metric Network. Support to country implementation will commence in the current biennium and accelerate subsequently as capacity increases and as a function of needs at country level. Progress will be evaluated at regular intervals in the context of the biennial reviews of the programme budget.

[See summary record of the fourth meeting, Section 3.]

1. Resolution EB118.R5 Confirmation of amendments to the Staff Rules	
2. Linkage to programme budget	
Area of work	Expected result
Human resources management in WHO	4. Conditions of service improved and staff-friendly policies implemented; WHO pay and benefits system brought into line with the United Nations field-oriented organizations' system.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
The improved conditions of service outlined in the contract reform proposal represent the implementation of a staff-friendly policy that aims to ensure that the Organization can attract and retain the highest calibre of staff.	
3. Financial implications	
(a) Total estimated cost for implementation over the "life-cycle" of the resolution (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 22.8 million. This figure relates to the additional costs that will result from the improvement of the conditions of service for temporary staff, applying the principle of equal pay for equal work, which had not been foreseen in the Programme budget 2006-2007. The cost for future bienniums will be subsumed within the revised staff costs projected for each budgeting cycle and in accordance with the need for temporary functions.	
(b) Estimated cost for the biennium 2006-2007 (estimated to the nearest US\$ 10 000, including staff and activities) The costs indicated in (a) are estimated in respect of the year 2007, which corresponds to the period of implementation of the proposed new measures.	
(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities? None of the proposed additional financial implications can be subsumed under existing programme activities, as all clusters and regional offices concerned are in the process of converting a number of temporary functions into fixed-term positions; the amount indicated therefore represents the estimated net increase over and above present budgets.	
4. Administrative implications	
(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken and identify the specific regions where relevant)	
Implementation would be Organization-wide, using the revised human-resources plans from the regions and headquarters.	
(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile)	
Implementation of the proposed contract reform does not require additional staffing.	
(c) Time frames (indicate broad time frames for implementation and evaluation)	
Implementation will take place throughout 2007.	

PART II

SUMMARY RECORDS

LIST OF MEMBERS AND OTHER PARTICIPANTS

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Mme C. GOY, Représentant permanent adjoint, Genève

Mme E. COLOTTE, Secrétaire de Légation, Direction de la Coopération et de l'Action humanitaire, Ministère des Affaires étrangères, Luxembourg

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World Federation for Medical Education

Dr H. KARLE
Professor L. CHRISTENSEN

World Federation for Mental Health

Mrs M. LACHENAL
Dr S. FLACHE
Ms A. YAMADA-VETSCH

**World Federation of Public Health
Associations**

Professor T. ABELIN
Mrs J.B. DAVENPORT

World Self-Medication Industry

Dr D. WEBBER
Ms S. DURAND-STAMATIADIS

World Vision International

Dr M. AMAYUN
Mr T. GETMAN

COMMITTEES AND WORKING GROUPS¹

1. Programme, Budget and Administration Committee

Mr M.N. Khan (Pakistan), Chairman of the Executive Board, member ex officio, Dr D. Hansen-Koenig (Luxembourg), Vice-Chairman of the Executive Board, member ex officio, Ms J. Halton (Australia), Dr N.A. Haffadh (Bahrain), Dr Jigmi Singay (Bhutan), Mr I. Shugart (Canada), Professor D. Houssin (France), Dr A.M. Ali Mohammed Salih (Iraq), Mr J. Junor (Jamaica), Dr M. Phooko (Lesotho), Professor J. Pereira Miguel (Portugal), Dr J.D. Ntawukuliryayo (Rwanda), Dr Suwit Wibulpolprasert (Thailand), Dr V. Tangi (Tonga).

First extraordinary meeting, 24 February 2006: Ms J. Halton (Australia, Chairman), Dr S.A. Khalfan (Bahrain, alternate to Dr N.A. Haffadh), Dr Jigmi Singay (Bhutan), Mr D. Strawczynski (Canada, alternate to Mr I. Shugart), Dr J.-B. Brunet (France, alternate to Professor D. Houssin), Dr E.A. Aziz (Iraq, alternate to Dr A.M. Ali Mohammed Salih), Dr B. Wint (Jamaica, alternate to Mr J. Junor), Mr T.J. Ramotsoari (Lesotho, alternate to Dr M. Phooko), Professor J. Pereira Miguel (Portugal), Mr A. Kayitayire (Rwanda, alternate to Dr J.D. Ntawukuliryayo), Dr Viroj Tangcharoensathien (Thailand, alternate to Dr Suwit Wibulpolprasert), Dr V. Tangi (Tonga).

2. Programme, Budget and Administration Committee

Mr M.N. Khan (Pakistan), Chairman of the Executive Board, member ex officio, Dr D. Hansen Koenig (Luxembourg), Vice-Chairman of the Executive Board, member ex officio, Ms J. Halton (Australia), Dr N.A. Haffadh (Bahrain), Dr Jigmi Singay (Bhutan), Mr I. Shugart (Canada), Professor D. Houssin (France), Dr A.M. Ali Mohammed Salih (Iraq), Dr B. Wint (Jamaica), Dr M. Phooko (Lesotho), Professor J. Pereira Miguel (Portugal), Dr J.D. Ntawukuliryayo (Rwanda), Dr Suwit Wibulpolprasert (Thailand), Dr V. Tangi (Tonga).

Fourth meeting, 19 May 2006: Ms J. Halton (Australia, Chairman), Dr S.A. Khalfan (Bahrain, alternate to Dr N.A. Haffadh), Dr Jigmi Singay (Bhutan), Mr P. Oldham (Canada, alternate to Mr I. Shugart), Dr J.-B. Brunet (France, alternate to Professor D. Houssin), Dr B. Wint (Jamaica), Mr T. Ramatsoari (Lesotho, alternate to Dr M. Phooko), Professor J. Pereira Miguel (Portugal), Dr Viroj Tangcharoensathien (Thailand, alternate to Dr Suwit Wibulpolprasert), Dr V. Tangi (Tonga).

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

3. Committee of the Executive Board to discuss the Report of the Commission on Intellectual Property Rights, Innovation and Public Health¹

Meeting of 28 April 2006: Dr Suwit Wibulpolprasert (Thailand, Chairman), Ms C. Patterson (Australia, alternate to Ms J. Halton, Vice-Chairman), Dr Jigmi Singay (Bhutan), Dr P.M. Buss (Brazil), Mr M. Sanger (Canada, alternate to Mr I. Shugart), Mr D.Á. Gunnarsson (Iceland), Dr H. Shinozaki (Japan), Dr J. Nyikal (Kenya), Mr J.-M. Rasolonjatovo (Madagascar, alternate to Dr R.R. Jean Louis), Mr R.S. Sheikh (Pakistan, alternate to Mr M.N. Khan), Professor J. Pereira Miguel (Portugal), Dr I.E.M. Abdulla (Sudan, alternate to Dr T. Botros Shokai).

4. Standing Committee on Nongovernmental Organizations

Mr O.K. Shiraliyev (Azerbaijan), Dr P. M. Buss (Brazil), Dr Ren Minghui (China), Dr R.R. Jean Louis (Madagascar), Dr Suwit Wibulpolprasert (Thailand).

¹ Two members per region participated.

SUMMARY RECORDS

FIRST MEETING

Monday, 29 May 2006, at 09:40

Chairman: Mr M.N. KHAN (Pakistan)

later: Dr F. ANTEZANA ARANÍBAR (Bolivia)

1. OPENING OF THE SESSION AND ADOPTION OF THE AGENDA: Item 1 of the Provisional agenda (Documents EB118/1 and EB118/1 (annotated))

The CHAIRMAN expressed his sorrow and sympathy at the tragedy of the recent earthquake in Indonesia, in which more than 5000 people had lost their lives, over 20 000 had been injured and many more displaced. His country, Pakistan, had experienced a similar tragedy in 2005.

Declaring the 118th session of the Executive Board open, he invited members to consider the provisional agenda, with the exception of the two proposals for supplementary items.

Dr SHANGULA (Namibia) proposed that items 5.5 and 8.3 should be considered together, since they both concerned the Millennium Development Goals.

Professor PEREIRA MIGUEL (Portugal), speaking on behalf of the Member States of the European Union, requested that the European Commission should be invited to participate without vote in the deliberations of the meetings of subcommittees or other subdivisions of the Board at its 118th session, in accordance with Rule 4 of the Rules of Procedure of the Executive Board.

Mr BURCI (Legal Counsel) recalled that the same request had been made at the Board's 117th session in January 2006, when the Board had agreed to the Commission's participation for the relevant agenda item, subject to the provision of a clear statement of the distribution of competencies between the Community and its Member States.¹ The Board might wish to proceed along the same lines at the present session.

The CHAIRMAN said that, as there were no objections, he took it that the Board wished to grant the request.

It was so agreed.

¹ See document EB117/2006/REC/2, summary record of the first meeting, section 1.

The CHAIRMAN, referring to documents EB118/17 and EB118/18, proposed the inclusion on the agenda of two supplementary agenda items entitled “Consideration of the acceleration of the procedure to elect the next Director-General of the World Health Organization” and “Deputy Director-General of the World Health Organization”. As there were no objections, he took it that the Board wished to include both items, which would become agenda items 9 and 10, respectively.

The agenda, as amended, was adopted.¹

2. ELECTION OF CHAIRMAN, VICE-CHAIRMEN AND RAPPORTEUR: Item 2 of the Agenda

The CHAIRMAN invited nominations for the office of Chairman.

Dr GOMES TEMPORÃO (Brazil) nominated Dr F. Antezana Aranibar (Bolivia), the nomination being seconded by Dr WINT (Jamaica).

Dr Antezana Aranibar was elected Chairman.

The ACTING DIRECTOR-GENERAL thanked Mr Khan, outgoing Chairman, for his excellent work and leadership during the past year. He, too, had been shocked by the disaster in Indonesia. WHO would respond as it had to the disaster in Pakistan.

The Acting Director-General presented Mr Khan with a gavel.

Mr M.N. KHAN (Pakistan) said that he had been honoured to take on the stimulating challenge of chairing the Executive Board, and thanked Board members and the late Director-General for their help. Conflicts, natural disasters and disease outbreaks were increasing in number and posing a great risk for health security. On such occasions, resources must be mobilized quickly in order to support recovery and the transition to a sustainable health system. For rapid, equitable and cost-effective action, emergency response centres needed to be set up around the world, such as that being considered for Pakistan by the Regional Office for the Eastern Mediterranean. In order to avoid the loss of precious time in mobilizing funds, it had been proposed by the Board at its 117th session that special funds should be placed at the disposal of the Director-General, allowing immediate action and subsequent accounting for expenditure.² WHO and the United Nations system in general must intensify efforts in order to provide emergency relief to victims of conflicts and natural disasters.

He paid tribute to the late Director-General, who would remain in the thoughts of all members of the Board, commended the smooth transition of leadership, and welcomed the new Board members.

Dr Antezana Aranibar took the Chair.

The CHAIRMAN said that he looked forward to contributing his experience to help the Board through the difficult situation it was facing, and to ensure the welfare of the Organization and its future. He was grateful for the wisdom and knowledge of the Board members, as he had been for that of the late Director-General, whose memory should inspire the Board's work concerning the Organization's management, leadership and future. He invited nominations for the four posts of Vice-Chairman.

¹ See page 57.

² See document EB117/2006/REC/2, summary record of the second meeting, section 1.

Dr SHANGULA (Namibia), seconded by Dr RAHANTANIRINA (Madagascar), nominated Dr Gakuruh (Kenya).

Dr HANSEN-KOENIG (Luxembourg), seconded by Professor PEREIRA MIGUEL (Portugal), nominated Mr Shiraliyev (Azerbaijan).

Dr SINGAY (Bhutan), seconded by Mr DE SILVA (Sri Lanka), nominated Dr Suwit Wibulpolprasert (Thailand).

Ms HALTON (Australia), seconded by Dr SHINOZAKI (Japan), nominated Dr Sadasivan (Singapore).

Dr Gakuruh (Kenya), Mr Shiraliyev (Azerbaijan), Dr Suwit Wibulpolprasert (Thailand) and Dr Sadasivan (Singapore) were elected Vice-Chairmen.

The CHAIRMAN noted that, under Rule 15 of the Rules of Procedure of the Executive Board, if the Chairman were unable to act between sessions, one of the Vice-Chairmen should act in his 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 should serve in the following order: Dr Sadasivan (Singapore), Mr Shiraliyev (Azerbaijan), Dr Suwit Wibulpolprasert (Thailand) and Dr Gakuruh (Kenya).

The CHAIRMAN invited nominations for the office of Rapporteur.

Dr AL-SHAMMARI (Iraq), seconded by Mr MIGUIL (Djibouti), nominated Dr Saheli (Libyan Arab Jamahiriya).

Dr Saheli was elected Rapporteur.

3. PROGRAMME OF WORK

The CHAIRMAN noted that the Board was scheduled to finish its work no later than 1 June 2006. Members would be consulted should any unforeseen circumstances arise that might make it necessary to alter the timetable. He proposed that the Board consider the two supplementary items, consideration of the acceleration of the procedure to elect the next Director-General of the World Health Organization (item 9) and Deputy Director-General of the World Health Organization (item 10), following the conclusion of its discussion of agenda items 3 and 4.

Professor PEREIRA MIGUEL (Portugal), speaking on behalf of the Member States of the European Union and supported by Professor PAUNESCU (Romania), requested that consideration of supplementary agenda item 9 be taken up at the Board's third meeting.

Dr STEIGER (alternate to Dr Agwunobi, United States of America), noting that the Board had a full timetable before it, expressed a strong preference for taking up the two supplementary agenda items during the first and second meetings. If a conclusion were to be reached, the necessary translation work could be done and revised texts prepared for consideration by the Board at its third meeting.

Mr MIGUIL (Djibouti), Dr SHANGULA (Namibia), Dr KHALFAN (Bahrain), Ms HALTON (Australia) and Mr DE SILVA (Sri Lanka) endorsed the views of the Chairman and the member for the United States of America that it would be advisable to consider the supplementary agenda items expeditiously.

Dr GWENIGALE (Liberia) recalled that, at the Board's special session, he had requested that the Secretariat should resolve the issue of the Deputy Director-General.¹ He had noted the contents of the report contained in document EB118/20, but had not been able to find the item in the agenda.

The CHAIRMAN explained that the matter would be discussed during consideration of the two supplementary agenda items.

Referring to the request from the member for Portugal and highlighting the relevance of the subject matter to other agenda items, including technical matters, he said that most speakers had indicated their preference for taking up the two supplementary items immediately after consideration of agenda items 3 and 4.

Professor PEREIRA MIGUEL (Portugal) withdrew his proposal; its purpose had been to reflect the fact that there had not been enough time for consultation about the contents of document EB118/20.

The CHAIRMAN said that he took it that the programme of work he had proposed was accepted.

It was so agreed.

4. OUTCOME OF THE FIFTY-NINTH WORLD HEALTH ASSEMBLY: Item 3 of the Agenda (Document EB118/2)

The CHAIRMAN reminded members that the Board had been represented at the Fifty-ninth World Health Assembly by Ms Halton (Australia), Dr Hansen-Koenig (Luxembourg), Mr M.N. Khan (Pakistan) and Dr Shangula (Namibia), and he asked Dr Shangula to present a report.

Dr SHANGULA (Namibia) introduced document EB118/2 which summarized the work done during the Health Assembly. Further consideration of the destruction of variola virus stocks, health promotion in a globalized world, and WHO's role and responsibilities in health research had been deferred until the session of the Board in January 2007.

Dr WINT (Jamaica) said that, in view of the exceptional circumstances in which the Health Assembly had opened, the Secretariat's response had been commendable. Owing to its prompt action, Member States had been able to proceed with the work, despite their sadness at the untimely passing of Dr Lee.

The CHAIRMAN agreed that all credit was due to the Secretariat for the way in which it had handled the situation. He took it that the Board wished to take note of the report.

The report was noted.

¹ See summary record of the special session, this volume, page 33.

5. REPORT OF THE PROGRAMME, BUDGET AND ADMINISTRATION COMMITTEE OF THE EXECUTIVE BOARD: Item 4 of the Agenda (Document EB118/3)

Ms HALTON (Australia), speaking in her capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, said that the Committee's fourth meeting had been constructive and confirmed that the Committee had a genuine purpose and direction. Many items discussed at the meeting had been reported to the Health Assembly and did not require further comment. The Committee had continued to discuss the process of management reform in WHO. It was useful for the Committee, on behalf of the Board, to be able to provide feedback and guidance to the Secretariat on the need for continued efforts in that area. The suggestion to focus the January 2007 meeting on the monitoring of WHO's financial resources had been accepted by consensus.

The Committee had also discussed the report on progress of the medium-term strategic plan and acknowledged the plan's close relation to the Eleventh General Programme of Work, which had subsequently been approved by the Health Assembly.¹ The Committee had finalized that document on behalf of the Board. Members had also highlighted the Millennium Development Goals, the need for collaboration with other organizations in the United Nations system and the need for WHO to work more strategically with partners in public health and development. It had been requested that the medium-term strategic plan and the performance assessment report should be submitted to all the regional committees for their consideration. Regarding the confirmation of amendments to the Staff Regulations and Staff Rules, the late availability of document EB118/11 had obliged the Committee to forward the matter to the Board for consideration without discussion in the Committee. In regard to the strategic resource allocation (document EB118/7), a vigorous discussion had taken place on the validation mechanism, which had been amended after the Committee's previous meeting to take account of concerns about least developed countries. There had been extensive discussion about the revised proposal submitted by the Secretariat and, in a spirit of compromise, the Committee had decided to accept it, and to treat all least developed countries as equal in weight to the neediest group of countries; however, the engagement factor would continue to be applied as in the earlier model. The Committee recommended that the Board should also consider the document in a spirit of compromise, as it ensured that the guiding principles on strategic resource allocation and the associated validation mechanism would, if adopted, provide a solid foundation on which to proceed.

The CHAIRMAN observed that it would be useful to discuss, at some future date, how strategic resource allocations would pass from headquarters to the regional offices and then to countries.

The Board noted the report.

6. CONSIDERATION OF THE ACCELERATION OF THE PROCEDURE TO ELECT THE NEXT DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION: Item 9 of the Agenda (Document EB118/20)

The CHAIRMAN recalled that the Board, at its special session the previous week, had asked the Secretariat to submit options at the current session for accelerating the procedure to elect the next Director-General. The various options were set out in document EB118/20. The Board might usefully start with a general debate on the concepts involved before discussing the options in detail, although members were free to give their views directly regarding the option they preferred.

¹ Resolution WHA59.4.

Dr SUWIT WIBULPOLPRASERT (Thailand) requested clarification from the Legal Counsel on the meaning of “next meeting” in Rule 109 of the Rules of Procedure of the World Health Assembly. As the 118th session was the next regular session of the Board after Dr Lee’s death, did it mean that the Board would have to proceed to nominations at the current session? Rule 108 of the same Rules of Procedure specified that the term of office of the Director-General was five years. The Board had before it three options: if it chose one that did not include the normal five-year time frame, it might affect the next Director-General’s term of office. Did that imply that the Board would also need to decide the term of the office of Director-General? If so it would have to propose that the next Health Assembly should suspend Rule 108.

Mr BURCI (Legal Counsel) said that Rule 109 had been drafted at a time when there was no set procedure for the presentation and screening of candidatures for the post of Director-General, and candidatures were presented directly to the Executive Board. Subsequent changes of approach were reflected in Rule 52 of the Rules of Procedure of the Executive Board but Rule 109 had remained unchanged, leaving the possibility, under special circumstances, of a contradiction between Rule 109, with its request for an immediate nomination, and Rule 52 with its six-month process to arrive at a nomination. According to the letter of Rule 109, the “next meeting” had been the meeting held on 23 May, the day after the Director-General had died. That did not mean that the Executive Board was acting illegally. The rules should be interpreted flexibly in the light of their object and purpose, and bearing in mind the background he had described. In his view, therefore, the Board had the authority to defer consideration of the nomination until a later session if it considered that to be in the best interests of the Organization and to avoid incompatibility with the process set out in Rule 52 of the Board’s Rules of Procedure.

With regard to Rule 108, should the Director-General be appointed in October or December, his or her term of office would terminate in October or December five years later, in other words between Health Assemblies. The Health Assembly would therefore have to decide, on an ad hoc basis, to suspend that aspect of Rule 108 in order to waive the five-year rule and enable the Director-General’s term of office to run until a Health Assembly, back-to-back with the next appointment. The Board at its current session did not need to discuss the term of office, but it would be appropriate for it to recommend to the Health Assembly that the latter suspend Rule 108 and take the relevant ad hoc decision.

Mr DE SILVA (Sri Lanka) said that no time should be lost in appointing a new Director-General. A pragmatic approach should be adopted to changing the Rules if that was necessary. He supported Option 1, Timetable 1A. The cost would be high, but that was secondary to the importance of making the appointment as soon as possible in order to enable the new Director-General, equipped with a clear mandate, to take office as from 1 January.

Dr STEIGER (alternate to Dr Agwunobi, United States of America) said that he too preferred Option 1, Timetable 1A in the belief that a long campaign would paralyse the Organization. He had a strong preference for a special session of the Health Assembly lasting no more than one day, with only one agenda item, namely, the confirmation of the Executive Board’s nominee. Consideration might be given to reducing costs by renting facilities other than the Palais des Nations. His Government would be drawing to the extent possible on its Geneva-based mission for its delegation to the session, and he encouraged other countries to follow suit.

It should be made clear in the Board’s current deliberations that any member of staff of WHO intending to stand as candidate should take leave of absence for the duration of the campaign.

Dr WINT (Jamaica) supported Option 1, Timetable 1A. Unusual circumstances called for unusual responses. Given the ongoing changes within WHO, with the reform process and new budget preparation strategy, it was crucial to shorten the period during which there would be no Director-General at the helm.

Dr SHANGULA (Namibia) requested the Secretariat to provide the Board with an official staffing list of WHO, in particular at the level of the Assistant Directors-General, together with the names of the incumbents. He further requested a written definition – which should also be included in WHO's *Basic Documents* – of the terms “senior officers” and “Secretariat”. Those terms appeared to be open to different interpretations, leading to confusion.

Was WHO facing a crisis or an emergency? The answer would help to determine how the process could be accelerated. Among the implications of the options presented was the question of the suspension of the Rules of Procedure. Recalling the emphasis placed on due process and acting in accordance with the Rules at the Board's special session on 23 May, he was in favour of overriding existing Rules of Procedure only when absolutely necessary and minimum interference would be particularly important during the phase leading to the nomination of a candidate by the Executive Board.

Dr GOMES TEMPORÃO (Brazil) said that, at its special session, the Board had guaranteed sound technical and administrative governance; that had to be ensured. He therefore supported Option 1, Timetable 1A.

Dr KHALFAN (Bahrein) likewise supported Option 1, Timetable 1A.

Dr REN Minghui (China) endorsed the statement made by the member for Namibia. Certain basic principles were involved. Ample time was needed in order to assess the candidates for the post of Director-General. Every effort should be made in order to avoid amending or waiving the Rules of Procedure. The selection process should be efficient, but not unduly protracted. On the basis of past experience, what was the time frame for the Director-General to take office, once the Health Assembly had approved the Board's nomination?

Mr RAMOTSOARI (Lesotho), also supporting the statement made by the member for Namibia, recalled that at the special session of the Board the African position had been that due diligence should be exercised with regard to compliance with the Rules of Procedure of the governing bodies, bearing in mind that, in exceptional circumstances, it might be necessary to amend or suspend those Rules.

Funding ought to be forthcoming to cover the costs indicated in some of the options proposed, and the implementation of programmes should not be affected. Looking to the future, he proposed that consideration should be given to regional rotation for the post of Director-General. He supported Option 1.

Dr GØTRIK (Denmark) agreed to an accelerated process, but emphasized that sufficient time was needed in order to find the right candidate. The process should involve the strictest compliance with the Rules of Procedure. Another important election was to be held in the United Nations system later in the year, and perhaps the two elections should not coincide. He agreed with the member for the United States of America that any extraordinary arrangement should be as inexpensive as possible, and could therefore support Option 1, Timetable 1B or possibly Option 2.

Dr HANSEN-KOENIG (Luxembourg) endorsed the comments made by the previous speaker and associated herself with the statement made by the member for Jamaica. Credit was due to the Secretariat for ensuring that the Health Assembly had proceeded smoothly in such difficult circumstances. WHO needed strong political leadership and a new Director-General should be appointed as soon as possible. She stressed the need to choose the best possible candidate. She would therefore prefer to avoid undue haste and also unnecessary interference with existing Rules of Procedure. She could therefore support Option 1, Timetable 1B, or possibly Option 2.

Dr SUWIT WIBULPOLPRASERT (Thailand) concurred with the view of the member for China on the importance of obtaining information on past experience of the time between the

appointment of the Director-General by the Health Assembly and the beginning of his or her term of office.

Mr AITKEN (Adviser to the Director-General) said that there was no specific rule governing that point. However, a two-month period had usually been observed.

Dr SUWIT WIBULPOLPRASERT (Thailand) said that, in the light of the current unstable global health situation, the impending avian influenza pandemic, and the recent series of natural disasters, a new Director-General should be appointed as soon as possible. However, none of the options proposed would sufficiently accelerate that process. Although he believed that the Rules of Procedure should not in principle be infringed, he agreed that a flexible interpretation could be justified in view of the urgency of the situation. He would thus prefer Timetable 1A, because Timetables 1B or 2 would delay the process considerably. He endorsed the proposal by the member for the United States of America that any candidate from the Secretariat should be requested to leave his or her post during the campaign period in order to ensure transparency.

Dr SHINOZAKI (Japan) agreed that, in order to ensure the stability and proper functioning of the Organization, a smooth and swift transition from Acting Director-General to elected Director-General was essential.

Dr GWENIGALE (Liberia) said that, although certain members who supported Timetable 1A probably already knew who they wished to be elected as Director-General, it was important to examine all the candidates, since political considerations could be involved. He favoured Option 1B, since it did not contravene either Rule 52 of the Rules of Procedure of the Executive Board or Rule 108 of the Rules of Procedure of the World Health Assembly, and would allow the new Director-General to take up office immediately after his or her election.

Mr MIGUIL (Djibouti) strongly favoured Timetable 1A. Acceleration of the election process would lead to better governance of the Organization. Strong leadership and clear vision were needed as the world was faced with a series of pandemics and health crises, and the relevance and sustainability of WHO's actions should prevail over any budgetary considerations.

He urged the Board to draw the appropriate lessons from the power vacuum generated by Dr Lee's demise, which had led to loose interpretations of the Rules of Procedure, and he fully shared the views expressed by the member for Thailand. He endorsed the proposal that there should be rotation between regions at the higher management level, so as to reflect the different, yet complementary, contributions of Member States.

Professor PEREIRA MIGUEL (Portugal) said that there were three key priorities: to choose the best candidate, not to infringe the Rules of Procedure, and to speed up the election process. He supported the option proposed by the member for Namibia.

The CHAIRMAN stressed that no attempt was being made to infringe the Rules of Procedure. The suggestion was rather to modify them if the option selected meant that that was necessary.

Dr TANGI (Tonga) pointed out that Article 31 of the Constitution stated that the Director-General should be appointed by the Health Assembly on the nomination of the Board on such terms as the Health Assembly might determine. There would thus be no need to suspend Rule 108 in that connection. The next Director-General should be in office in time for the January session of the Board, and should be involved in setting the agenda for both the Board's session and the Health Assembly. Timetables 1A and 1B could thus both be envisaged; as the only factor distinguishing the two was the duration of the nomination process, he favoured Timetable 1A.

Dr SINGAY (Bhutan) agreed that the aim should be to select the best candidate. The Organization was indeed facing a crisis. He endorsed the statement made by the member for Thailand. The new Director-General should be actively involved in the preparation of the programme budget and should have extensive knowledge of the General Programme of Work. He too supported Timetable 1A.

Dr JAKSONS (Latvia) associated himself with the views expressed by the members for Denmark and Luxembourg. He doubted whether Board members could complete the process within a two-month period, particularly during the less active season of summer in the northern hemisphere; trying to do so could lead to unexpected problems. Since Timetables 1B and 2 did not present major differences, he opted for Timetable 2.

Mr SHUAAIB (alternate to Dr Al-Shammari, Iraq) expressed support for Option 1, Timetable 1A, which would enhance the role of the Organization in the current difficult situation.

Dr VOLJČ (Slovenia) recalled the crucial question of whether the Organization was experiencing a crisis. If a crisis indeed existed, then speedy action should be taken; if not, the procedure should be normalized and time allowed for all regions and countries to propose their best candidates.

The CHAIRMAN pointed out that the special session of the Board had been convened in order to deal with a crisis, and to solve the problem of the lack of an automatic procedure for the replacement of the Director-General, owing to the absence of a Deputy Director-General. That problem had been resolved, but it was undeniable that an unusual situation, calling for unusual decisions, had arisen.

The meeting rose at 12:30.

SECOND MEETING

Monday, 29 May 2006, at 14:05

Chairman: Dr F. ANTEZANA ARANÍBAR (Bolivia)

1. CONSIDERATION OF THE ACCELERATION OF THE PROCEDURE TO ELECT THE NEXT DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION: Item 9 of the Agenda (Document EB118/20) (continued)

Dr NTAWUKURIRYAYO (Rwanda) noted that the existing rules for the replacement of the Director-General were inadequate and an accelerated process was needed for good governance and effectiveness, particularly in the areas of budgetary and administrative management. He therefore supported Timetable 1A, which would ensure that the appointment was made as soon as possible. He also supported the proposal by the member for Namibia that the post of Director-General should be rotated among the various regions.

Professor AYDIN (Turkey) said that Timetable 1A appeared to be the best solution, but expressed concerns about the suspension and possible infringement of the Rules of Procedure. Would Timetable 1A infringe Article 31 of the Constitution? Although Timetable 3 was a safer option, it would not help to resolve the matter. Accordingly, he preferred Timetable 2.

Mr BURCI (Legal Counsel) said that both Rule 53 of the Rules of Procedure of the Executive Board and Rule 122 of the Rules of Procedure of the World Health Assembly provided for suspension of the Rules in specific circumstances, on condition that advance notice was given. Accelerating the process for the election of the next Director-General would not therefore be a breach of the Rules of Procedure.

Ms HALTON (Australia) said that confidence in WHO was paramount if global health was to be improved and health crises such as that caused by the recent earthquake in Indonesia were to be handled effectively. People around the world were becoming increasingly nervous as a result of the health threats posed by avian influenza and bioterrorism. A crisis of confidence or a constitutional crisis could arise from a lack of clarity as to how to proceed, given the absence of specific guidance in the Constitution and Rules of Procedure. A loss of confidence in WHO could affect its delivery of vital services and have an economic impact that made it unable to do its job. Accordingly, procedures had to be clarified not only for the current situation but also for the future. The Board would be failing in its responsibilities if it did not set out procedures for dealing with the current and with future situations.

In the current case, the Board must decide on a desired outcome and time frame. It must plan around the meetings of the regional committees, budgetary meetings and its own session in January 2007. It must consider the practical implications of the appointment process. There was no possibility of appointing a Director-General before the meetings of the regional committees, and there might even be some slippage with regard to the budgetary meetings, but the Board would be remiss if it failed to nominate a Director-General by its session in January 2007. Clearly, Member States would need time to consider candidates' credentials thoroughly, especially as imminent summer holidays in the northern hemisphere might cause delays. Nonetheless, opting for Timetable 3 would be a breach of the Board's responsibilities. Timetable 2 would be too slow because it might take two months for a new Director-General to take up his or her post. Timetable 1A might not give some countries enough time to look at candidates' credentials. Timetable 1B might make it difficult to have the Director-General in place in time. If the Board wished to nominate the best candidate possible, it must

accept that the nominee would need a certain interval before taking up the post. She asked, therefore, whether there might be a compromise solution that fell somewhere between Timetable 1A and Timetable 1B. For instance, if the next session of the Board and the Health Assembly were convened in early November, the new Director-General would have two months in which to take up the post.

The CHAIRMAN commented that holidays might have to take second place when it came to considering candidates for such an important post.

Dr KAKAR (Afghanistan) noted that members' preferences were guided by various considerations, such as the concern not to infringe Rule 52 and the need for sufficient time to identify the best candidate. The public interest, however, demanded that a new Director-General should be appointed as soon as possible. He favoured Timetable 1A but could support the compromise solution proposed by the member for Australia. He also supported the proposal that consideration should be given in the selection process to regions from which a Director-General had so far not been appointed.

Dr SAHELI (Libyan Arab Jamahiriya) said that global health needs arising from natural disasters, conflict and epidemics made it essential to accelerate the selection process. Like most members of the Board, he preferred Timetable 1A and felt that a period of eight to nine weeks was sufficient to conduct the process.

Mr AITKEN (Adviser to the Director-General), referring to the financial implications outlined in document EB118/20, said that there were two possible locations for the proposed special session of the Health Assembly, namely the Palais des Nations and the International Conference Centre, Geneva. The Swiss Government would not charge for the use of the Centre, but it would not be available on all the dates proposed in the various timetables. The cost of using the Palais des Nations would be US\$ 30 000.

It was the practice for WHO to pay the travel costs of delegations from the least developed countries. The cost for all 50 such countries would be US\$ 180 000, but if the 35 of those countries with missions in Geneva chose to be represented by their missions, the cost would be only US\$ 60 000. The Secretariat had proposed the dates of October for Timetable 1A and December for Timetable 1B, but it might be possible for the special sessions to take place in November. The special session of the Health Assembly would be held on a Thursday, to follow the Board's session held from Monday to Wednesday. It had been ascertained that both the Palais des Nations and the Conference Centre would be available on Thursday, 2 November and Thursday, 9 November.

Dr GWENIGALE (Liberia) said that the West African countries, which had to contend with transportation and communication difficulties, favoured Timetable 1B. However, he would not oppose a November session of the Board and the Health Assembly.

The CHAIRMAN said that there was agreement, first, that WHO must secure the best possible candidate for the post of Director-General, and secondly that such a candidate should be appointed as soon as possible. The new Director-General would have to be in place before the Board session in January 2007 in order to lead the programme budget process. Clearly, he or she would not be appointed in time for the Regional Committee meetings in September 2006. That narrowed the options down to Timetable 1A, Timetable 1B or some other alternative, such as that proposed by the member for Australia, which would reconcile the various interests involved. He suggested, therefore, that the Board consider a "Timetable 1A Plus" that would enable the best possible candidate to be appointed following the Board's consideration of candidates at the most appropriate time, the objective being to have a new Director-General in place by January 2007.

Dr STEIGER (alternate to Dr Agwunobi, United States of America) said that that compromise seemed to be good. The nomination period would begin on 1 June 2006 and continue until the end of September. The special session of the Executive Board could be held from 6 to 8 November, followed

by the special session of the Health Assembly on 9 November. For financial reasons, he would prefer that the latter take place at the International Conference Centre, Geneva.

Dr GØTRIK (Denmark) endorsed that proposal, but queried whether the Board would need to meet for three days when two days might be sufficient.

Dr SHANGULA (Namibia) observed that the Board was discussing a further option, “Timetable 1A Plus”, that did not exist in writing. Since all the other options and their financial implications had been submitted in writing, the same procedure must be followed with the latest proposal. He preferred Timetable 1B, which would involve the least disruption of the Rules of Procedure and at the same time allow sufficient time for candidates’ credentials to be considered and for a consensus to be reached on the best candidate for nomination.

Mr AITKEN (Adviser to the Director-General) said that the cost of the proposed “Timetable 1A Plus” would be the same as that of Timetables 1A and 1B. Written information about the intermediate timetable, together with a draft resolution for the Board’s consideration, would be available the following morning. The Board was likely to need a full three days of meetings for the election process, as it would have to agree on a shortlist of candidates, decide how they were to be interviewed and conduct the election itself.

Mr MIGUIL (Djibouti) asked whether the elections could take place at the end of October, since many important meetings were scheduled for the beginning of November.

The CHAIRMAN said that members would have to decide which of the many calls on their time was the most important.

Dr SUWIT WIBULPOLPRASERT (Thailand) agreed to join the consensus on the intermediate timetable, although he would have preferred the election to take place sooner.

The CHAIRMAN said that, if he saw no objection, he would take it that the Board wished to postpone further consideration of the procedure for electing a new Director-General until the following morning, when information about the proposed intermediate timetable and a draft resolution would be available in writing.

It was so agreed.

(For adoption of the resolution, see summary record of the third meeting, section 2.)

2. DEPUTY DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION: Item 10 of the Agenda (Document EB118/19)

The CHAIRMAN explained that the item had been added to the agenda in order to clarify the status of the Deputy Director-General.

Dr SHANGULA (Namibia) recalled that at the previous meeting he had asked for information in writing about the number of posts at Assistant Director-General level and above, and the number of them that were currently vacant. He still needed that information.

Mr AITKEN (Adviser to the Director-General) listed the names and countries of origin of all staff at Assistant Director-General level and above, namely the Assistant Directors-General, including

himself, and the Regional Directors. The Acting Director-General had previously been Assistant Director-General for General Management.

Dr SHANGULA (Namibia) asked which post Dr Nordström formally occupied at present.

Mr AITKEN (Adviser to the Director-General) said that Dr Nordström's formal position was that of Acting Director-General, which he had assumed on 22 May 2006. The Board had confirmed the appointment on 23 May.

The ACTING DIRECTOR-GENERAL said that in the light of his current position he would not continue to exercise the functions of Deputy Director-General.

Following a query by Dr STEIGER (alternate to Dr Agwunobi, United States of America), Mr AITKEN (Adviser to the Director-General) explained that legally Dr Nordström still occupied the post of Deputy Director-General. If it was deemed necessary for someone to exercise the functions of the occupier of that post, another staff member would have to be designated to act in Dr Nordström's place. However, the current situation was unique in that, when a new Director-General was appointed, Dr Nordström would revert not to the position of Deputy Director-General but to his original post of Assistant Director-General.

Dr KHALFAN (Bahrain) asked whether an acting Assistant Director-General had been appointed.

The ACTING DIRECTOR-GENERAL said that three of his senior staff would exercise the function of acting Assistant Director-General, General Management, on a rotational basis.

Dr SUWIT WIBULPOLPRASERT (Thailand) asked what salary the Acting Director-General would receive.

Mr AITKEN (Adviser to the Director-General) said that, after three months, the Acting Director-General would receive the same salary as the Director-General, which was standard practice for any staff member acting in place of another. Until then, he should receive the salary of a Deputy Director-General. However, the salary of the Deputy Director-General had not been reviewed since 1998 and the last available figure was lower than that of an Assistant Director-General. Dr Nordström would therefore continue to receive the salary of an Assistant Director-General for that three-month period. It was expected that the Health Assembly would decide on the salary of the Deputy Director-General at its next session in May 2007, and adjust Dr Nordström's salary retroactively.

Dr SUWIT WIBULPOLPRASERT (Thailand) said that, if Dr Nordström was Deputy Director-General, he should receive the salary for that post, even if it was lower than his previous one.

Dr GWENIGALE (Liberia) pointed out that not all members of the Board had accepted Dr Nordström's assumption of the position of Deputy Director-General. Personally, he considered Dr Nordström to be an Assistant Director-General acting as Director-General.

Replying to a question from Dr TANGI (Tonga), Mr AITKEN (Adviser to the Director-General) said that, as stated in paragraph 8 of document EB118/19, the salary of the Deputy Director-General had traditionally been set at the same level as that of an Under-Secretary-General of the United Nations. However, the Health Assembly would need to take a formal decision to that effect.

Dr STEIGER (alternate to Dr Agwunobi, United States of America) agreed with the member for Thailand that, if Dr Nordström was Deputy Director-General, he should receive the salary for that post, and not be awarded a higher salary.

However, he did not support the view expressed by the member for Liberia. The Executive Board could not challenge the late Dr Lee's designation of his deputy: its mandate was to appoint an Acting Director-General.

Mr AITKEN (Adviser to the Director-General) said that a staff member drawing a certain salary generally continued to be entitled to that salary even if he or she later took up a post at a lower level, unless he or she had been demoted because of misconduct.

Mr BURCI (Legal Counsel) confirmed that it was the prerogative of the Director-General to appoint his or her deputy. Under Rule 113 of the Rules of Procedure of the World Health Assembly, the Executive Board appointed the Acting Director-General.

Mr AITKEN (Adviser to the Director-General), in reply to a question by Dr KHALFAN (Bahrain), explained that Dr Nordström's responsibilities as Acting Director-General and Deputy Director-General would cease on the appointment of a new Director-General, and that he would then revert to his post of Assistant Director-General with responsibility for General Management, as indicated in the late Director-General's memorandum.

Mr SHIRALIYEV (Azerbaijan) said that it was fitting that Dr Nordström should receive the benefits of the post of Deputy Director-General while he was officially in that post. Consideration should also be given to his remuneration as Acting Director-General. Would there be a post of Deputy Director-General after the new Director-General had been appointed, and would such an appointment be at the discretion of the Director-General?

Dr TANGI (Tonga), recalling the terms of the late Director-General's memorandum¹ and drawing attention to Regulation 4.5 of the Staff Regulations, which referred to the appointments and terms of office of the Deputy Director-General, Assistant Directors-General and Regional Directors, said that it was important for the Board to take all aspects into account in reviewing the various procedures involved.

Dr FRENK (alternate to Mr Bailón, Mexico) remarked that the discussions at the current session and the special session had illustrated the need for an in-depth review, not only to clarify the present situation but also to determine what revisions were needed to remove any doubts and ambiguities in the relevant rules and regulations. He proposed that a working group should be established to clarify the definitions and procedures involved, so that the Organization could act more efficiently and with greater certainty in the future.

The ACTING DIRECTOR-GENERAL welcomed that proposal and suggested that the Secretariat might be requested to undertake such a review, which would include all relevant aspects of the situation that had arisen over the past week, including those pertaining to the post of Deputy Director-General, and to prepare a report for consideration by the Programme, Budget and Administration Committee of the Executive Board and subsequently by the Board at its session in January 2007.

Mr AITKEN (Adviser to the Director-General) confirmed the feasibility of that procedure.

Dr KHALFAN (Bahrain) said that a serious consideration should be whether the appointment of a Deputy Director-General should become mandatory or be left to the discretion of the Director-General.

¹ Document EBSS/2.

The CHAIRMAN proposed that the Board should proceed as suggested by the Acting Director-General. However, it would be necessary to coordinate the review with the procedures adopted for the selection of a new Director-General.

It was so agreed.

In reply to a question from Mr MIGUIL (Djibouti), the CHAIRMAN gave an assurance that all relevant aspects, including the earlier suggestion that nominations for the post of Director-General should be subject to regional rotation, would be taken into account during the review.

3. TECHNICAL AND HEALTH MATTERS: Item 5 of the Agenda

Control of leishmaniasis: Item 5.1 of the Agenda (Documents EB118/4 and EB118/4 Add.1)

Dr KAKAR (Afghanistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that several different forms of leishmaniasis occurred in 21 of those 23 countries. There were regular severe outbreaks of anthroponotic visceral leishmaniasis in Somalia and Sudan with high mortality resulting from the difficulties of reaching people in affected areas and the high cost of diagnostic tools and medicines. Anthroponotic cutaneous leishmaniasis, caused by *Leishmania tropica*, was the second most important form of the disease in the Region, particularly in Afghanistan, the Islamic Republic of Iran, northern Pakistan and the Syrian Arab Republic. Since there was no effective preventive strategy for reducing or preventing transmission, control was limited to case detection and treatment, which constituted a heavy burden for health systems. Regular outbreaks of zoonotic cutaneous leishmaniasis occurred in desert zones across the Region and were usually the result of explosions in the population of the rodent reservoir in rainy years or after water resource development projects. Zoonotic visceral leishmaniasis, with a reservoir in dogs, occurred in 18 Member States in the Region. The sporadic pattern of human disease made it difficult to develop cost-effective prevention strategies.

He supported adoption of the draft resolution in the report and stressed initiatives to reduce the prices of medicines. He commended the UNICEF/UNDP/World Bank/WHO Special Programme on Research and Training in Tropical Diseases for its promotion of new and affordable diagnostic and treatment tools. More field research was needed in affected areas in order to improve understanding of the ecology of the various *Leishmania* species and to develop cost-effective preventive strategies. Leishmaniasis deserved a more structured programme at the global level, with more ambitious long-term targets, given that there was no immediate prospect of any reduction in the transmission or burden of leishmaniasis.

Dr SHANGULA (Namibia) recalled that his country, in its statement made to the plenary of the Fifty-ninth World Health Assembly on behalf of the Member States of the Southern Africa Development Community, had argued for the development of appropriate and affordable technologies in order to combat neglected tropical diseases, including leishmaniasis. The report gave possibly undue emphasis to the association between leishmaniasis and HIV infection, providing little evidence; it was not clear whether persons who were HIV-positive were more susceptible to leishmaniasis or whether the association was coincidental. Moreover, countries where leishmaniasis was endemic were those with the lowest HIV prevalence rates. Leishmaniasis was a disease in its own right that had occurred long before the advent of HIV.

Supporting the draft resolution, he proposed that in the third preambular paragraph, the word “new” should be inserted before “cases”. The seventh preambular paragraph should be deleted, as should the words “bearing in mind the baseline status of malnutrition and HIV” in paragraph 1(4). Current research focused mainly on treatment and management of leishmaniasis. In order to give more emphasis to vector control, a new subparagraph should be inserted in paragraph 1(7) to read

“(a) identify appropriate and effective methods of vector control” and the existing paragraphs should therefore be renumbered. In the new paragraph 1(7)(b), “cheap” should be replaced by the more appropriate word “affordable”.

Professor PEREIRA MIGUEL (Portugal), supporting the draft resolution, said that human serological studies in endemic regions were expensive and not always cost-effective. The epidemiological assessments called for in paragraph 1(4) should therefore be multidisciplinary and seek to identify reservoirs of infection and determine the proportion of contaminated vectors in the areas surveyed. Difficulties arose mainly from the lack of access to health services and from non-adherence to treatment, which facilitated the development of drug resistance. Campaigns should be conducted in order to increase public awareness of leishmaniasis.

Dr PHUSIT PRAKONGSAI (adviser to Dr Suwit Wibulpolprasert, Thailand) said that cases of leishmaniasis had been reported by 33 countries. However, inconsistencies between reports from WHO and the Infectious Disease Research Institute (Seattle, Washington, United States of America) on the number of people at risk or infected confirmed the lack of reliable data for estimating the magnitude and impact of the disease, although the figures were clearly substantial.

Leishmaniasis was not included on the list of notifiable communicable diseases in Thailand, where only three cases had been detected since 1966. However, capacity for prevention and control of the disease was limited. His country was therefore strengthening surveillance of both humans and the sandfly vector, and undertaking field research on sandfly ecology and incidences of infection in the human population at risk and the animal reservoir.

The fact that the rapid diagnosis test and first-line treatment, costs for which were quoted in the report as US\$ 1-3 and US\$ 30-150, respectively, had to be administered in hospitals was an obstacle to access, since prevalence of the disease was highest in rural areas with peripheral health centres of only limited capacity. An alternative prevention method was the use of insecticide-impregnated bednets, which cost US\$ 5 per unit and lasted for five years.

WHO and the Infectious Disease Research Institute had collaborated in clinical trials of a therapeutic vaccine in Brazil, Colombia and Peru. Leishmaniasis should therefore be included as one of the neglected diseases that required a strategic plan of action, and should be referred to the intergovernmental working group to be established in pursuance of resolution WHA59.24 on public health, innovation, essential health research and intellectual property rights in order to draw up a global strategy and plan of action in that respect.

He proposed 12 amendments to the draft resolution, which he would submit in writing.

Dr STEIGER (alternate to Dr Agwunobi, United States of America) suggested that the report should be revised before submission to the Sixtieth World Health Assembly in order to include information on therapeutic vaccines and prophylactic vaccination as part of a control strategy for cutaneous leishmaniasis, which had proved effective in parts of South America and Africa. Also, the importance of the development of immune-based therapies for treating patients with visceral leishmaniasis needed emphasis; current medicines reinforced immune responses in them, but worked only poorly in those coinfecting with HIV. He was confident that the WHO Advisory Expert Panel for Leishmaniasis would provide sufficient guidance on a policy framework for leishmaniasis control, and that it should not be necessary to establish a global task force as called for in the draft resolution. However, he supported the suggestion by the member for Thailand that leishmaniasis should be considered by the intergovernmental working group.

The draft resolution should be amended by replacing the sixth preambular paragraph with “Noting the burden that treatment can place on families;”. In paragraph 1(6), “lower drug pricing” should be replaced by “advocate for high-quality and affordable drugs”. He supported the amendment to paragraph 1(7) proposed by the member for Namibia, and further proposed the addition of the words “safe, effective” after the word “alternative” in existing paragraph 1(7)(a). In paragraph 3(4), the words “set up a global task force in order to determine priorities and” should be deleted, and

paragraph 3(5) should be amended to read “to promote research pertaining to leishmaniasis control and the dissemination of the findings of that research”.

Dr GØTRIK (Denmark) pointed out that, although action on leishmaniasis was needed in some Member States, it was not a public health problem for all. The draft resolution might therefore be amended so that the action called for in paragraphs 1(1) to 1(5) was aimed at Member States where leishmaniasis was a substantial public health concern. He supported the draft resolution, but emphasized the need to take its financial implications into account, bearing in mind that the Board would have to consider how to change priorities from communicable diseases to noncommunicable diseases in discussing the budget.

The CHAIRMAN pointed out that document EB118/4 Add.1 contained details of the administrative and financial implications of the draft resolution.

Dr AL-SHAMMARI (Iraq) said that leishmaniasis remained a health concern in his country, particularly for children under five years of age. Although the number of people with visceral leishmaniasis had fallen from 2448 in 2004 to 2048 in 2005, the number of cases of cutaneous leishmaniasis had risen from 2137 to 2538 in the same period. The Ministry of Health was making efforts to fight the disease and screen for it on a regular basis. Two rounds of treatment were provided annually, in the spring and the autumn, with care being provided throughout the summer. Insecticides were also used in an effort to control the disease and medication was provided free of charge where needed. He supported the draft resolution.

Dr GOMES TEMPORÃO (Brazil) said that, in view of the spread of visceral leishmaniasis and its changing epidemiological profile in the Region of the Americas and the diversity of the *Leishmania* species, surveillance of cutaneous and human visceral leishmaniasis should take into account the different clinical, laboratory and epidemiological aspects. In the light of recommendations made at an expert consultation on visceral leishmaniasis in Brazil in 2005, a sustainable approach to leishmaniasis control and surveillance for continued research was needed. Given Brazil's experience of research into alternative antileishmanial agents and serological diagnostic methods, he proposed that the words “and define appropriate doses and duration of therapy schedules for these medicines” should be added at the end of paragraph 1(7)(a) of the draft resolution, and that two new subparagraphs should be added that would read: “(c) evaluate and improve sensitivity and specificity of serological diagnostic methods for canine and human visceral leishmaniasis, including standardization and effectiveness evaluation;” and “(d) evaluate effectiveness of alternative control measures such as the use of bednets impregnated with long-lasting insecticide”.

Dr SHINOZAKI (Japan) acknowledged that leishmaniasis was a serious problem, particularly in Africa. Many difficulties remained, such as lack of appropriate epidemiological data, and unsatisfactory access to prevention, treatment and care. He supported the draft resolution, with the amendments proposed.

Dr HANSEN-KOENIG (Luxembourg) said that she would welcome action on leishmaniasis, which should be a public-health priority. There should be close coordination with the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases in order to avoid duplication of efforts and ensure optimum use of limited financial resources. As the Director-General was requested to draft guidelines on prevention and management of leishmaniasis in paragraph 3(2) of the draft resolution, she asked whether the establishment of a global task force, referred to in paragraph 3(4), was necessary.

Dr FRENK (alternate to Mr Bailón, Mexico) expressed support for the draft resolution, as amended. An epidemiological surveillance system for leishmaniasis was in place in Mexico, providing for notification of the disease in all its clinical forms. It was difficult for countries where the

prevalence of the disease was low, such as his own, to produce medicines locally. Leishmaniasis was a high-priority disease for which collective action through WHO, in order to ensure access to high-quality, safe and effective medicines, including for low-prevalence countries, should be clearly stated.

Dr VOLJČ (Slovenia) said that, although leishmaniasis was not a public health concern in his country, there should be no adverse financial implications if the global task force was not established, and that the funds earmarked for controlling leishmaniasis itself would not be reduced.

Ms CAÑAVATE CAÑAVATE (Spain)¹ said that, in view of the high cost of the medicines and the fact that the disease was often to be found in remote areas, appropriate treatment was often delayed, increasing morbidity and mortality and thus further impoverishment. Confection with HIV was a serious emerging public health problem that had begun in the endemic countries of southern Europe and extended to some 34 countries, most of which were developing countries. Spain, as an endemic country, had proposed that the topic should be included on the Board's agenda, and had recently approved a donation of US\$ 2.5 million for WHO to strengthen action against leishmaniasis in Ethiopia and Sudan.

Dr CHAN (Assistant Director-General) acknowledged the sound advice and guidance. The Department of Control of Neglected Tropical Diseases had been established by the late Director-General in order to place greater emphasis on diseases that affected the poorest of the poor. Efforts would be made to ensure synergy between relevant programmes, and to ensure optimum use of limited resources. She welcomed the strong support for the draft resolution and the amendments proposed.

The CHAIRMAN said that the item would be left open until the following day when the text of the amended draft resolution would be available.

(For adoption of the resolution, see summary record of the fourth meeting, section 2.)

Thalassaemia and other haemoglobinopathies: Item 5.2 of the Agenda (Documents EB118/5 and EB118/5 Add.1)

Dr KHALFAN (Bahrain), speaking on behalf of the Member States of the Eastern Mediterranean Region, expressed support for the draft resolution contained in document EB118/5. The prevalence of blood disorders varied greatly across the Region, ranging from 5% in countries of the Gulf Cooperation Council to 27% of the population in the eastern province of Saudi Arabia. In most countries where sickle-cell anaemia was a major concern, its management was inadequate, national control programmes had not been established, and there was a lack of reliable epidemiological data. However, the disease was preventable. Pre-marital detection was particularly important where consanguinity rates were high. Bahrain and Saudi Arabia had made pre-marital screening mandatory; other countries in the Region should do likewise. In Cyprus, Greece and Italy, countries where pre-marital screening was promoted and where couples most at risk were identified before their first pregnancy, the number of children born with blood disorders had fallen by at least 75%. WHO must set strategies for genetic population screening, bearing in mind social and religious reservations about interventions during pregnancy.

The draft resolution was comprehensive, but the Eastern Mediterranean countries would find it challenging to implement all the actions proposed, as would most developing countries, owing to poor infrastructure and a lack of clear policies and strategies. The Region sought support in order to tackle

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

sickle-cell anaemia at primary care level; to elaborate guidelines and cost-effective national policies for the prevention and care of blood disorders; to promote cooperation between WHO Collaborating Centres and institutions in the area of blood diseases; and to strengthen prevention and control programmes for blood disorders of public health importance.

Dr SADASIVAN (Singapore) said that thalassaemia was the most common genetic disease worldwide, occurring in some 60 countries, including Singapore. His country recognized the threat that the disease posed to future generations, and had established a national thalassaemia registry. Screening was recommended for pregnant women, especially those found to be anaemic, and any pregnant woman found to be a carrier was referred to the national thalassaemia registry for further screening of family members and genetic counselling. Rates of thalassaemia had declined significantly in Singapore over the previous decade, the incidence of beta-thalassaemia major having fallen to 0.05 per 1000 live births from 0.14 per 1000 live births in 1987. He supported the draft resolution, which would help to highlight the importance of national policies that addressed hereditary diseases and ensure good health for future generations.

Dr RAHANTANIRINA (Madagascar) said that thalassaemia was a public health concern in the developing countries, particularly in Africa, where it was difficult for patients to access health-care services and treatment was often prohibitively expensive. Action should focus on prevention, while respecting individual autonomy, the right to appropriate and full information, and confidentiality. Diagnosis and treatment helped to lessen risks, and should be integrated at the primary health-care level in order to reach as many people as possible. Furthermore, world leaders should make more funds available for genetics, and national, regional and global partnerships should be developed to allow developing countries equal access to treatment. She supported the draft resolution.

Mr DE SILVA (Sri Lanka) said that there were about 2000 reported cases of thalassaemia in Sri Lanka. As the positive experience of other countries such as Cyprus and Singapore had shown, prevention, rather than treatment, was the key to success. National governments had a social responsibility to provide those suffering from thalassaemia with the necessary medication to enhance their quality of life. Unfortunately, that was often expensive, owing to the monopoly in the pharmaceutical industry. Supporting the draft resolution, he proposed that the text might be amended in order to indicate that WHO should promote research into the disease, and establish a public/private partnership with the pharmaceutical industry in order to ensure that the necessary medicines were made available at an affordable price.

Dr AL-SHAMMARI (Iraq) said that thalassaemia and haemoglobinopathies were genetic diseases for which prevention was preferable to treatment. Until a gene map was available that would allow a cure for such conditions to be found, efforts should be concentrated on prevention in view of the complications often involved in treatment. Prevention meant educating populations about the risks of intermarriage and identifying carriers through haemoglobin electrophoresis so that marriages between them could be avoided. The issue was complicated, requiring proper social and medical support.

Ms VALDEZ (alternate to Dr Agwunobi, United States of America), commenting on the ongoing scientific and ethical debate on the subject, said that community education, population screening, genetic counselling and early diagnosis were an effective part of any treatment strategy. In her country, targeted screening was available for haemoglobinopathies, including a simple blood test for sickle-cell anaemia on all neonates, using blood from samples taken for other routine tests. All Member States should adopt similar screening policies, based on the prevalence of disease in their populations or subpopulations, as resources permitted. Integrating educational, non-prescriptive, voluntary genetic counselling into primary health-care settings could be an effective way of reaching the general public. In countries with limited resources, local authorities should determine the

feasibility of training all medical staff, as called for in the draft resolution, taking into account other competing training priorities.

In areas of high prevalence, screening programmes and public education programmes should be available to inform individuals of their potential to pass on the diseases. In cases of prenatal diagnosis of haemoglobinopathies, ethical considerations should come first. She expressed concern that national programmes promoting carrier screening might be stimulating social change towards overall greater acceptance of pregnancy termination. The United States was at the forefront of genomics and biomedical research into the treatment and prevention of genetic diseases and associated congenital malformations. Incentives should be introduced in order to encourage the development of appropriate treatment. As indicated in the report, there were several problems with current methods of treatment which necessitated increased investment in targeted clinical research.

Revision of the report should give more attention to aspects such as the need for effective blood-safety surveillance programmes in order to prevent the spread of blood-borne illnesses among thalassaemics, and for substantive recommendations in order to prevent treatment complications and secondary conditions associated with thalassaemia.

In the draft resolution she proposed that the words “insufficiency of relevant epidemiological data” should be replaced by “insufficient epidemiological data” in the fourth preambular paragraph; that the word “officially” should be deleted from the fifth preambular paragraph; that the words “the current inequality worldwide” should be replaced by “the current worldwide lack of” in the sixth preambular paragraph; and that the words “particularly prenatal screening” should be inserted after “haemoglobinopathies” in the last preambular paragraph. The words “and support” should be deleted from paragraph 2(3); paragraph 2(4) should end with the word “haemoglobinopathies” and the remainder of the text should be deleted; and the words “support and coordinate” should be deleted from paragraph 2(5).

Professor AYDIN (Turkey) said that haemoglobinopathy was a major disease burden for public health in his country. Around 2.1% of the population, some 1.3 million people, were estimated to carry the beta-thalassaemia gene, and there were around 4000 patients with the condition. Turkey had initiated haemoglobinopathy control programmes in 27 provinces, and there were plans to extend coverage to 33 provinces where a high proportion of the population was at risk of thalassaemia. The programme’s main aims were genetic counselling, public education, carrier screening and termination of pregnancies, if necessary, along with providing a better quality of life for sufferers. By the end of 2005, 70% of couples were being screened before marriage in provinces where the programme had been established. To implement its goals, Turkey was establishing centres with the capacity to develop approaches to prevention and treatment. He expressed full support for the draft resolution.

Professor PEREIRA MIGUEL (Portugal), expressing a particular interest in the issues of health and migration as related to haemoglobinopathies, said that it was particularly important to focus on prevention, since carrier screening stimulated social changes. Portugal, with WHO support, had been operating a national programme for the control of haemoglobinopathies since 1984. Its current priority was better integration of control measures into primary health care, and its strategic goals included improving the quality of genetic services, creating conditions for the certification of genetic laboratories, particularly those targeting prenatal diagnosis, and establishing protocols for proven and cost-effective treatment. He expressed full support for the draft resolution.

Dr SHINOZAKI (Japan) recalled the regional characteristics of haemoglobinopathies; as a major cause of death in African and Asian countries was infectious disease, the importance of haemoglobinopathies was often overlooked. In an age with a high level of international interaction, however, the possibility of hereditary diseases spreading all over the world could not be denied. The report should act as a catalyst for WHO, other international organizations and donor countries to recognize the problem in countries affected. He supported the draft resolution.

Mr RAMOTSOARI (Lesotho), observing that haemoglobinopathies were a major problem for Africa, expressed support for the draft resolution, but suggested that the wording of paragraph 1(7) should read: “to provide support for basic and applied research on thalassaemia, in collaboration with international organizations;”.

Dr PHUSIT PRAKONGSAI (adviser to Dr Suwit Wibulpolprasert, Thailand) said that thalassaemia was a significant health problem in Thailand, with more than 500 000 cases in 2005 and some 12 000 affected births every year. There was a high prevalence of both alpha- and beta-thalassaemia, particularly in the northeast of the country, and the various combinations of defective genes could lead to more than 60 thalassaemia syndromes, ranging in severity from asymptomatic conditions to fatal diseases. All regions had centres offering prenatal diagnosis and prevention and control programmes for pregnant women. Efforts had been made by governmental and nongovernmental organizations to provide better care for thalassaemic patients and to promote prevention and control. Thailand's comprehensive thalassaemia control strategy comprised several approaches, including educating people about the disease, screening, providing genetic counselling and family planning, detecting couples at risk and providing prenatal diagnosis. A simple screening tool had been used at community level and success had been achieved in early detection through cooperation between health volunteers and health-care providers at district level.

Knowledge of the cost-effectiveness of interventions was crucial for making informed and strategic decisions that would lead to improvements in preventing and controlling thalassaemia and other haemoglobinopathies. Such information could be used by all Member States, particularly developing countries in order to plan and implement effective and efficient policies. All WHO regions were affected by haemoglobinopathies and, although there was an annual International Thalassaemia Day (8 May), he suggested adding a new paragraph 2(6) to the draft resolution that would read “to consider having a World Health Day on haemoglobinopathy diseases such as thalassaemia and sickle-cell anaemia in the near future”, in order to raise awareness and ensure political support for longer-term solutions to the problem.

Ms VALDEZ (alternate to Dr Agwunobi, United States of America) clarified that she supported the draft resolution on the understanding that nothing contained in it either advocated or supported abortion as a means to prevent or control thalassaemia and other haemoglobinopathies.

Mr SHIRALIYEV (Azerbaijan) attached great importance to the question of haemoglobinopathies, since around 80% of Azerbaijan's population carried the gene. He supported the Secretariat's programme for treatment and care and emphasized the role of WHO and nongovernmental organizations in tackling the problems. Azerbaijan was already creating a national thalassaemia centre in order to provide prophylactic treatment for those disorders. However, care of patients with the disease was also important, and an act had been passed in 2005 establishing the organizational and legal basis for State support and regulated treatment and prevention issues, ensuring that diagnosis and treatment for patients with inherited blood disorders would be financed from the State budget. Parliament had also passed an act on safe blood containing measures to phase out remuneration for blood donations.

The CHAIRMAN emphasized the importance of the Board's discussion, which enabled members to learn from the experience of others and reflected the technical nature of the Organization's work. In response to the concerns expressed by the member for the United States of America, he confirmed that nothing in the draft resolution or in the Board's discussion conveyed any implication with regard to abortion.

Dr LE GALÈS-CAMUS (Assistant Director-General) welcomed the indications for future work, including the need for better epidemiological data and for public health policies not only to take account of prevention, early detection, treatment and general management of the disease but also to respect the social and religious values of communities. The importance of research in order to improve

the situation for sufferers and at-risk groups had been noted. If the draft resolution were adopted by the Health Assembly, the Secretariat would suggest that its implementation should be closely linked to that of resolution WHA59.20 on sickle-cell anaemia in order to maximize synergy and efficiency.

Dr KEAN (Executive Director, Office of the Director-General) said that it had been proposed that in the fourth preambular paragraph “insufficiency of epidemiological data” should be amended to read “insufficient epidemiological data”; in the fifth preambular paragraph, the word “officially” should be deleted; in the sixth preambular paragraph “inequality” should be deleted and “lack of” inserted after “worldwide”; in the last preambular paragraph, “particularly prenatal screening” should be inserted after “haemoglobinopathies”; in paragraph 1(7), the two phrases should be inverted; in paragraph 2(3), “and support” should be deleted after “promote”; in paragraph 2(4) the entire text after “haemoglobinopathies” should be deleted; in paragraph 2(5) “support and coordinate” should be deleted. A new subparagraph 2(6) had also been proposed, that would read: “2(6) to consider having a World Health Day on haemoglobinopathy diseases, such as thalassaemia and sickle-cell anaemia, in the near future”. Sri Lanka’s proposal might best be incorporated into paragraph 2(1), by inserting “and to drugs” after “health services”.

The CHAIRMAN invited the Board to adopt the draft resolution, as amended.

The resolution, as amended, was adopted.¹

The meeting rose at 17:30.

¹ Resolution EB118.R1.

THIRD MEETING

Tuesday, 30 May 2006, at 09:05

Chairman: Dr F. ANTEZANA ARANÍBAR (Bolivia)

1. TECHNICAL AND HEALTH MATTERS: Item 5.3 of the Agenda (continued)

Rational use of medicines: progress in implementing the WHO medicines strategy (Documents EB118/6 and EB118/6 Add.1)

The CHAIRMAN drew attention to the progress report and the draft resolution therein.

Dr WINT (Jamaica) said that the report highlighted the large sums that countries spent on essential medicines. Countries like Jamaica, with no manufacturing capacity, had to find scarce foreign exchange in order to import most of their medicines. His Government had implemented many of the strategies suggested in the report. Registration and surveillance systems had been established, a national formula had been devised in order to limit the number of pharmaceuticals available to prescribers, and legislation had been enacted that required pharmacists to offer generic substitutes. Nevertheless, physicians were often influenced by representatives of the pharmaceutical industry and the small amount that countries invested in training and continuing education was not enough to change the situation. In Jamaica, reviews of the patterns of use of medicines had been introduced: prescriptions were examined and doctors informed of the findings of the survey. The results had thrown light on some irrational prescribing practices. However, consumer expenditure on over-the-counter medicines exceeded the amount spent on prescribed medicines and such sales were subject to minimal controls. Because of insufficient investment in patient education, consumers were often unduly influenced by advertising campaigns organized by the pharmaceutical companies. The topic was vital, and he supported the draft resolution.

Mr IWABUCHI (alternate to Dr Shinozaki, Japan) stressed the importance of the rational use of and access to medicines, as well as ensuring their quality, efficacy and safety, as set out in WHO's medicines strategy for 2004-2007. He commended the current initiative and WHO's activities over the past 10 years in order to promote the rational use of medicines. Health systems must adopt a comprehensive approach that included the strengthening of human resources and provision of information to consumers. Medicines policies should also include safety measures and mechanisms for monitoring promotional activities. He welcomed the draft resolution. WHO should continue to take the lead in fostering the rational use of medicines. Referring to paragraph 7 of the report and the eleventh preambular of the draft resolution, he pointed out that there were major global initiatives, such as the DOTS strategy against tuberculosis and the Global Malaria Programme, both of which included precautions in order to ensure that medicines were used rationally, and asked for a fuller explanation.

Dr AL-SHAMMARI (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the serious problem of irrational use of medicines might increase as a result of privatization of health-care services, deterioration in public health systems and the introduction of initiatives in order to increase access to medicine without investment in rational use. As a result, patients often suffered serious harm, for instance through antimicrobial resistance and adverse reactions, as well as wasted out-of-pocket payments. Despite the enormity of the problem, available WHO resources were scant; during the past two bienniums, only 0.2% of its overall budget

had been spent on the rational use of medicines. Although numerous resolutions had already been adopted on medicines strategies and specific aspects, none provided a practical approach to rational use, partly because a practical solution was lacking. However, the body of evidence on effective practical interventions in order to promote rational use was growing. The draft resolution was holistic, with practical and effective interventions. Its adoption would mandate the Organization to promote the rational use of medicines through increased resources to Member States and thus deal with the problem more effectively.

Mr DE SILVA (Sri Lanka) emphasized the close connection between the rational use of medicines and WHO's medicines strategy. Sri Lanka was experiencing problems arising from the irrational use of medicines, antibiotic resistance and use of too many drugs, all of which had led to a sharp increase in costs. The Government was overhauling its drug control authority in order to ensure better quality control. Countries should balance the cost of medicines against the benefits derived, but that would require increased technical assistance. The reported global sales of medicines in 2004 of about US\$ 550 000 million made it the second most capital intensive trade in the world. In Sri Lanka, the influence of the multinational pharmaceutical companies on members of the medical profession was making it very difficult to implement the legislation on generic medicines. The focus should therefore be on educating health professionals to abide by the policies on essential medicines and rational use of medicines.

Dr REN Minghui (China) said that in China expenditure on medicines accounted for half of all hospital costs. Among the consequences of irrational use were the improper use of antibiotics and, in rural areas, the availability of counterfeit and poor-quality medicines and lack of essential medicines. Hence, the provision of universal access to safe, effective and affordable medicines had become a major public health concern. Rational use could be achieved only through cooperation and the coordination of activities at all levels, from the technical and practical, encompassing research and development, production, prescription and delivery, to government, the pharmaceutical industry and civil society. Global cooperation also needed to be strengthened by more financial and technical support to developing countries. He supported the draft resolution with three amendments: the addition of "and medical students" after "health professionals" at the end of paragraph 1(3); the replacement of "programmes" in paragraph 1(5) by "policies, including programmes and clinical guidelines"; and the addition of new text after paragraph 2(3) to read "to strengthen the coordination of financial and technical support from developed countries to developing countries, in terms of rational use of medicines."

Dr SINGAY (Bhutan) noted that the draft resolution was broader than previous approaches. Previous resolutions had been relevant mainly to the medical profession, in particular prescribers and dispensers, who had vested interests; without pressure placed on them, the problem would persist. He emphasized the need for increased public, political and educational awareness. The growing involvement of the private sector in health-care delivery would necessitate better surveillance and monitoring so that medicines were used appropriately. He asked for more information regarding the reference in the report to shortcomings associated with many global initiatives, such as the delivery of treatment for HIV/AIDS, tuberculosis and malaria.

He welcomed WHO's health-system based approach and called for technical support to Member States, particularly developing countries, to be strengthened and more financial resources allocated for enhancing the rational use of medicines as part of WHO's medicine strategy. He expressed support for the draft resolution.

Dr RAHANTANIRINA (Madagascar) said that, in an effort to promote the rational use of medicines within the overall WHO medicines strategy, her Government had increased the allocation for medicines from 10% to 20% of the total health budget. In 2005, strategies to promote the rational use of medicines had also been strengthened through the application of a national medicines policy. Guidelines were available in order to provide assistance in the treatment of illnesses, particularly in the integrated management of childhood illness and the prevention and control of sexually transmitted infections. A

national medicines committee was responsible for the implementation of the medicines policy, and the list of essential medicines had recently been updated. Training for health workers promoted the use of effective, generic medicines in public health centres. The shortage of human resources in the health system limited the training follow-up and supervision, and that affected the distribution and prescribing of medicines, and the supervision and control of their use. The private sector tended to ignore the regulations and medicines could still be bought in the street despite the existence of legislation. She supported the draft resolution.

Dr SHANGULA (Namibia) said that safe and effective medicines needed to be accessible and affordable, and used appropriately by prescribers, dispensers and patients. In the public sector in Namibia, the cost of medicine was included in the consultation fee. In order to implement WHO's medicines strategy, in 1998 Namibia had introduced its national medicines policy accompanied by a national pharmaceutical plan with an annual budget. The division of pharmaceutical services was linked with the regions, government ministries, professional associations, councils, and medical aid funds which paid for generic medicines only when they were available. Patients who insisted on branded products had to pay the difference. The medicines control council was a regulatory body that required medicines to be registered before they were marketed. Only safe and effective medicines were registered. The essential medicines committee, composed of appropriately qualified health professionals, reviewed and approved medicines for inclusion on the national list. Other medicines could be obtained by following an agreed procedure. The national procurement agency purchased only those listed medicines through open international tenders from manufacturers that conformed to good practices. The use of medicines was monitored through surveys at public health facilities. An annual week-long public education campaign was conducted on themes such as the appropriate use of antibiotics, the pharmacist's role and the treatment of HIV/AIDS. Implementation suffered from the acute shortage of pharmacists and health professionals. Namibia had to recruit health professionals from other countries whose training did not necessarily reflect its own policies and treatment guidelines. Moreover, private practitioners were reluctant to comply with national treatment guidelines. His country organized various events in order to encourage use of the guidelines. He supported the draft resolution, but proposed the deletion from paragraph 2(2) of the words "in collaboration with governments and civil society".

Dr STEIGER (alternate to Dr Agwunobi, United States of America) said that his country strongly supported the rational use of medicines by prescribers and patients, and recognized the huge costs caused by medication errors and other kinds of irrational medicine use; in the United States such costs amounted to 10% of health expenditure. However, the report illustrated philosophical differences among Member States and between the United States and the Secretariat on that matter. The solution to the problems identified in the report was not to limit consumer choice and restrict the information available to patients or the channels through which that information flowed. It was not a matter of "health-related human rights", nor could the problem be blamed on the private sector, as the report appeared to suggest.

The Secretariat could work with Member States in several ways. There was a need for commonly accepted standards to accurately measure compliance; for a focus in health systems on improving the quality of drug use; and for attention to solving medication errors and clinical problems through strategies such as disease management rather than through emphasis on medicine and medicine use alone. Member States and the Secretariat together should ensure that prescribers and dispensers had access to adequate education and to evidence-based practices concerning advances in prescription medicines. In many countries, pharmacies and pharmacists were not well regulated. Member States should also work with the Secretariat in order to develop strategies to educate patients about the need to take all medicines as prescribed. Consumer advertising could be part of that educational process, but should be monitored to ensure the accuracy and quality of drug advertising and promotional practices, with sanctions for violation of national law. He agreed that the appropriate use of generic medicines could be part of that strategy and that the emphasis on access to medication in certain international programmes, especially on HIV/AIDS, tended to deflect attention from the rational use of pharmaceuticals.

He proposed that in the seventh preambular paragraph of the draft resolution, the words “as a prerequisite for achieving equitable access to essential medicines” should be deleted. In the tenth preambular paragraph, all the words following “recognizing that many countries” should be deleted and replaced by “do not have a national body mandating adherence to specific medical policy including medication use”. In the twelfth preambular paragraph beginning “Concerned that”, the words “political” and “economic investment” should be deleted. In the last preambular paragraph, the words “ensuring that sufficient investment is made for” should also be deleted. Paragraph 1(2) should be deleted. In paragraph 1(3), he supported the amendment proposed by China to add “and medical students” at the end. In paragraph 1(5), the word “national” should be deleted and the amendment proposed by China introduced. In paragraph 2(1), the words “and advocacy” should be deleted. The whole paragraph 2(2) should also be deleted. Paragraph 2(3) should be amended to read “to promote research, particularly on development of sustainable interventions for rational medicine use at all levels of the health sector, both public and private”.

Professor PEREIRA MIGUEL (Portugal), speaking on behalf of the Member States of the European Union, recalled the Board’s resolution EB115.R6 on the containment of antimicrobial resistance, adopted in January 2005. That being only one aspect of the subject, the time had come to take a wider view. The irrational use of medicines was a global public health problem, with severe health consequences and costs. It was an important aspect of patient safety, discussed the previous week by the Health Assembly. The Health Assembly had adopted seven resolutions on the matter, but the situation had not improved. Greater efforts were needed, since solutions were known but there was only partial compliance with guidelines and recommendations. The European Union was strengthening its system of health-technology assessment in order to gather evidence on the rational use of medicines which could contribute to the technical support given by WHO in that area. The draft resolution would give WHO a new mandate to promote the rational use of medicines by advocating a health system and medicines policy in order to tackle a growing global crisis. Its adoption would be timely as 2007 would be the thirtieth anniversary of the adoption of the Essential Drugs Concept and the first Model List of Essential Drugs.

Speaking as the member for Portugal, he said that promotion of the rational use of medicines depended on a proactive attitude by the health authorities in each country, including a well-prepared technical staff and a reliable information system. Portugal shared the concerns expressed in the report. Its new regulations in that field advocated the rational use of medicines and its national institute for medicines was monitoring hospital consumption of antimicrobial agents, evaluating the economic impact and studying the correlation between the level of consumption and the prevalence of resistant microbial strains. Although commending the draft resolution, he suggested the inclusion in paragraph 2 of a further request to the Director-General, to read: “to promote an international discussion among health authorities, professionals and patients, on general criteria for the preparation and communication of information on the rational use of medicines to specific patient groups”.

Dr VOLJČ (Slovenia) said that he would submit his comments in writing to the Secretariat.

The CHAIRMAN thanked him for his pragmatism but said that he would not prevent any member from speaking.

Dr GAKURUH (Kenya) said that Kenya was currently experiencing drug-resistant tuberculosis. In Kenya the main problem was access to essential medicines in the private sector. Where there was no access to affordable medicines, the public sector was providing them in appropriate dosages. A small pilot project had been introduced in which medicines were provided to the private sector where they were prescribed free of charge. The results had been encouraging, indicating that a common problem in that sector was the provision of essential medicines. He supported the draft resolution, but proposed an amendment to operative paragraph 1(5) in which the words “and the provision of essential medicines to the private sector” should be inserted after “national medicines programmes”.

Dr SUWIT WIBULPOLPRASERT (Thailand) said that, contrary to other members, he had been disappointed by the work of the Secretariat and Member States, including his own country, on the rational use of medicines. He recalled that the present Chairman of the Board had been responsible in WHO for that area around 20 years previously, a time when WHO had been much more active than at present. Since the adoption of resolution WHA39.27, more than 13 related resolutions had been adopted, yet only 28% of countries had national medicine policies with national monitoring systems, and in 75% of countries, antimicrobial medicines were still available over the counter for self-medication. Ample evidence existed to support the rational use of medicines, but policies were not implemented effectively. The fee-for-service method perversely encouraged overprescription and overuse of medicines and wastage of resources, whereas capitation payments promoted the rational use of medicines and other health resources. Yet fees for services remained the prevalent payment method in most countries. The private sector's increasing role in developing countries, inadequate regulation and increasing irrational use of medicines in the private sector constituted the biggest problems; moreover, in almost all countries, the private sector did not respect the national essential medicines list unless the medicines were reimbursable by insurance agencies. Special attention and action were needed for that sector. Promoting the rational use of medicines required a major reform of health policy and systems. The power of vested interest groups, especially the pharmaceutical industry and health professionals, should not be underestimated – the pharmaceutical industry invested more in marketing than in research and development and had a large number of parliamentary lobbyists. The irrational use of medicines could not be corrected by education or the health system alone: close cooperation with consumer groups and local and multinational industry was essential in order to improve transparency and social accountability. He proposed 14 amendments to the draft resolution, which he would submit in writing. In view of the large number of other amendments, he suggested that a drafting group should be constituted.

Dr TANGI (Tonga) expressed surprise that, after 20 years and many resolutions, so little had been achieved. He had been struck by the Chinese member's reference to medical students; WHO adopted many resolutions, but many thousands of students were unaware of them and even medical and pharmaceutical schools were ignorant of their details. The sound principles concerning the rational use of medicines must be included in the educational system of health professionals, otherwise the same problem would persist in 15 years' time.

Dr GOMES TEMPORÃO (Brazil) stressed the need for doctors and patients to have independent information about medicines. He was concerned about the statement in the report (paragraph 7) that the irrational use of medicines was significantly worse in the private sector. In Brazil their use was irrational in both the public and the private sectors. He did not agree with the statement in the same paragraph on increased access to essential medicines in relation to certain neglected diseases; the main problem was not inappropriate use but difficulty of access. The paragraph should be redrafted. In regard to the draft resolution, he proposed that the eleventh preambular paragraph beginning "Aware that many global initiatives" be deleted and replaced by the words "Emphasizing that global initiatives to increase access to essential medicines should also address the fundamental and widespread problem of irrational use of medicines;".

Dr ÁLVAREZ LUCAS (alternate to Mr Bailón, Mexico) said that Mexican health institutions had learnt to cooperate actively and transparently with the private sector, as in the case of tuberculosis, for which the cost of treatment had been reduced by some 40%. He supported the draft resolution and proposed the addition of wording to paragraph 2 to the effect that transparent and equitable strategic alliances should be concluded with the manufacturers of medicines, and policies promoted in order to influence awareness of the costs, access and promotion of rational use of medicines, particularly those related to priority programmes of international public health.

Dr ZUCKER (Assistant Director-General) said that he had noted members' concerns, including collaboration between national agencies and international partners; correct formulations, properly used

and available to all who needed them; the great potential for better treatment; the need for adherence to treatment regimens; and containment of drug resistance; that setting and applying commonly accepted standards were crucial in ensuring the rational use of medicines; and that disease management was appropriate. Experience in some countries had shown that programmes on rational medicine use had great economic potential and could lead to savings amounting to at least three times the cost of the programme.

The Secretariat was working on education and public-private partnerships, both crucial areas. Some of the concerns regarding HIV/AIDS and tuberculosis were similar to those relating to other diseases and, there again, education was essential. Concerns about private practitioners existed at all levels and ought to be examined. With regard to the proposal to promote an international discussion, meetings were organized by WHO and should perhaps be more widely publicized. He shared the concerns about information given to medical students and the role of physicians in the use of medicines. Patients, their family members and prescribers needed to be educated about the effects of irrational use in terms of outcomes, drug resistance and cost.

With the 30th anniversary of the Essential Medicines List to be celebrated in October 2007, the adoption of the draft resolution would attest to the commitment of all Member States in order to ensure that the irrational use of medicines would be eliminated as a factor in illness.

Mr REED (Churches Action for Health), speaking at the invitation of the CHAIRMAN, commended WHO's efforts to facilitate access to essential medicines and to ensure that the medicines were safe, effective and of good quality. The Health Assembly's recent call for reorientation of research and development into the neglected diseases of the world's poor would certainly promote such access. Access to essential medicines would remain limited if medicines were not used rationally. Medicines must be prescribed in a therapeutically appropriate and cost-effective way, and with monitored adherence to treatment regimens. Noting the evidence of such limitations as described in document EB118/6, the Board should recommend that the next Health Assembly consider urging Member States to promote and implement rational use; strengthen training; and limit promotional activity which might distort the prescribing habits of doctors or the treatment adherence of patients. WHO's advocacy and leadership in promoting the rational use of medicines, and its technical support for monitoring of medicine use should be strengthened. Research should be conducted into sustainable interventions.

Dr KEAN (Executive Director, Office of the Director-General) suggested that, given the many proposed amendments to the draft resolution, a drafting group should convene following the afternoon meeting to consider a fresh draft to be prepared by the Secretariat, incorporating all the amendments.

The CHAIRMAN took it that the Board agreed to the convening of an open-ended drafting group. He drew attention to the financial implications of the draft resolution, as contained in document EB118/6 Add 1.

It was so agreed.

Professor PEREIRA MIGUEL (Portugal) asked for the proposed amendments to the draft resolution to be circulated among Board members before the drafting group's meeting.

The CHAIRMAN said that an amended text would be produced for consideration.

(For continuation of the discussion, see summary record of the fifth meeting, section 4.)

Arsenic mitigation for safe groundwater: Item 5.4 of the Agenda (Document EB118/14)

Mr IWABUCHI (alternate to Dr Shinozaki, Japan), recognizing the damage to health caused by exposure to arsenic in drinking-water, said that prevention and control involved coordination between

such areas as health and the environment. Effective policies were needed: provision of safe drinking-water through the establishment of alternative, arsenic-free water sources; a system for measuring concentrations of arsenic in water; public health awareness-raising; and the treatment of arsenic-poisoned patients. WHO should take the lead in strengthening capacity in order to deal with arsenic contamination and promote the sharing of information.

Dr SOPIDA CHAVANICHKUL (alternative to Dr Suwit Wibulpolprasert, Thailand) said that in the previous 20 years Thailand had experienced two episodes of drinking-water contamination, prompting long-term health surveillance among the affected population. The first, in 1986, had concerned arsenic contamination of surface-water sources from tin-mining activities and had led to cases of basal-cell carcinoma. The second event, in 1998, concerned contamination of natural creek water from lead-mining activities. Thailand therefore welcomed the concept of preparedness for similar problems and recommended simple tools for rapid assessment and screening. Furthermore, cancer registration, cancer screening and early diagnosis were necessary for the long-term management of a population chronically exposed to high concentrations of arsenic in drinking-water. For such predictable health risks, resources and a clean water supply were needed.

Ms PATTERSON (alternate to Ms Halton, Australia) said that her country was assisting countries in South Asia and the Mekong area in facing the risk posed to health by arsenic-contaminated groundwater. One key strategy was a risk-management approach to water quality. A safe-water guide had been issued and was being used in programmes in the Asia-Pacific region. She urged all stakeholders to adopt that approach in order to identify and mitigate risks at each stage of water supply from catchments to consumer.

Dr AL-SHAMMARI (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the provision of safe drinking-water was central to improving the health conditions of populations. Although the most conspicuous risk was the transmission of water-borne diseases, the example of the presence of arsenic in groundwater used for drinking in Bangladesh and elsewhere demonstrated that the chemical risk required equally careful attention. The few records, if any, of health concerns related to the presence of high concentrations of arsenic in drinking-water in the Region prompted the question whether the problem was indeed minor or nonexistent or if drinking-water quality monitoring and surveillance were insufficient to identify the problem. Fluoride was another chemical whose presence in water had recognized adverse health effects and whose occurrence in high concentrations in groundwater in some areas of the Region was likely. The Secretariat should recommend Member States specifically to target arsenic and other risk chemicals in their water quality monitoring programmes. Use of simple, inexpensive analytical methods should be encouraged in order to ensure the widest possible coverage by monitoring programmes in all countries.

Dr REN Minghui (China) said that arsenic contamination was a serious problem in China, affecting 500 000 people across more than half its territory, and threatening drinking-water safety and the economic development of the contaminated areas. Surveys conducted with UNICEF on contaminated groundwater and the pattern of arsenic poisoning had led to investment in arsenic mitigation and the improvement of groundwater quality. Water improvement surveillance and research had been conducted and the programme in all affected areas should be completed by 2010. China welcomed the report and was willing to continue its cooperation with WHO and other international organizations.

Mrs WEBER-MOSDORF (Assistant Director-General) replied that the response to arsenic contamination demonstrated the value of WHO's cooperation with other organizations and partners. In Bangladesh, environmental and health specialists had worked closely with advisers in the regions and at WHO headquarters. The same applied to WHO's partnership programme, an example being its partnership with Australia in the Asia-Pacific region, focusing on the quality of drinking-water,

including arsenic-contaminated drinking-water. Such cooperation was to be seen in conjunction with WHO's standard-setting role, which it implemented through its *International standards for drinking-water* and *Guidelines for drinking-water quality*. The risk-management approach was embedded in the guidelines. Drinking-water quality was an area in which WHO exerted leadership and leverage. It was also associated with a large and preventable burden of disease: diarrhoea alone accounted for 1.6 million deaths a year. One of WHO's core activities was to monitor progress in the implementation of Target 10 of the Millennium Development Goals to halve, by 2015, the proportion of people without sustainable access to safe drinking-water and sanitation.

As there was no cure for arsenicosis, prevention was crucial. The key was to reduce water-related disease by raising awareness, developing and providing analytical methods to detect concentrations of arsenic in drinking-water and, where necessary, removing arsenic from drinking-water. The Secretariat was ready to provide technical support to any Member State that required it.

The Board noted the report.

2. CONSIDERATION OF THE ACCELERATION OF THE PROCEDURE TO ELECT THE NEXT DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION:
Item 9 of the Agenda (Documents EB118/20 and EB118/20 Add.1) (continued from the second meeting, section 1)

The CHAIRMAN drew attention to the note by the Secretariat (document EB118/20 Add.1) containing "Timetable 1A plus", in respect of the proposal by some members to conduct the process for nomination and appointment of the next Director-General in November 2006, together with its financial implications and a draft resolution.

Professor PEREIRA MIGUEL (Portugal), speaking on behalf of the European Union and its Member States, said that a postponement of the final date for receipt of proposals for the post of Director-General had been requested from 22 August 2006 to the beginning of September, in view of the somewhat slack period in August when it would be difficult to make the necessary contacts and complete formalities.

Dr SHANGULA (Namibia), speaking on behalf of the Member States of the African Region, said that the countries of his Region likewise sought an extension of the deadline for receipt of proposals on account of national and regional processes that needed to be completed during that period. Their preference was to extend the deadline until the beginning of October, but they would be prepared to agree to an extension until the end of September.

Dr GWENIGALE (Liberia) suggested extending the deadline for the submission of candidatures until after the meeting of the Regional Committee for Africa, scheduled between the end of August and the beginning of September.

The CHAIRMAN said that all regional meetings were held in September, which might entail some sacrifice on the part of Member States, although he believed that decisions in the present case were required by Member States rather than at regional level.

Dr STEIGER (alternate to Dr Agwunobi, United States of America) said that he was willing to compromise regarding the deadline for the submission of proposals, but warned that sufficient time should be allowed for consideration of the candidates before the session of the Board, including time for the potential arrangement of interviews with Board members. That would be difficult if the deadline was in October and the Board was to meet in early November. Moreover, he proposed amending the draft resolution by inserting a new paragraph 5 to read "REQUESTS the Acting

Director-General to place staff members who are candidates on a temporary leave of absence from their current posts during the period following the deadline for nominations until the World Health Assembly appoints a new Director-General”.

Dr REN Minghui (China) said that flexibility could be considered with regard to Timetable 1A plus, but he also stressed that sufficient time should be allowed between the deadline for submission of proposals and the Board session. He supported the amendment proposed by the member for the United States of America, but wondered whether the Acting Director-General would have the authority to place regional directors who were candidates on a temporary leave of absence from their current posts.

Ms PATTERSON (alternate to Ms Halton, Australia) supported the timetable proposed by the Secretariat with flexibility surrounding the deadline. She welcomed the amendment proposed by the member for the United States, which would contribute to the stable functioning of the Organization during that period. She proposed to amend paragraph 2 of the draft resolution by inserting “to Member States” after “supporting information”, in order to ensure consistency with the rest of the document.

Dr SUWIT WIBULPOLRASERT (Thailand) believed that Timetable 1A plus provided a satisfactory compromise. He agreed with a flexible approach, but concurred with the member for China that sufficient time must be allowed between the deadline for submission and the session of the Board. That session should not be postponed. Flexibility should apply instead to the deadline for submission of proposals and dispatch of materials. Before considering the proposal by the member for the United States of America, and in the light of the question raised by the member for China, he asked for clarification of the definition of “staff member”, and whether that included the Acting Director-General, since his understanding had been that the latter would not stand for election. Furthermore, did leave of absence apply from the deadline for submission of proposals or from the date of submission of an application?

Dr KHALFAN (Bahrain) drew attention to the extraordinary nature of the process, which would normally take place at a slower pace than currently envisaged. He approved the request of the member for Namibia, provided that the date of the special session of the Health Assembly, scheduled for 9 November, was not affected. He endorsed the amendments proposed by the members for the United States of America and Australia.

Dr GØTRIK (Denmark) strongly supported the view that the final date for receipt of proposals should be postponed until the beginning of September 2006, at the earliest. In reference to the amendment proposed by the member for the United States of America, would it then be mandatory or optional for the members of staff concerned to take leave? Taking the question further, in the hypothetical case in which the Director-General stood for re-election, would he or she be expected to take leave of absence in the run-up to the election?

Professor PAUNESCU (Romania) considered that the most suitable option was to set the deadline for submission at the beginning of September.

Dr WINT (Jamaica) endorsed Timetable 1A plus, and requested that the last two dates listed in the timetable be fixed, although the preceding dates could be flexible. He supported the amendment proposed by the member for Australia, and awaited clarification regarding the amendment proposed by the member for the United States of America.

Mr MIGUIL (Djibouti) said that he would support a consensus among Board members, but would prefer that the special session of the Health Assembly was not delayed beyond 9 November, as set out in Timetable 1A plus. With regard to the question of staff members who were candidates being placed on leave, he said that candidates should voluntarily free themselves from all their WHO duties, but leave could not be imposed on them. He requested clarification on that point. He wished the

declaration by the Acting Director-General that he would not stand for election to the post of Director-General to be stated in the document so that the situation was clear.

Dr KAKAR (Afghanistan) said that the final date for receipt of proposals could be flexible and suggested 1 September 2006. In connection with the amendment proposed by the member for the United States of America, did WHO's Constitution not contain provisions governing WHO staff members who were candidates?

Dr TANGI (Tonga) said that he favoured Timetable 1A plus. Under the terms of Rule 52 of the Rules of Procedure of the Executive Board, a period of six months was required before the date fixed for the opening of a session of the Board at which a Director-General was to be nominated. That consisted of four months between the time of notification to Member States that they might propose candidates and the final date for receipt of proposals for nomination, followed by two months for the work of the Board. Did Member States really wish to maintain a period of four months for the submission of proposals and then shorten the period of work of the Board, thus exerting extraordinary pressure on the latter?

He was willing to accept the timetable, with the proviso that the materials on the proposals should be dispatched to Member States speedily and adequately provide for their consideration. He agreed with the amendment proposed by the member for the United States of America requiring staff members who were candidates to be placed on a leave of absence.

Dr SADASIVAN (Singapore) accepted the compromise represented by Timetable 1A plus. Some flexibility could apply to the final date for receipt of proposals, but the dates indicated for the special sessions of the Board and Health Assembly should be adhered to.

Dr SHANGULA (Namibia), speaking on behalf of the Member States of the African Region, expressed appreciation on the flexibility shown by Board members concerning the final date for receipt of proposals. Flexibility was needed in view of the differences in regional procedures for the submission of nominations. By requesting an extension of the deadline, the countries in his Region sought to ensure that they had the same opportunities as other regions in order to identify and put forward appropriate candidates.

Dr KHALFAN (Bahrain) asked whether leave of absence would be paid.

Dr NTAWUKULIRYAYO (Rwanda) favoured postponing the final date for receipt of proposals until the beginning of September 2006 and endorsed the amendment proposed by the member for the United States of America. Referring to the question raised by the member for Bahrain, he said that he saw no reason why leave of absence should not be paid.

Dr STEIGER (alternate to Dr Agwunobi, United States of America) said that he had proposed the amendment because the provisions of WHO's Staff Rules governing leave for staff members while running for political office did not apply in the current case since they referred to political elections in a staff member's home country rather than election in the Organization. While he expected any WHO staff member standing for election, whether in a regional office or headquarters, to take leave, and his Government would not support any candidate that did not, the amendment as formulated left the implementation of the resolution to the discretion of the Acting Director-General. He expected that such leave would be paid. As it would be difficult to establish the exact date on which a staff member became a declared candidate and therefore obliged to take leave, it would be appropriate for leave to take effect from the final date for the submission of nominations which, in the light of the current discussion, would probably be at the beginning of September.

Mr BURCI (Legal Counsel), in reply to questions raised, said that the possibility of placing staff members on special leave with pay was already foreseen in Rule 650 of WHO's Staff Rules, which

stated that the Director-General may, at his or her initiative, grant such leave if he or she considered it to be in the interest of the Organization. It was therefore fitting for the Board to make such a request. However, he questioned the suitability of the wording of the proposal, which obliged the Acting Director-General to grant special leave. He thus suggested replacing the words “REQUESTS the Acting Director-General to place staff members” by “REQUESTS the Acting Director-General to consider placing staff members”. He also suggested that the Acting Director-General might consider granting the staff member concerned the opportunity to attend special events, such as an important conference, if he considered that to be in the interest of the Organization, during his or her leave. He concurred with the member for the United States of America on the date from which the period of leave should take effect, since the envelopes containing the proposals were opened only on the expiry of the period for submission of proposals. The definition of staff members was contained in WHO’s Constitution, Articles 30 and 35 referring. Staff members were broadly defined as all those persons in the service of the Organization who had received a contract of appointment by the Director-General and served the Organization, subject to the provisions of the Staff Regulations and Staff Rules.

Dr REN Minghui (China) said that the requirement of special leave would create a temporary vacancy in a regional office if its director was nominated for the post of Director-General. He therefore asked whether the Acting Director-General would have the authority to nominate someone to replace that regional director during the leave period. Currently, the nomination of regional directors was the responsibility of the Regional Committees.

Dr KHALFAN (Bahrain) sought clarification as to whether the Acting Director-General would have the authority to place elected officers on leave of absence with pay.

Dr GØTRIK (Denmark) asked whether the Director-General would have to take leave of absence during a process of re-election.

Dr SUWIT WIBULPOLPRASERT (Thailand), after echoing the questions raised by the members for China and Bahrain, asked why the names of candidates could not be released before the envelope was officially opened on the last day of the nomination period.

Dr GWENIGALE (Liberia) suggested that the final date for receipt of proposals should be 5 September, as that would give the Member States in the African Region time to transmit any nominations that the Regional Committee might decide to submit at its meeting on 2 September. He echoed the question raised by the member for Denmark.

Dr STEIGER (alternative to Dr Agwunobi, United States of America) clarified that his proposed amendment had not been intended to set a precedent regarding the re-election of the Director-General, but rather to address the current, specific situation. Should the Director-General decide to stand for re-election, the Board could make another decision on that matter and on his or her leave of absence. The amendment had been intended to cover all people on WHO contracts, and he asked whether the definition of WHO “staff members”, and thus the requirement to take leave of absence, could extend to those staff covered by administrative service agreements.

Mr AITKEN (Adviser to the Director-General) said that, if the final date for receipt of proposals was to be 5 September, the date for the dispatch of materials on the proposals to Member States should be 5 October, as experience had shown that the Secretariat would need one month to carry out the substantial work involved. In response to the question raised by the member for China, he affirmed that the Director-General could request regional directors to take leave of absence; in that case they would usually nominate their own replacements. In order to clarify the fact that the draft resolution applied only to the current election process, he suggested amending the new paragraph proposed by the member for the United States of America to include a reference to the “present election”.

The ACTING DIRECTOR-GENERAL said that he would not be a candidate for the post of Director-General, but would be responsible for overseeing a clear, transparent election process. He confirmed that, because of the considerable amount of processing work involved, the Secretariat would need one month between the receipt of proposals and the dispatch of materials to Member States, but the dates could be changed. With regard to the status of WHO staff members under administrative service agreements, those staff members might not have access to the same job opportunities as other WHO staff members.

Mr BURCI (Legal Counsel), in response to the question raised by the member for Thailand, said that waiting until all applications had been received before releasing the names of candidates was a requirement of Rule 52 of the Rules of Procedure of the Executive Board, and was in the interest of greater transparency and legitimacy.

Dr SUWIT WIBULPOLPRASERT (Thailand) said that, if he had understood correctly, the term “staff member” applied from the most senior position, that of the Director-General, through Assistant Director-General and Regional Director, to the position of janitor. He agreed with the proposed dates concerning receipt of proposals and dispatch of materials. If, in accordance with Rule 52 of the Board’s Rules of Procedure, the amendment proposed by the member for the United States of America would apply from the date of closure of applications, he agreed to the amendment. He drew attention to the need for vigilance concerning use of WHO’s resources for election campaigns, and suggested that the Board might wish to set up a mechanism in order to deal with that matter.

Mr AITKEN (Adviser to the Director-General) said that the Secretariat was extremely vigilant on that matter and that he would re-circulate a memo that had been issued before Dr Lee’s election, to the effect that it was a serious offence to use WHO’s resources for election purposes.

Turning to the draft resolution, as amended, he said that paragraph 2(b) would read: “final date for receipt by WHO of proposals for nominations: 5 September 2006”. Paragraph 2(c) would read: “date of dispatch of proposals, curricula vitae and supporting information to Member States: 5 October 2006”. The new paragraph proposed by the member for the United States of America, as amended, which would be inserted after paragraph 4, would read: “REQUESTS the Acting Director-General to consider placing staff members who are candidates for the election referred to in the present resolution on temporary leave of absence with pay from their current posts during the period from 5 September 2006 until the World Health Assembly’s appointment of a new Director-General”.

Dr KHALFAN (Bahrain) proposed inserting in the new paragraph the words “officers and” before “staff members”.

Dr SHANGULA (Namibia) supported the draft resolution, as amended, and said that the dates in paragraph 3 of document EB118/20 Add.1 would have to be changed accordingly.

Dr GOMES TEMPORÃO (Brazil) asked the Legal Counsel to reply to the question raised by the member for the United States of America as to whether the special leave provisions would apply to staff members employed under administrative service agreements.

Mr BURCI (Legal Counsel) replied that WHO staff members under administrative service agreements, such as those with UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria, were subject to certain restrictions, which did not apply to other staff members, as the Acting Director-General had explained. At the same time, they remained WHO staff members, and the provisions covering leave of absence of candidates could, in principle, be applicable to them. That was his preliminary response, subject to further reflection.

Mr MUGUIL (Djibouti) said that the Board should discuss the important matter of regional rotation in relation to the appointment of the Director-General before considering the adoption of the draft resolution. He requested that a date should be set for that discussion.

The CHAIRMAN recalled the decision to set up a working group on the necessary changes to the Rules of Procedure in relation to the election of the Director-General. That would be set up shortly, and would examine regional rotation. Its work would be forward-looking, and not related to the current election.

Dr AL-SHAMMARI (Iraq) endorsed the view expressed by the member for Djibouti.

Ms PATTERSON (alternate to Ms Halton, Australia) said that she had understood that the proposed changes to the Rules of Procedure would be referred to the Programme, Budget and Administration Committee. She sought clarification of the mandate and timing of the working group concerned, if that was the case.

The CHAIRMAN emphasized that the draft resolution was not necessarily linked to the matter of changes to the basic texts. Its purpose was to examine an exceptional situation.

Mr AITKEN (Adviser to the Director-General) recalled that it had been the view of the Chairman that the Programme, Budget and Administration Committee would be the most appropriate body to deal with the proposals relating to regional rotation and other similar matters. The Board could make a decision the following day as to when that Committee should meet. The Committee could then report back to the Board in January 2007, on the basis of a report by the Secretariat.

Dr NTAWUKULIRYAYO (Rwanda) said that, although he endorsed the principle of regional rotation, the Board should be pragmatic and adopt the draft resolution. The working group would examine regional rotation, a separate matter from the draft resolution.

Dr SHANGULA (Namibia) concurred with the previous speaker that the two matters were separate. The matter of regional rotation did not need a working group, since the practice already existed within the United Nations system. The Board could simply decide whether to embrace that principle and, if it did not decide, could apply it where appropriate.

Dr TANGI (Tonga) agreed that there was no link between the draft resolution and the matter of regional rotation. He questioned the compatibility of the principle of regional rotation with Rule 52 of the Rules of Procedure. In his view, the main criterion to be taken into account in the election of the Director-General was that the best possible candidate should be chosen.

The resolution, as amended, was adopted.¹

Dr KHALFAN (Bahrain) suggested that the matter of rotation should be postponed until the session of the Executive Board to be held on 6 to 8 November 2006.

The meeting rose at 12:35.

¹ Resolution EB118.R2.

FOURTH MEETING

Tuesday, 30 May 2006, at 14:05

Chairman: Dr F. ANTEZANA ARANÍBAR (Bolivia)

1. CONSIDERATION OF THE ACCELERATION OF THE PROCEDURE TO ELECT THE NEXT DIRECTOR-GENERAL OF THE WORLD HEALTH ORGANIZATION:
Item 9 of the Agenda (Documents EB/118/20 and EB118/20 Add.1) (continued)

Mr MIGUIL (Djibouti) recalled that the matter of the geographical rotation of the post of Director-General was to be discussed by the Programme, Budget and Administration Committee. In view of the importance and political nature of the matter, it should also be discussed by the Board at its session in January 2007.

The CHAIRMAN said that he believed the Board to be so disposed.

It was so agreed.

2. TECHNICAL AND HEALTH MATTERS (continued)

Control of leishmaniasis: Item 5.1 of the Agenda (Documents EB118/4 and EB118/4 Add.1) (continued from the second meeting, section 3)

The CHAIRMAN drew attention to the revised draft resolution, which involved no additional financial implications for the Organization and read as follows:

The Executive Board,
Having considered the report on control of leishmaniasis,¹

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:

The Sixtieth World Health Assembly,
Having considered the report on control of leishmaniasis;
Recognizing that leishmaniasis is one of the most neglected tropical diseases, with more than 12 million people worldwide currently infected, and two million new cases each year;
Noting with concern that 350 million people are considered at risk and the number of new (Namibia) cases is on the increase;
Recognizing the lack of accurate information on the epidemiology of the disease for better understanding of the disease and its control (Thailand);

¹ Document EB118/4.

Noting with concern that the disease affects the poorest populations in 88 countries, placing a heavy economic burden on families, communities and countries, particularly in developing countries;

Noting with concern that treatment is either unaffordable, may be toxic, cause resistance leading to suboptimal treatment, or results in a heavy economic burden, including substantial loss of wages, plunging families into a vicious circle of disease-poverty-malnutrition-disease (Thailand);

OR

Noting the burden that treatment can place on families (USA); (Namibia)

Bearing in mind that malnutrition and food insecurity are often identified as major causes of disposition to, and severity of, leishmaniasis;

Acknowledging the significant support extended by Member States and other (Thailand) partners and appreciating their continuing cooperation,

1. URGES Member States where leishmaniasis is a substantial public health problem (Denmark):

- (1) to reinforce efforts to set up national control programmes that would draw up guidelines and establish systems for surveillance, (Thailand) data collection and analysis;
- (2) to strengthen prevention, active detection and treatment (Thailand) of cases of both cutaneous and visceral leishmaniasis in order to decrease the disease burden;
- (3) to strengthen the capacity of peripheral health centres to provide appropriate affordable (Thailand) diagnosis and treatment, and to act as sentinel surveillance sites;
- (4) to conduct epidemiological assessments in order to map foci and calculate the real impact of leishmaniasis through accurate studies of prevalence and incidence, socioeconomic impact and access to prevention and care (Thailand);(Namibia)
- (5) to establish a decentralized structure in areas with major foci of disease, strengthening collaboration between countries that share common foci, increasing the number of WHO collaborating centres for leishmaniasis and giving them a greater role, and relying on initiatives taken by the various actors;

2. FURTHER URGES Member States (Denmark):

- (1) to advocate high quality and affordable medicines, (USA) and appropriate national drug policies;
- (2) to encourage research on leishmaniasis control in order;
 - (a) to identify appropriate and effective methods of vector control; (Namibia)
 - (b) to find alternative safe, effective (USA) and affordable (Namibia and USA) medicines for oral, parenteral or topical administration involving shorter treatment cycles, less toxicity, (Thailand) and new drug combinations, and to define appropriate doses and duration of therapy schedules for these medicines (Brazil);
 - (c) to determine mechanisms to facilitate access to existing control measures, including socioeconomic studies and health-sector reform in some developing countries;

- (d) to evaluate and improve sensitivity and specificity of serological diagnostic methods for canine and human visceral leishmaniasis, including evaluation of standardization and effectiveness (Brazil);
- (e) to evaluate effectiveness of alternative control measures such as use of bed nets impregnated with long-lasting insecticide (Brazil);
3. CALLS ON partner bodies to maintain and extend their support for national leishmaniasis prevention and control programmes, and to speed up research on, and development of, leishmaniasis vaccine (Thailand);
4. REQUESTS the Director-General:
- (1) to raise awareness of the global burden of leishmaniasis, and to promote equitable access to health services for prevention and disease management;
 - (2) to draft guidelines on prevention and management of leishmaniasis, with emphasis on updating the report of WHO's Expert Committee on Leishmaniasis,¹ with a view to elaborating regional plans and fostering the establishment of regional groups of experts;
 - (3) to strengthen collaborative efforts among multisectoral stakeholders, interested organizations and other bodies in order to support the development and implementation of leishmaniasis control programmes;
 - (4) to (USA) frame a policy for leishmaniasis control, with the technical support of the WHO Advisory Expert Panel for Leishmaniasis;
 - (5) to promote research pertaining to -leishmaniasis control and dissemination of the findings of that research (USA);
 - (6) to monitor progress in the control of leishmaniasis in collaboration with international partners;
 - (7) to report to the Sixty-third World Health Assembly on progress achieved, problems encountered and further actions proposed in the implementation of leishmaniasis programmes (Thailand).

Professor PEIREIRA MIGUEL (Portugal) proposed addition of the following phrase at the end of paragraph 1(4): “and the extent of malnutrition and HIV in the disease”, or words to that effect. Coinfection with leishmaniasis and HIV was an important issue in some areas.

Dr SHANGULA (Namibia) accepted the proposed amendment. He had suggested deleting the original wording related to HIV, which might have given the impression that leishmaniasis and HIV were associated. There was no scientific evidence that they were.

Ms VALDEZ (alternate to Dr Agwunobi, United States of America) drew attention to the new version of the sixth preambular paragraph that she had proposed, which was of wider scope, since it referred only to the “burden” which treatment might place on families, rather than specifying issues such as expense, toxicity and resistance, which might only be part of the burden. In paragraph 3, “expand their support” would be preferable to “extend their support” and, since research could not always be speeded up, she supported the wording “and, as appropriate, to accelerate research”.

The CHAIRMAN invited the Board to consider the draft resolution, with the amendments proposed by the members for Portugal and the United States of America.

¹ *Control of leishmaniasis. Report of a WHO Expert Committee.* Geneva, World Health Organization, 1990 (WHO Technical Report Series, No. 793).

The resolution, as amended, was adopted.¹

Essential health technologies: Item 5.5 of the Agenda (Documents EB118/15 and EB118/15 Corr.1)

The CHAIRMAN said that the current agenda item would be considered jointly with item 8.3 on health information systems in support of the Millennium Development Goals. It might also be relevant to item 5.3 on the rational use of medicines, which had been discussed the day before. He invited the Board to consider the following draft resolution, submitted by Mexico, and its administrative and financial implications for the Secretariat:

The Executive Board,
Having considered the report on essential health technologies,²

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:

The Sixtieth World Health Assembly,
Having considered the report on essential health technologies;
Defining health technologies as all those applications of knowledge used in order to meet the health needs of healthy or sick people, either individually or collectively, such as medicines, medical equipment and devices, medical procedures and the organizational models and support systems employed;

Further defining essential health technologies as those technologies that contribute to attaining the internationally agreed health-related development goals, including those contained in the Millennium Declaration; those that, through a dynamic process, are adapted to the needs and epidemiological, demographic, cultural, ethical, legal and economic context of Member States, considering that they are safe, cost-effective, based on scientific evidence and comply with international standards;

Noting that essential health technologies are used at all levels of health systems, for prevention, diagnosis, treatment and rehabilitation in order to improve equity, accessibility and quality of life, especially for vulnerable groups, helping to strengthen solidarity and fundamental human rights;

Recognizing that evaluation, incorporation, access to, and operation, maintenance and replacement of, medical equipment and devices are a challenge to many of the health systems of Member States on account of the inadequacy of mechanisms for managing, evaluating, rationalizing, distributing and planning such health technologies in order better to benefit from, and use them while ensuring quality, efficiency and safety, in accordance with the necessary clinical procedures and infrastructure available;

Further recognizing that essential health technologies must be appropriate and relevant to, and in keeping with, the local and regional needs of each health system, and linked to training in order to ensure the best use thereof in terms of quality, efficiency and safety;

Mindful that technologies are evaluated in order to provide guidance for decision-making, on the basis of risk/benefit analysis and the clinical, ethical and social impact of their use, and that such evaluations are important when human, technical and financial resources are limited, in order to seek the optimum use thereof,

1. INVITES Member States:

¹ Resolution EB118.R3.

² Documents EB118/15 and EB118/15 Corr. 1.

- (1) to establish or adapt national interdisciplinary agencies linked to the ministries of health, whose purpose is to determine policies and guidelines for rational planning, management and safe use of health technologies, including medical equipment and devices, implementation of interoperable eHealth systems and medical protocols suited to their needs, together with the corresponding organizational models;
- (2) to assess and use essential health technologies in order to improve equity, and access to health care and quality of life, with emphasis on meeting the needs of vulnerable groups;
- (3) to recognize both the importance of health technologies and the limits to their application at the different levels of health care, and to define and adapt technologies to the specific preventive, diagnostic, treatment and rehabilitation activities for each level and region;
- (4) to formulate local strategies so that health technologies are subject to appropriate regulation and surveillance;
- (5) to apply, adopt or design methodology for evaluating health technologies, undertaking clinical, financial, ethical and social evaluations that facilitate decision-making in order to give priority to essential health technologies that are safe, offer the best available solution, improve access, equity and quality of life, and strengthen problem-solving, efficiency and the health-care follow up;
- (6) to determine criteria and agreements that facilitate use of essential health technologies and strengthen national awareness of their benefits;
- (7) to facilitate the exchange of information on essential health technologies regarding safety, effectiveness, standards, public-health policies and indicators, with a focus on medical devices and equipment, eHealth/telemedicine and clinical practice guidelines;

2. REQUESTS the Director-General:

- (1) to encourage the establishment and organization of information networks on health technologies at local, regional and global levels for the purpose of decision-making at all levels;
- (2) to set up a committee of experts with collaborating centres to advise on the definition of norms and standards for essential health technologies, and in particular for medical devices, clinical practice guidelines and eHealth systems;
- (3) jointly to work with other bodies of the United Nations system and other international organizations in order to consolidate projects relating to essential health technologies in Member States;
- (4) to report on implementation of this resolution to the Sixty-first World Health Assembly.

1. Resolution Essential health technologies	
2. Linkage to programme budget	
Area of work	Expected result
Essential health technologies	<p>1. Appropriate strategies promoted and support provided for blood safety and availability, injection safety and prevention of blood-borne infections, including HIV and hepatitis B and C, in health-care settings.</p> <p>2. Capacity strengthened and quality and safety of, and access to, appropriate diagnostics, laboratory services (including basic laboratory tests and screening for HIV, hepatitis B and C) and cell, organ and tissue transplantation services improved.</p> <p>3. Guidance and support provided for implementation of safe, efficient and appropriate essential emergency and surgical care at first-level referral health facilities.</p> <p>4. Support provided to capacity building and to development of standard procedures, and model lists of essential medical devices used.</p> <p>5. Establishment of appropriate components of electronic information for use in health-care systems promoted and effectively supported.</p>
<p>(Briefly indicate the linkage with expected results, indicators, targets, baseline)</p> <p>The resolution is fully consistent with the expected results mentioned above and is linked to all the indicators in the Programme budget 2006-2007 for this area of work. There are also linkages to the technology-related indicator in the other areas of work; furthermore, the resolution calls for a technology programme with an even broader base, covering health technologies as a whole and focusing on needs at country level.</p>	
3. Financial implications	
<p>(a) Total estimated cost for implementation over the “life-cycle” of the resolution (estimated to the nearest US\$ 10 000, including staff and activities) Implementation of the resolution is not limited in time. US\$ 5.2 million are required per biennium (US\$ 4.1 million for staff costs and US\$ 1.1 million for operational costs, including provision of technical support to Member States).</p> <p>(b) Estimated cost for the biennium 2006-2007 (estimated to the nearest US\$ 10 000, including staff and activities) Estimated total cost is US\$ 3.9 million</p> <p>(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities? US\$ 1.7 million can be subsumed under existing headquarters funds for human resources and activities.</p>	
4. Administrative implications	
<p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken and identify the specific regions where relevant)</p> <p>Work will be carried out at global, regional and country levels; attention will be paid to the regions and countries that do not have the resources to support an effective health technology programme.</p> <p>(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile)</p>	

Six additional full-time professional staff will be required across the Organization, together with six half-time general service staff. One professional staff member and one of the general service staff will be required at headquarters to support the development of norms and standards for health technologies, and five regional advisers will be needed, together with the remaining five support staff, at regional offices in order to facilitate regional and country work.

(c) Time frames (indicate broad time frames for implementation and evaluation)

Implementation of the resolution will be part of the continuing programmatic activities and services of this area of work. Monitoring will therefore be subject to the periodic evaluation of WHO's essential health technology activities.

Ms VELÁSQUEZ BERUMEN (alternate to Mr Bailón, Mexico), introducing the draft resolution, said that her country was greatly concerned by the problem of assessing and managing health technologies, especially medical equipment and devices, eHealth and telemedicine systems, medical procedures and support systems. The draft resolution did not deal with pharmaceuticals.

Patient care should be safe, effective and of high quality, and use appropriate, cost-effective and minimally invasive technology. Telemedicine and eHealth networks should provide access to diagnosis and treatment. Unfortunately, these goals could not be attained because equipment was often out of date or not properly maintained, medical staff and technicians were not trained in its use, and it was overused, underused or inaccessible to users. There were many incidents or threats to the safety of patients and health workers and a lack of information about new medical procedures. Sometimes, a patient's file was unavailable because it had been sent to the wrong department.

The draft resolution called upon Member States to determine policies and guidelines for the management of health technologies. Biomedical engineers in health facilities should manage health technologies, including planning, acquisition, maintenance and training of staff in the safe and effective use of medical equipment. It also called upon Member States to evaluate health technologies, taking into account ethical, social, economic and cost considerations, for decision-making and policy-making.

Essential health technologies should be those which were indispensable for the achievement of the Millennium Development Goals. Other technologies were required for the implementation of health-care protocols and for the achievement of health-care goals in a specific region.

Mr MIGUIL (Djibouti), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that, despite the billions of dollars spent every year on health technologies, many Member States still did not recognize their management as an integral part of public health policy. In his Region, national policies and regulations were lacking, and examples of inequitable access, unavailability of medical technologies, a lack of monitoring and safety of use, and evidence of mismanagement and defective maintenance. The Region had some experience in the selection, procurement, installation, use, maintenance and repair of medical technology, particularly during the period of international sanctions against Iraq.

He recalled resolution WHA55.18 on "Quality of care: patient safety", which urged Member States to develop national regulations, systems for quality assurance and procedures for procurement and risk assessment. Strategies relating to cost inflation and inefficiencies in the management of medical technology should be made available to all the countries of the Region. Also needed were tools for updating and refining the regional data set; establishment of national and regional centres of excellence; and national guidelines and sharing of information within and across regions. In September 2006, the Regional Committee would discuss medical devices and equipment in contemporary health-care systems.

Dr VOLJČ (Slovenia) said that he had been shocked to read in the report that almost 95% of medical technology imported into developing countries was unsuited to the needs of national health systems.

Professor PEREIRA MIGUEL (Portugal) said that many Member States of the European Region felt that consideration of essential health technologies should be postponed until the Board's session in January 2007. That would allow matters such as the one just raised by the member for Slovenia to be discussed in more detail.

Dr PHUSIT PRAKONGSAI (alternate to Dr Suwit Wibulpolprasert, Thailand) said that developing countries were consumers rather than producers of medical technologies and were open to exploitation. Technology was sometimes overconcentrated in urban areas. Some technologies, such as computerized tomography, magnetic resonance imaging and X-radiology, were underused or misused, particularly in private-sector facilities where governments found it difficult to regulate their use. Such technologies should be registered for safety monitoring. WHO should examine the matter of donations of second-hand or renovated equipment and contributions of unwanted medicines by developed countries, especially since some lacked the laboratory capacity to verify safety and efficacy. Agencies that used health technology should produce an annual report showing their caseload and other information. Stakeholders in the management of health technologies included national regulatory authorities, which ensured that technologies were safe, effective and suitable for the health needs of the population; they might consult national laboratories about the safety and efficacy of the technology before licensing it. The regulatory authority and laboratories were responsible for post-marketing surveillance, adverse-event reporting and safety, and took immediate legal action where necessary. The health ministry laid down standards governing the mix of services, human resource needs and medical technologies at primary, secondary and tertiary levels. Where necessary, it issued a "certificate of need" for a specific technology, based on evidence of the burden of disease and the existing distribution of medical technology.

An oversupply of medical technology should be countered by increased regulatory capacity. In countries with sufficient institutional capacity, a national health technology assessment system should be set up, in order to compare the cost-effectiveness of existing and new technology. That evidence should be passed on to public and private health-care purchasers.

The report was not comprehensive enough and dealt inadequately with the certificate of need or strengthening institutional capacity for technology assessment. Management of health technologies required a multiple approach, including the legislative framework and its enforcement, and sufficient institutional capacity to produce evidence about cost-effectiveness and burden of disease; certification of need; post-marketing surveillance; and immediate action to withdraw unsafe products from the market.

In paragraph 2(4) of the draft resolution, the Director-General should be asked to report on implementation of the resolution to the Sixty-second World Health Assembly, rather than the Sixty-first. With that change, he supported the draft resolution.

Dr REN Minghui (China) said that the matter of essential health technologies raised questions of basic health care and accessibility. The concept was not clear: different countries understood the term differently. He welcomed WHO's essential health work on technologies, leading to the preparation of guidelines. Since there was little time to discuss the matter at the present session, the Board should take it up again at its session in January 2007.

Ms VALDEZ (alternate to Dr Agwunobi, United States of America) agreed that the matter should be held over to the Board's session in January in order to allow the report to be revised and to give members the opportunity to consult the relevant agencies in their own countries. The draft resolution had been submitted very recently and required further consideration. The Secretariat should substantiate some of the statements in the report, including that in paragraph 7 that almost 95% of medical technology in developing countries was unsuited to the needs of national health systems, and the assertion in paragraph 14 that the acquisition and use of essential health technologies should be determined by the needs of patients and by the best evidence available.

Mr IWABUCHI (alternate to Dr Shinozaki, Japan) said that safe, affordable and effective health technology for people around the world was essential for the attainment of health-related development targets such as the Millennium Development Goals. He welcomed the draft resolution but, as it had only just been issued, more time was needed to consider it.

Dr MBOYA (alternate to Dr Gakuruh, Kenya) observed that for developing countries most health technologies, especially medical equipment, were imported or donated, and required different expertise for use and maintenance, resulting in high costs. A list of essential health technologies that could be adapted by countries to their own needs should be drawn up urgently. Kenya had an essential health package that specified interventions at the various health-care levels from the community upwards. Essential technologies were listed for each level. An international review, with consideration of eHealth technologies and how Member States could be supported in implementing them, would provide useful guidance and harmonization.

Mr RAMOTSOARI (Lesotho) supported the calls for more time to consider the item. Should the Board wish to take a decision at the current session, however, he would propose some amendments to the draft resolution.

Dr GØTRIK (Denmark) also thought that more time should be allowed for the consideration of such an important item and suggested its inclusion in the agenda of the session in January 2007.

Dr JAKSONS (Latvia) supported the previous speaker. In order to facilitate further discussions the term “health technologies” should be clearly defined. If it comprised processes, including treatment procedures, in addition to equipment and staffing, the draft resolution would require much closer scrutiny.

Dr SHANGULA (Namibia) also agreed that more time was needed. The Secretariat should revise the report, clarifying the definition of health technologies and reviewing paragraphs 6 and 7, so that the matter and the draft resolution might be considered at the Board’s session in January 2007.

Mr MIGUIL (Djibouti) supported the draft resolution in principle but agreed that it would be better to postpone further consideration until the session of the Board in January 2007.

Dr ZUCKER (Assistant Director-General), observing that no disease prevention or control programme would be successful without diagnostic services and safe medical devices and equipment, gave the example of emergency relief to Indonesia after the recent earthquake, which was relying heavily on health technologies in dealing with injuries and providing blood transfusions, diagnostic and laboratory tests, and imaging and surgical devices. Similar technologies were required in the prevention and control of communicable and noncommunicable diseases. The Secretariat was seeking to ensure appropriate transfer of technology to all countries. It was also working on definitions of health technologies and preparing a list of 100 essential health technologies to which all communities should have access, with more sophisticated equipment such as computerized tomography scanners and magnetic resonance imaging equipment perhaps being restricted to the tertiary level.

Professor NAGEL (International Federation for Medical and Biological Engineering), speaking at the invitation of the CHAIRMAN, said that his nongovernmental organization had been cooperating with WHO for more than 20 years in policy and planning, quality, safety, norms and standards, technology management and capacity-building, mainly in respect of medical devices. Those devices and equipment safety were covered by the WHO Essential Healthcare Technology Package, a set of guidelines for improved management of physical resources in health care, which included software for resource planning and management. The Federation had the necessary expertise, resources, research capabilities and delivery potential to provide support for maintaining and managing the scientific, engineering and technological aspects of essential health technologies and to facilitate their transfer to

developing countries. It could also provide training in the proper and efficient use of health technologies, including the newer electronic applications, and support the development of maintenance policies; it offered further collaboration with WHO in those matters. It was collaborating with industry, the World Standards Cooperation and the regulatory authorities in Member States to foster good manufacturing and regulatory practices, including before- and after-sales surveillance and measures to curb misuse of health technologies. The report should have provided more guidance for the development and planning of future activities and for links to other WHO initiatives such as the World Alliance for Patient Safety and the Global Health Workforce Alliance. The Federation offered its support in devising a comprehensive strategy for safe and efficient health technologies and their management and suggested that the strategy should cover health technologies as a whole, without the qualification “essential”. Regrettably, the draft resolution had been received too late for detailed comment, but the Federation endorsed it in principle and was willing to collaborate in taking the proposal further and in working to achieve the stated goals. The Board might consider including provisions to regulate the profession of clinical engineer.

The CHAIRMAN said that there appeared to be a consensus that more time should be allowed for consideration of such a complex topic and that a decision at the current session would be premature. The Secretariat should therefore be asked to revise and expand the report to reflect the members’ concerns and to take into account any relevant additional material. The item, together with the draft resolution, should be included in the agenda of the Board’s session in January 2007.

It was so agreed.

3. MATTERS FOR INFORMATION: Item 8 of the Agenda

Health information systems in support of the Millennium Development Goals: Item 8.3 of the Agenda (Document EB118/16)

The CHAIRMAN drew attention to the following draft resolution proposed by the delegations of Afghanistan, Bhutan, Kenya, Madagascar, Mexico, Sri Lanka and Thailand, and a report on its administrative and financial implications for the Secretariat:

The Executive Board,
Having considered the report on health information systems in support of the Millennium Development Goals,¹

RECOMMENDS to the Sixtieth World Health Assembly the adoption of the following resolution:

The Sixtieth World Health Assembly,
Recalling resolution WHA58.30 on achieving internationally agreed health-related development goals, including those contained in the Millennium Declaration;
Noting resolution WHA58.28 on eHealth, and mindful of resolution WHA58.34 on the Ministerial Summit on Health Research;
Acknowledging that sound information is critical in framing evidence-based health policy and making decisions, and fundamental for monitoring progress towards

¹ Document EB118/16.

internationally agreed health-related development goals, including those contained in the United Nations Millennium Declaration;

Recognizing that health information systems in most developing countries are weak, fragmented, understaffed, and inadequately resourced;

Convinced of the importance of health information, especially about inequities, to inform decisions on delivery of interventions to those who need them most;

Acknowledging that health information and research are complementary as foundations for strengthening health systems and health policy;

Mindful of the key role of national statistics offices in developing and implementing national statistical strategies and contributing to population health information;

Noting the constitutional normative mandates of WHO in health information and epidemiological reporting and reaffirming the Organization's role as a founding partner of and hosting secretariat for the Health Metrics Network which has determined core standards for health information systems,

1. URGES Member States to mobilize the necessary scientific, technical, social, political, human and financial resources in order:

- (1) to develop, implement, strengthen and assess plans to strengthen their health information systems through collaboration between health and statistics sectors and other partners;
- (2) to bring together technical and development partners around a coherent and coordinated country-led strategy and plan for strengthening health information systems that is fully integrated in the mainstream of national health programmes and plans;
- (3) to strengthen the capacity of planners and managers at national and local levels to synthesize, analyse, disseminate and use country evidence to inform decision-making and raise public awareness;
- (4) to link strengthening of health information systems to policies and programmes for building of statistical capacity in general;

2. CALLS UPON the health information and statistical communities, other international organizations, including global health initiatives and funds, the private sector, civil society and other concerned stakeholders to provide strong, sustained support for strengthening of information systems using the standards and guiding principles set out in the framework of the Health Metrics Network, and covering the spectrum of health statistics, including health determinants; health resources, expenditures and system functioning; service access, coverage and quality; health outcomes and health status; and according particular attention to information on poverty and inequity in health;

3. REQUESTS the Director-General:

- (1) to strengthen the information and evidence culture of the Organization and to ensure the use of accurate and timely health statistics to generate evidence for major policy decisions and recommendations within WHO;
- (2) to further strengthen WHO's activities in health statistics at global, regional and country levels and provide support to Member States to build capacities for development of health information systems and generation, analysis, dissemination and use of data;
- (3) to promote better access to health statistics, encourage information dissemination to all stakeholders in appropriate and accessible formats, and foster transparency in data analysis, synthesis and evaluation, including peer review;
- (4) to promote improved alignment, harmonization and coordination of health information activities, bearing in mind the Paris Declaration on Aid Effectiveness -

Ownership, Harmonization, Alignment, Results and Mutual Accountability (2005) and the Best Practice Principles for Global Health Partnership Activities at country level¹;

(5) to undertake regular reviews of country experiences, to provide support for updating the framework of the Health Metrics Network in line with lessons learnt and evolving methodologies, and to report on progress as from the Sixty-second World Health Assembly.

1. Resolution Health information systems in support of the Millennium Development Goals	
2. Linkage to programme budget	
Area of work	Expected result
Health information, evidence and research policy	1. Strengthened and reformed country health-information systems that provide and use quality and timely information for local health problems and programmes and for monitoring of major international goals
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
The resolution is fully consistent with the expected result through its focus on strengthening country health-information systems in keeping with international standards defined in the Health Metrics Network, together with the priority given by WHO to evidence-based decision-making. The resolution is in line with indicators and targets concerning both a WHO database of core health indicators with metadata, focusing on the health-related Millennium Development Goals, and the development and implementation by countries of norms and standards, such as the <i>International statistical classification of diseases and related health problems</i> and the <i>International classification of functioning, disability and health</i> , and reviews of health status and health-systems metrics.	
3. Financial implications	
(a) Total estimated cost for implementation over the “life-cycle” of the resolution (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 40 million (does not include the Health Metrics Network budget)	
(b) Estimated cost for the biennium 2006-2007 (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 11 million (does not include the Health Metrics Network budget)	
(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities? About US\$ 7 million of the proposed expenditure for the current biennium can be absorbed under existing programmed activities. Additional funding of US\$ 4 million is required to enable WHO to play a lead role at global, regional and country levels and continue to be a key player in the Health Metrics Network.	
4. Administrative implications	
(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken and identify the specific regions where relevant)	
Headquarters, in collaboration with the regional offices, will continue to develop and test tools and methods and set normative guidance. Globally, WHO will continue to serve as the repository of sound health statistics and evidence. Adaptation of normative guidance and implementation of plans to strengthen health information systems will take place at country level with strong regional office support.	

¹ Best Practice Principles for Global Health Partnership Activities at Country Level. Report of the Working Group on Global Health Partnerships. Paris, High-level Forum on the Health MDGs, 14-15 November 2005.

(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile)

A total of seven full-time equivalent professional staff are required to enable the regional offices to provide strong support to country implementation (one in each region, with two in the Regional Office for Africa). The staff concerned require skills in statistics, epidemiology, planning and monitoring and evaluation.

Limited additional staffing is required at headquarters (two full-time equivalent professional staff) in order to ensure quality technical work on health statistics at global level and adherence to agreed standards. The staff concerned require skills in statistics, epidemiology, biostatistics, demography and health economics.

(c) Time frames (indicate broad time frames for implementation and evaluation)

Implementation of normative work and support to regions and countries will start immediately, in collaboration with Health Metric Network activities. Support to country implementation will commence in the current biennium and accelerate subsequently as capacity increases and as a function of needs of country level. Evaluations of progress will be undertaken at regular intervals in the context of the biennial reviews of the programme budget.

Dr KAKAR (Afghanistan), speaking as a sponsor of the draft resolution, said that every good health system was associated with a good information system. Better measurement required good information. He urged the Board to support the draft resolution.

Ms WARANYA TEOKUL (adviser to Dr Suwit Wibulpolprasert, Thailand), also speaking as a sponsor, underlined the importance of evidence for decision-making. It could also be used for advocacy in parliaments, civil society and the international community, besides helping set programme priorities and targets, guiding resource allocation, and serving as a monitoring and evaluation tool. The report emphasized that information collected in the health sector and by national statistical offices should be combined. Health information systems required strengthening in most developing countries in order to provide baseline data on health status and access to health services, and their distribution across population groups.

Dr ABEYKOON (alternate to Mr de Silva, Sri Lanka) said that health information systems had been repeatedly discussed over the years yet further work was needed. With support from WHO and other partners, Sri Lanka had launched initiatives in order to obtain reliable disaggregated data more quickly; strengthen its public health information system; strengthen the hospital information system with its two components, patient records and the management information system; and increase the use of information technology for electronic consultation with peripheral areas and continuing staff development. Those activities required considerable effort. The report could have provided further guidance on processing and dissemination of health information and the draft resolution should be amended in order to draw attention to those aspects, including more use of information technology.

Dr KHALFAN (Bahrain) supported the draft resolution.

Ms PATTERSON (alternate to Ms Halton, Australia) said that Australia had identified strengthening of health systems, including health information systems, as essential to achieving the Millennium Development Goals and a core element of its increased health support to the Asia-Pacific region over the four years ahead. She proposed that, in the fifth preambular paragraph of the resolution recommended in the draft resolution, the words “especially about inequities” should be replaced with “disaggregated by gender, age and key socioeconomic factors”. A new paragraph 1(4) should read “to strengthen the capacity of health workers to collect accurate and relevant health information”.

Professor PEREIRA MIGUEL (Portugal) said that Member States of the European Union, recognizing the importance of the topic, wanted more time to consider the draft resolution.

Dr SINGAY (Bhutan) endorsed the views of previous speakers on the importance of health information systems and supported the draft resolution.

Dr WINT (Jamaica) said that health information systems were crucial for health systems development, and especially for evidence-based decision-making. They were part of all the work done in health, not only the efforts to achieve the Millennium Development Goals. He supported the draft resolution with the amendment suggested by the member for Australia, and proposed substituting “increase” for “further strengthen” in paragraph 3(2).

Dr MBOYA (alternate to Dr Gakuruh, Kenya) said that Kenya had sponsored the draft resolution because insufficient investment in health information systems was compromising the capacity of countries to prevent disease. High-quality information was needed in formulating policy and directing the implementation of programmes.

Ms VALDEZ (alternate to Dr Agwunobi, United States of America) said that her country strongly supported the use of health information technology in order to improve the quality and efficiency of health-care, and to provide crucial vital statistics and epidemiological data. The report highlighted the many challenges that countries faced in collecting and analysing data for use in national policy and decision-making. The United States supported the role of WHO and of its regional offices in exploring ways to use health information technology and systems in order to improve the delivery of primary health care, particularly in resource-poor settings. She welcomed the draft resolution, as amended by the members for Australia and Jamaica. Because there were standards and guiding principles other than those framed in the Health Metrics Network mentioned in paragraph 2, she suggested inserting the word “including” after “information systems”.

Mr MIGUIL (Djibouti) supported the draft resolution. Reliable, timely and relevant information was essential for enlightened decision-making, particularly as WHO had just adopted a results-based management approach in planning its activities. However, the title of the resolution was too restrictive: the topic of health information systems was much broader in scope than the three Millennium Development Goals relating to health. A list of indicators should be drawn up in order to ensure better follow-up for WHO’s activities at all levels. As for the Millennium Development Goals, WHO should be making an annual report to the United Nations on progress in achieving the three health-related ones.

Dr KAKAR (Afghanistan) accepted the proposed amendments. Referring to paragraph 1(3), he said that planners and managers were sometimes found at provincial level, as well as the national and local levels; the paragraph should therefore read: “to strengthen the capacity of planners and managers at various levels of the health system to utilize health information for evidence-based decision-making and for raising public awareness”.

Professor PEREIRA MIGUEL (Portugal) said the proposed amendments made the draft resolution acceptable.

Dr REN Minghui (China) supported the draft resolution and emphasized the importance of establishing health information systems, especially for obtaining evidence on which to base decision. He asked for clarification of the role of the Health Metrics Network.

Dr GØTRIK (Denmark), supported by Mr PIRONEA (alternate to Professor Paunescu, Romania), supported the draft resolution, with the amendments proposed. However, the practice of submitting draft resolutions to the Board at very short notice, as in the present case, should not be followed in future.

The CHAIRMAN, speaking in his capacity as the member for Bolivia, agreed with the member for Djibouti. However, the three principal Millennium Development Goals were related to health and so were the goals for education, because without proper nutrition education was of little use. He welcomed the amendments suggested by the members for Australia and Jamaica. There was a direct relationship between international health matters and legislation relating, in particular, to endemic diseases. Sound, accurate national information systems on health were a prerequisite for the development of international policies. He endorsed the draft resolution, with the amendments proposed.

Speaking in his capacity as Chairman, he agreed with the member for Denmark about the late submission of documents and draft resolutions which did not leave enough time for the members themselves, let alone national experts, to form a view on them. Nor should the Board be submitting to the Health Assembly resolutions that it had not had sufficient time to study. It was the quality, not the quantity, of decisions that mattered, and it might be preferable to have fewer but more representative and more realistic resolutions.

Dr KEAN (Executive Director, Office of the Director-General) read out the proposed amendments. In the fifth preambular paragraph the words “especially about inequities” should be replaced by “disaggregated by gender, age and key socioeconomic factors”. Paragraph 1(3) would read: “to strengthen the capacity of planners and management at various levels of the health system to utilize health information for evidence-based decision-making and for raising public awareness”. An additional paragraph 1(4) would read: “to strengthen the capacity of health workers to collect accurate and relevant health data”. The present paragraph 1(4) would become 1(5). In paragraph 2, the word “including” would be inserted after “information systems”. In paragraph 3(2) the words “further strengthen” would be replaced by “increase”. The title of the resolution would be amended to read “Strengthening of health information systems”.

Dr WINT (Jamaica) mentioned the importance of analysing information. He would prefer to retain the reference in paragraph 1(3) to the analysis of evidence.

Dr KAKAR (Afghanistan) said that in his experience it was difficult to find professionals at the local level able to analyse statistics.

Dr KEAN (Executive Director, Office of the Director-General) suggested rewording paragraph 1(3) to read “to strengthen the capacity of planners and managers at various levels of the health system to synthesize, analyse, disseminate and to utilize health information systems for evidence-based decision-making and for raising public awareness”.

The CHAIRMAN said that he took it that the Board wished to adopt the draft resolution, as amended.

The resolution, as amended, was adopted.¹

Dr EVANS (Assistant Director-General) quoted the late Director-General who, when referring to the fundamental value and ethic of strengthening health information systems, had said that if people were to count, it was first necessary to be able to count people. The present focus on outcomes was an opportunity to strengthen health information systems. Everything done in order to track particular interventions could enhance health information systems.

The Secretariat was using information technology for disseminating health information, especially knowledge management and eHealth, in order to facilitate access to information. Those

¹ Resolution EB118.R4.

activities were fully compatible with the results-based management framework. Progress on implementing the General Programme of Work and the medium-term strategic plan was being actively monitored.

With regard to reporting on progress in achieving the health-related Millennium Development Goals, the Secretariat already contributed significantly to reports to the United Nations on the subject. Other bodies, including UNICEF and UNFPA, collaborated with WHO on specific types of data relevant to the indicators for the health-related Millennium Development Goals. The Secretariat would, however, look for a more specific reporting opportunity.

The Health Metrics Network aimed to strengthen country health information systems. A set of tools had been developed, and the Network was operating in 50 to 60 countries in order to promote greater investment in health information systems.

4. MANAGEMENT, BUDGET AND FINANCIAL MATTERS: Item 6 of the Agenda

Strategic resource allocation: Item 6.1 of the Agenda (Document EB118/7)

Dr JAKSONS (Latvia) emphasized evaluation of country needs, identifying outcomes, preparing programmes, and the cross-checking of outcomes described in paragraph 19 of the report. The Board could discuss the results of the cross-checking within the proposed programme budget. A validation mechanism that had nothing to do with the allocation of resources was valuable. If there were significant discrepancies between the results of resource allocation and the validation, it could be decided which of the two sets of indicators should be amended in future. The test of one process was its application in practice.

Mr IWABUCHI (alternate to Dr Shinozaki, Japan) enquired how the guiding principles would work. Principle 3 appeared to mean that both assessed and extrabudgetary contributions would be allocated in accordance with the guiding principles, and thus with the validation mechanism. However, according to the Eleventh General Programme of Work, the Secretariat expected to consult with individual donors in order to align extrabudgetary contributions with WHO's priorities. It was not the role of donors to adapt themselves to the validation mechanism. It was also unclear how the switch would be made from a resource-based to a results-based approach. Planning in any organization, including WHO, had to respect resource limitations.

Mr SHUAAIB (alternate to Dr Al-Shammari, Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, commended the late Director-General's efforts to decentralize the Organization and develop results-based budgeting. The Secretariat had to work together at all levels in order to improve performance. More would be expected of WHO regional and country offices, and resources transferred from headquarters to the regions should be distributed fairly.

Decision WHA57(10) emphasized support to countries in greatest need, as did the validation mechanism. He agreed that emergencies and the Global Polio Eradication Initiative should be excluded from the validation mechanism. Health needs not properly captured by the indicators used in the validation mechanism should be dealt with as separate entities. He supported the validation mechanism, on various conditions: that the distribution of resources between headquarters and the regions was apportioned and took full account of changes resulting from decentralization; that the regions in greatest need received their fair share of resources and were not deprived of new resources raised through the regular budget and voluntary contributions; that resources allocated for emergencies and poliomyelitis eradication and not covered by the needs assessment models were treated as a separate component of resource allocation; that the Human Development Index was used to assess the health needs of countries; and that countries with large populations were not unfairly treated.

Dr KHALFAN (Bahrain) disagreed with the statement in paragraph 19 in the Annex to the report that education was only one of many social determinants of health. Education was sometimes even more important than socioeconomic status.

Dr SUWIT WIBULPOLPRASERT (Thailand) recalled the intensive negotiations on the formula for regional resource allocation at the Fifty-second World Health Assembly in 1998. They had almost torn the Organization apart. The new validation mechanism and resource allocation did not show any redistribution of resources among WHO regions. No region would have its budget reduced because about 5% of the headquarters budget would be allocated to the regions, but he was not convinced of the benefits. At country level, funding from WHO's regular budget was negligible in comparison to that received from other sources. Moreover, the Organization's main function was knowledge generation, management and sharing and advocacy, and for those purposes it needed a Secretariat that was both technically and academically strong. However, headquarters was continuously being eroded by reductions in its budget, and that ran contrary to countries' expectations of the Organization.

WHO was increasingly being financed from extrabudgetary sources. In 1998, two-thirds of the Organization's resources had come from assessed contributions, compared with 25% in 2006. Nearly all the 75% from other contributions was earmarked for particular programme areas, rather than for the Organization as a whole. In having to negotiate with individual donors, the Secretariat had to strive merely to keep the Organization going. That was not healthy because the contributions from Member States were increasingly being used in compliance with the wishes of donors, whereas the 25% of resources raised from assessed contributions were used mainly in order to maintain the Secretariat, leaving very little money for programme activities. In order to do any actual work, the Organization had to negotiate with donors for assistance. That situation could be exploited in future by donors in order to further their own agendas. The Secretariat should find strategic directions to solving the problem in the long term, advise the Board accordingly, and ensure that the tax revenue given to the Secretariat was used to respond to the needs of Member States. Only thus would WHO sustain its social credibility.

Dr SHANGULA (Namibia) recalled that the contents of the report had been discussed on several previous occasions and common ground had been reached on some matters. Consultations with the regions had been taken into account. The Board should not reopen those discussions but should concentrate on items that had been referred back for further clarification. Chief among those was the validation mechanism, and the Board had to decide whether further work needed to be done on the report. Once the complex process was in operation, it could be monitored and adjustments made.

Mr RAMOTSOARI (Lesotho) proposed that the Board note the report, which dealt with previously raised concerns. Results-based management was important and its implementation should be monitored and reviewed if necessary.

Dr TANGI (Tonga) agreed with the two previous speakers.

Dr GØTRIK (Denmark) said that the preparation of the report had been long and complex, especially the task of devising the validation mechanism. The Programme, Budget and Administration Committee had discussed the guiding principles in detail, and had reached a conclusion based on consensus. He was willing to accept the report as it stood.

Dr REN Minghui (China) said that the preparation of the report had been a transparent process, taking into account the views of all parties. He expressed his support for the report and would be following its implementation.

The CHAIRMAN, speaking in his capacity as the member for Bolivia, said that the report was valuable and represented the accomplishment of the task assigned to the Secretariat. It should be

remembered that resources were more than money. In addition to budgetary and extrabudgetary funds, the Organization had a wealth of knowledge on science, public health and medicine. It also had its collaborating centres and relations with academic and scientific institutions and nongovernmental organizations. In dealing with the needs of developing countries and working towards the Millennium Development Goals, the Organization should take all its resources into account.

The ACTING DIRECTOR-GENERAL remarked on the observation of the member for Latvia that the validation mechanism was not the same as resource allocation. Great progress had been made in understanding the practical implications of a results-based management approach and the value of a validation mechanism as part of that system. The preparation of the Proposed programme budget 2008-2009 would involve recognizing the technical and substantive needs of both Member States and the Secretariat.

With regard to the concerns expressed by the member for Japan, progress had been made in managing the regular budget and extrabudgetary contributions within a single framework, although more remained to be done. All the Organization's financial resources had to be taken into account, because even with a results-based approach to budgeting, it was necessary to know what resources were available in order to draw up a realistic budget. The process should be driven by the desired results, rather than by taking the allocation of resources as a starting point.

Replying to the member for Iraq about results-based management, decentralization and the effective transfer of resources within the Organization, he said that most of WHO's work was done at country level, but that did not imply that the headquarters structure would be dismantled. The strategic directions agreed for the Organization's work required a balance between a strong headquarters, performance of global functions, and proper implementation of programmes at country level. Resources should be transferred to countries where they were needed.

The comment about education in the Annex on guiding principles was inappropriate and would be deleted.

The overall financing of the Organization, mentioned by the member for Thailand, had been discussed by the Programme, Budget and Administration Committee, in both general terms and with respect to specific management reforms. The effectiveness of WHO's financing, including alignment of resources and results and the administrative burden on the Organization of managing voluntary contributions, would be on the agenda of that Committee's next meeting.

Combining medical science with management had perhaps resulted in a rather simplistic overview of progress but, with regard to alignment between resources and results, the standard deviation had been reduced by half. However, monitoring of progress would require more time, a separate report and a different kind of consultation. The financing of the Organization could be discussed in the regional committees when they considered the Proposed programme budget, by the Programme, Budget and Administration Committee and the Board in January 2007.

Monitoring the results-based approach would be important.

Responding to the comments made by the Chairman, he said that the Organization's priorities were not expressed only in monetary terms. Some areas of work were of considerable technical and political importance, yet did not have large budgets.

The CHAIRMAN said that, if there were no objections, he took it that the Board wished to endorse the contents of the report.

It was so agreed.

Committees of the Executive Board: filling of vacancies: Item 6.2 of the Agenda (Documents EB118/9 and EB118/9 Add.1)

- **Standing Committee on Nongovernmental Organizations**

Dr KEAN (Executive Director, Office of the Director-General) drew attention to paragraph 2 of document EB118/9 Add.1, which contained the Chairman's proposals for filling the four vacancies on the Standing Committee on Nongovernmental Organizations.

Decision: The Executive Board appointed Dr P.M. Buss (Brazil), Dr Ren Minghui (China), Dr R.R. Jean Louis (Madagascar), and Dr Suwit Wibulpolprasert (Thailand) as members of its Standing Committee on Nongovernmental Organizations for the duration of their term of office on the Executive Board, in addition to Mr O.K. Shiraliyev (Azerbaijan), already a member of the Committee. It was understood that if any member of the Committee was unable to attend, his or her successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Committee.¹

- **Programme, Budget and Administration Committee**

Dr KEAN (Executive Director, Office of the Director-General) said that the Chairman's proposals for filling the six vacancies on the Programme, Budget and Administration Committee were contained in paragraph 3 of document EB118/9 Add.1.

Decision: The Executive Board appointed as members of the Programme, Budget and Administration Committee Dr F. Kakar (Afghanistan), Ms J. Halton (Australia), Dr J.K. Gøtrik (Denmark), Dr W.T. Gwenigale (Liberia), Mr N.S. de Silva (Sri Lanka) and Dr J. Agwunobi (United States of America) for a two-year period or until expiry of their membership on the Board, whichever occurs first, in addition to Dr Jigmi Singay (Bhutan), Dr A.H.I. Al-Shamari (Iraq), Dr B. Wint (Jamaica), Professor J. Pereira Miguel (Portugal), Dr J.D. Ntawukuliryayo (Rwanda) and Dr V. Tangi (Tonga), already members of the Committee, and Dr F. Antezana Aranibar (Bolivia), Chairman of the Board, member ex officio, and Dr J. Nyikal (Kenya), Vice-Chairman of the Board, member ex officio. It was understood that if any member of the Committee was unable to attend, his or her successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Committee.²

Dr KEAN (Executive Director, Office of the Director-General) said that, as Australia's membership of the Executive Board would expire in one year, the Western Pacific Region would need to nominate two members in 2007. He proposed that Dr J.N. Nyikal (Kenya), in his capacity as Vice-Chairman of the Executive Board, should, like the Chairman of the Executive Board, be a member ex officio of the Committee.

It was so decided.

- **Foundation Committees**

The CHAIRMAN announced that there was no vacancy on any of the Foundation Committees.

¹ Decision EB118(1).

² Decision EB118(2).

Representatives of the Executive Board at the Sixtieth World Health Assembly

Dr KEAN (Executive Director, Office of the Director-General) drew attention to the proposals in document EB118/9 Add.1 for the appointment of representatives of the Executive Board at the Sixtieth World Health Assembly.

Decision: The Executive Board, in accordance with paragraph 1 of resolution EB59.R7, appointed its Chairman, Dr F. Antezana Aranibar (Bolivia), and its first three Vice-Chairmen, Mr O.K. Shiraliyev (Azerbaijan), Dr B. Sadasivan (Singapore) and Dr Suwit Wibulpolprasert (Thailand), to represent the Board at the Sixtieth World Health Assembly. It was understood that if any of those members were not available for the Health Assembly, the other Vice-Chairman, Dr J. Nyikal (Kenya), and the Rapporteur, Dr A.H. Saheli (Libyan Arab Jamahiriya), could be asked to represent the Board.¹

Future sessions of the Executive Board and the Health Assembly: Item 6.3 of the Agenda (Document EB118/10)

Dr KEAN (Executive Director, Office of the Director-General) stated that, following the Board's decision to convene its next (119th) session in November 2006, the first of the decisions contained in paragraph 5 of the report would have to be amended by reference to both that and the 120th session in January 2007. The decision concerning the Sixtieth World Health Assembly would be unchanged.

Dr SHANGULA (Namibia) asked why the Sixtieth World Health Assembly would last 10 days when the Fifty-ninth Assembly had taken only six days to complete its work. Efforts should be made to manage the Health Assembly's time better, especially in Committee A.

Dr REN Minghui (China) asked why the session of the Board scheduled was numbered as a regular session.

Mr BURCI (Legal Counsel) explained that it would be a regular session convened under Rule 5 of the Rules of Procedure.

Dr REN Minghui (China) said that the Board's decision to accelerate the procedure to elect the next Director-General referred to the November 2006 session as a "special session".²

The CHAIRMAN noted that the discrepancy would have to be rectified.

Ms BLACKWOOD (alternate to Dr Agwunobi, United States of America) queried the numbering of the special session of the Executive Board held on 23 May 2006 and that of the special session of the Health Assembly to be held in November 2006.

Dr KAKAR (Afghanistan), referring to the statement by the member for Namibia, said that he would have preferred the two most recent Health Assemblies to have been given more time, because some decisions had been too precipitate because of lack of time, and several decisions had had to be referred back to the Executive Board.

¹ Decision EB118(3).

² Decision EBSS(2).

Mr BURCI (Legal Counsel) explained that a special session of the Executive Board was one convened under Rule 6, namely either at the joint request of any 10 members and held within the following 30 days or by the Director-General, in consultation with the Chairman, if events occurred that required immediate action under Article 28(i) of the Constitution. The special session held on 23 May 2006 clearly fell into that category. The November 2006 session of the Health Assembly was to be convened under Rule 2 of the Rules of Procedure of the World Health Assembly, according to which the Director-General could convene a special session of the Health Assembly “at the request of the Executive Board at such time and place as the Board shall determine”. The November session would in fact be the first special session of the Health Assembly.

Dr GØTRIK (Denmark) asked that serious consideration be given to the duration of the Health Assembly. Time management was indeed part of the problem. He congratulated the Chairman on his excellent time management, achieved by adhering strictly to the starting times of meeting; much time would be saved at the Health Assembly by doing the same.

Dr KEAN (Executive Director, Office of the Director-General) pointed out that the length of sessions of the Executive Board and the Health Assembly had been gradually reduced over the past 10 years. However, the Sixtieth World Health Assembly would be longer than the Fifty-ninth because it would be dealing with the Proposed programme budget.

The CHAIRMAN confirmed that programme budget sessions lasted longer because so many Member States wished to make statements.

Dr SHANGULA (Namibia) said that he accepted that explanation, but continued to believe there was scope for better time management.

Decision: The Executive Board decided that its 119th session should be convened on Monday, 6 November 2006, at WHO headquarters, Geneva, and should close no later than Wednesday, 8 November 2006. It further decided that its 120th session should be convened on Monday, 22 January 2007, at WHO headquarters, Geneva, and should close no later than Tuesday, 30 January 2007.¹

Decision: The Executive Board decided that the Sixtieth World Health Assembly should be held at the Palais des Nations, Geneva, opening on Monday, 14 May 2007, and that it should close no later than Wednesday, 23 May 2007.²

Professor PEREIRA MIGUEL (Portugal), speaking on behalf of the European Union and its Member States, expressed regret over the late dispatch of documents for the session, especially as it was a recurrent problem. Paragraph 15 of document EB118/2, on the outcome of the Fifty-ninth World Health Assembly, referred to an amendment to Rule 14 of the Rules of Procedure of the World Health Assembly to the effect that documents should be available six weeks in advance of a regular session of the Health Assembly. The report of the Programme, Budget and Administration Committee of the Executive Board, contained in document EB118/3, noted that one item of the Committee’s agenda had been forwarded to the Board for review as a result of the late distribution of the relevant document. Rule 5 of the Rules of Procedure of the Executive Board stated that documents for a regular session of the Board should be dispatched not less than six weeks before its commencement. In future, there should be better compliance with those Rules, and the only documents the Board should consider with less notice should be those relating to the Health Assembly immediately preceding its session.

¹ Decision EB118(4).

² Decision EB118(5).

The CHAIRMAN said that those comments would be noted by the Secretariat. The relevant Rules should be observed, but the Board should bear in mind that it took time to prepare documents, which needed to be as up-to-date as possible.

5. MATTERS FOR INFORMATION: Item 8 of the Agenda (resumed)

Progress report on implementation of resolution: Disability, including prevention, management and rehabilitation (resolution WHA58.23): Item 8.1 of the Agenda (Document EB118/12)

The Board noted the report.

Expert committees and study groups: Item 8.2 of the Agenda (Document EB118/13)

Ms VALDEZ (alternate to Dr Agwunobi, United States of America), referring to the report of the Joint FAO/WHO Expert Committee on Food Additives, noted that over the past few years WHO and FAO had successfully increased the transparency of the Committee's decisions and the process by which its experts were selected. She supported that and emphasized continuing vigilance in order to ensure the integrity of the Committee's programme. Expert committees had to be geographically balanced and accepted internationally. The Secretariat had to reconcile those needs with the requirements of high standards of scientific expertise; it should ensure that the Committee had the best scientists from around the world when shaping evidence-based safety standards for additives and contaminants. Maintaining such a standard of excellence would raise consumer confidence in the global food supply. Unfortunately the Committee's financial viability had recently been called into question. She urged the Secretariat and Member States to prioritize financial support for the Committee, so that the Member States and the Codex Alimentarius Commission could rely on sound, science-based advice on food safety issues.

The CHAIRMAN agreed that the panel of experts must be constantly updated and urged Member States to provide names of scientists to serve on the Committee, so that the Secretariat could achieve the desired geographical balance while keeping the requirement of scientific expertise paramount. Experts from developing countries without an international reputation should also be considered for the panel.

The Board noted the report.

The meeting rose at 17:25.

FIFTH MEETING

Wednesday, 31 May 2006, at 09:05

Chairman: Dr F. ANTEZANA ARANÍBAR (Bolivia)

1. TRIBUTE TO DR LEE

The CHAIRMAN said that a five-minute video film would be shown as a tribute to the late Director-General of WHO.

The film was projected.

The CHAIRMAN spoke of the gap left by the unexpected death of Dr Lee. He had held the office of Director-General for only three years, but had made a considerable mark on public health. The best tribute that could be paid to his memory would be to continue working for health for all, and especially for those most in need of it. The Board would pursue its efforts in that direction, and in so doing render a permanent and worthy testament to Dr Lee.

2. STAFFING MATTERS: Item 7 of the Agenda

Statement by a representative of the WHO staff associations: Item 7.1 of the agenda (Document EB118/INF.DOC./1)

Ms LALIBERTÉ (representative of the WHO staff associations), speaking at the invitation of the CHAIRMAN, expressed the sadness felt by all WHO staff members at the untimely passing of the Director-General.

She thanked the Chairman for enabling the staff of WHO to exercise their fundamental right of freedom of expression. The staff felt honoured to serve WHO and the headquarters Staff Association was seeking to promote an efficient, fair and rules-based Organization conducive to productive work in a climate of confidence and mutual respect. Solutions were sought to the staff's concerns. There was evidence of abuse of rules and procedures and gross inequalities in the treatment of staff in several departments, and productive work was often hampered by repeated restructuring exercises. The Staff Association objected strongly to a process of review that was non-transparent, arbitrary and unjust, particularly when the process excluded senior managers. Four specific concrete suggestions to improve staff/management relations were proposed in the document.

The Staff Association at headquarters wished to pioneer a new era of staff/management relations in the context of the United Nations reform process, and requested the Board to establish mechanisms to monitor progress and ensure a rules-based Organization. She invited the Chairman to mediate in the efforts to improve staff/management relations.

The CHAIRMAN said that, after consultations, it was evident that nothing had been done to prevent the representative of the staff associations from making her statement. The Board wished to foster good relations between the staff and the administration, and would be ready to take any action required. He welcomed the assurances of the cooperation and solidarity of the staff, not only during the current period of transition, but throughout the life of the Organization. As Dr Lee had said, the

progress achieved by WHO could not have been made without the dedication, skills and work of all the staff.

The ACTING DIRECTOR-GENERAL confirmed that the administration welcomed the strong engagement of the staff and the staff associations. Dr Lee had encouraged that engagement and the staff's representation. No attempt had been made to prevent the staff associations from making a statement to the Board. Concern had been expressed that the statement was not fully supported by the regional staff associations. It was important for staff members who represented all the staff associations, not just the headquarters Association, to be able to address the Board. However, staff concerns about the situation in Geneva should be voiced to the Board. The administration was committed to improve the functioning of the Organization and its results-based management approach. The Secretariat's work was driven by the need to respond to Member States. The competencies required had been defined in recruitment policy and performance assessment. Much had been invested in the past 18 months in management and leadership training and in staff development. Gaps and challenges remained. A major review had been made of the functions of the different departments at headquarters and of the necessary staff, within the budget. There was a steering committee to ensure close cooperation with the Staff Association. Problems had been addressed, perhaps not fully, and the input of the staff associations was valued.

He was willing to review the internal justice system. On the issue of direct appointments, Dr Lee had had a meeting with the Staff Association just before he died. He had expressed a clear preference for a standard selection process, but had said that sometimes direct appointments were more appropriate. Compared with other international organizations WHO had a low rate of direct appointments (7.8%), and Dr Lee had never initiated a direct appointment himself. Such appointments had always been based on a thorough process and proper documentation.

In an earlier submitted version of the statement, there had been very serious allegations about corruption in the Organization. Dr Lee, who had been committed to ethical conduct, had asked the Internal Auditor to investigate the allegations and had called for staff to come forward. In that particular case, it was agreed that, exceptionally, they could report to the External Auditor. The Acting Director-General undertook to pursue the matter. Any abuse of the rules must be investigated. Some instances might have occurred, but on balance, managers at WHO were fulfilling their functions responsibly.

The request for participation by the headquarters Staff Association in the Programme, Budget and Administration Committee had been forwarded to the Chairman of that Committee. It was for the Board to decide whether to overturn the existing decision on the matter.

The CHAIRMAN commented that that statement showed the good faith of the administration and its concern to maintain dialogue with the staff.

Dr SHANGULA (Namibia) queried an apparent contradiction between the phrase "on behalf of WHO staff members worldwide" and the footnote at the bottom of the first page of the statement to the effect that it did not reflect the view of the staff associations at WHO regional offices.

Dr TANGI (Tonga) stressed the principle that all WHO staff, at all levels, were accountable to the Member States and therefore to all the taxpayers in the world. The role of the staff was moreover to fulfil WHO's mission. Any statement on behalf of the staff should represent the majority view of all staff, including staff members working at regional offices – he proposed the figure of at least 70% of members. As for staff representation in the Programme, Budget and Administration Committee of the Executive Board, the decision should be left to the Committee itself. On the subject of performance management, it was important for Board members to be informed of all aspects, including the views of those assessing performance. As for appointments, he drew attention to Article 35 of the Constitution, which provided the regulatory framework.

Mr MIGUIL (Djibouti) asked why the independent audit requested in paragraph 6(b) of the statement should apply only to staff below D1 level. If an audit took place, it should apply to all levels of staff.

Dr SUWIT WIBULPOLPRASERT (Thailand) recalled the theme of World Health Day 2006, "Working together for health". Member States should take good care of WHO staff, their recruitment, retention and productivity. He agreed with the member for Tonga that WHO staff, being paid for by taxpayers' money, were also the staff of Member States.

He supported the four recommendations and said that he was pleased to hear that Dr Lee had never prevented the staff from speaking out. He had, however, witnessed instances of bias among senior officers of WHO, who had forbidden staff members, directly or indirectly, to do so. Clear accountability and transparency were needed for WHO to maintain its credibility. All staff members were international civil servants and should be loyal to their organization and all its Member States, which in turn should maintain vigilance on staff matters.

He shared the concerns expressed by the previous speaker about the scope of the proposed independent audit. Ungraded staff appointments were much more important for the work of the Organization. He also wanted to know why the staff associations should not be represented in the Programme, Budget and Administration Committee. There was no apparent reason why representatives of all the staff associations should not be allowed to attend meetings of Board committees, for example as observers. The serious matter of nontransparent financial transactions, nepotism, cronyism and other unethical conduct had been raised by the Internal Auditor and discussed by the Health Assembly. The Secretariat should follow up with action, and report to the Board and the Health Assembly on the steps taken. The credibility of WHO must not be put at risk by the actions of individuals or parts of the Organization.

Ms LALIBERTÉ (representative of the WHO staff associations), responding to comments about the non-representation of the views of staff in WHO regional offices, said that the headquarters Staff Association had followed a democratic decision-making process. Other staff associations had been asked on two occasions to submit their views so that a more representative statement could be produced but only that of IARC had done so.

She wished to make available to Board members the written refusal issued by the administration, on behalf of the Acting Director-General, to allow the Staff Association to address the Board. She assured the members for Tonga and Thailand that the Association had great concern for taxpayers' money and even greater concern for the poor of the world who did not pay taxes and were affected by disease; she called for greater democracy in the Organization, to ensure that their voices too could be heard.

In the course of the preparation of its statement to the Board, the Staff Association had encountered a number of problems in regard to its freedom of speech and that situation was not acceptable. The concerns raised about corruption, nepotism and cronyism had not related to Dr Lee, but other parts of the Organization. The Association would willingly provide evidence in support of its statement to Board members on request, with adequate staff protection.

The ACTING DIRECTOR-GENERAL stressed that the Organization promoted and upheld freedom of expression, but certain technical aspects of the work of an international civil servant entailed specific responsibilities. Copies could be provided to all members of the message he had sent to staff, stating that the Staff Association was not and would not be prevented from presenting its statement to the Board. The concern that he had raised was whether the statement submitted represented the views of all the staff associations. Responsibility for the decision to submit a statement that provided only a partial view did not lie with him but with the elected members of staff associations across the Organization. He had consulted the Chairman about the submission of the statement in the light of the right conferred on him by the Executive Board to submit, through the Director-General, a statement reflecting the views of the staff associations on such matters. The Chairman had not objected to the submission of the statement.

In his previous capacity, he had appreciated collaborating with Board members to improve the working conditions of the Organization and its staff. He welcomed discussion on ways of improving the internal justice system. He did not consider it appropriate to conduct an independent audit only of staff below D1 level, for reasons that Dr Lee had explained to the headquarters Staff Association the previous week. That did not preclude the possibility of reviewing individual cases as necessary, and processes for such reviews were already in place. A major exercise had been undertaken to provide a significant number of staff members on short-term contracts with the opportunity of applying for fixed-term positions. With regard to the investigation of allegations of misconduct, mechanisms including recourse to the Office of Internal Oversight Services and the Internal Auditor also existed, and these could be further strengthened. Staff protection was a priority and he was committed to providing yet further guarantees in that respect, particularly where suspicions of misconduct arose. Representation in the Programme, Budget and Administration Committee was a matter for the Board itself to consider.

The CHAIRMAN, in reply to a question from Mr MIGUIL (Djibouti), said that the issue of the proposed audit had been taken into account in the Acting Director-General's response. It was clear that any such audit should apply to all staff.

There had been positive and open dialogue on both sides, and the Board could help to foster that dialogue, as the well-being of staff was central to the functioning of the Organization.

The Board noted the statement by the representative of the WHO staff associations.

Confirmation of amendments to the Staff Regulations and Staff Rules: Item 7.2 of the Agenda (Documents EB118/11 and EB118/11 Add.1)

Ms BLACKWOOD (alternate to Dr Agwunobi, United States of America) noted that the report contained a large number of amendments. It also indicated (paragraph 2) that the International Civil Service Commission had made numerous recommendations that awaited decisions by the United Nations General Assembly. Since the proposed date for the amendments to become effective was 1 January 2007, she preferred to defer its approval until those decisions had been taken. The additional costs that had not been foreseen in the Programme budget 2006-2007 would be subject to the availability of funds. Consideration of the amendments could thus be proposed to the Board at its January session and, if approved, they could be applied retroactively rather than prematurely.

Ms PATTERSON (alternate to Ms Halton, Australia) asked how the Secretariat planned to absorb the additional costs of US\$ 22.8 million in 2007, and whether efficiency and productivity enhancement strategies would be applied. If the amendments were approved, she would welcome an update, perhaps at the January session of the Board, on the absorption of those costs.

Dr GØTRIK (Denmark) asked whether the matter under consideration had been discussed in the Programme, Budget and Administration Committee, and whether a recommendation should have been made by the Committee to the Board.

Mr HENNING (Human Resources Services), in response to the comments by the member for the United States of America, said that approval of the recommendations by the United Nations General Assembly had been delayed until later in the year as a result of the recent reform proposals by the Secretary-General. Those proposals were entirely independent of the recommendations of the International Civil Service Commission. One reason for submission of the recommendations ahead of the General Assembly had been that they were expected to be approved effective as from 1 January 2007. However, the lack of synchronization did not allow the Secretariat to plan the implementation procedures well in advance. One alternative would be to endorse the recommendations on condition that the General Assembly approved the Commission's recommendations. That would still provide an opportunity to prepare and introduce some measures, for instance the waiving of the

44-month rule to which many staff members were subject under the present contractual arrangements, provided that a framework for the implementation of such measures was in place by 1 January 2007.

In response to the questions raised by the member for Australia, the cost had not been contemplated at the time, owing to the late submission by the Commission of the recommendations on contract reform, and thus the calculations presented in document EB118/11 Add.1 reflected a maximum expenditure scenario. Some entitlements would not be applied with immediate effect in 2007, since all depended on the duration of contracts. If the Board was not ready to recommend an increase in the budget of the Organization, other strategies would have to be resorted to, in consultation with regional partners. Turning to the question posed by the member for Denmark, he said that, owing to the delays already mentioned, the Programme, Budget and Administration Committee had not received the document sufficiently early to be able to consult and had consequently referred the matter to the Board.

The ACTING DIRECTOR-GENERAL said that he hoped that the Board would endorse the amendments to the Staff Rules subject to approval by the United Nations General Assembly of the Commission's recommendations, which constituted an important management reform for the United Nations system and would improve the functioning of the Organization. The previous speaker had outlined the favoured approach to the associated costs. Following confirmation by the Board, the amendments could be implemented on 1 January 2007, subject to a review of financial feasibility.

Dr SHANGULA (Namibia) asked whether staff members would be negatively affected if the decision to confirm the amendments were postponed. He had reservations about endorsing the amendments subject to conditions. What would happen if those conditions were not met? Given that the date for implementation of the amendments was 1 January 2007, could the Board not take a decision at its meeting in January 2007 and apply it retroactively? If the amendments were implemented at the end of January, for example, surely no staff member would be negatively affected. He would have preferred the Programme, Budget and Administration Committee to have dealt with the matter and submitted a recommendation to the Board.

Ms BLACKWOOD (alternate to Dr Agwunobi, United States of America) agreed on the undesirability of a conditional decision, but said that she understood the need to set certain processes in motion between that decision and January 2007. She could be flexible, but sought clarification from the Secretariat as to what those processes were. It was important that the associated costs be absorbed as far as possible.

The CHAIRMAN, speaking as the member for Bolivia, concurred with the member for Namibia on the importance of an opinion from the Programme, Budget and Administration Committee, particularly in view of the cost implications, which had not been taken into account in the current budget. The possible savings and efficiency measures mentioned should help, although in that case approval for the amendments be less urgent. He also asked what processes remained to be carried out. No member of the Board wanted to slow down the Organization's work, especially in regard to country cooperation.

Mr HENNING (Human Resources Services) said that one process concerned the global management system, which was at the final design stage. The procedures to be used by the system had to be defined by 30 June. If the proposed amendments to the Staff Rules were not approved by then, the system would reflect current policies and procedures and would subsequently have to be redesigned, at great expense. Implementation of all the contract changes had to be put in place. Straightforward conversions into continuing appointments would not involve extra cost. Review of fixed-term appointments might not have financial implications, but would require practical measures. Temporary appointments were the main problem because of the 44-month rule and the desirability of starting the year 2007 with the new type of contract with its economies of scale and based on the proposed amendments to the Staff Rules. That would be in the best interests of the Organization and

its programme delivery, as it had been identified, in some regions, that WHO was losing highly competent staff to competitors, including nongovernmental organizations, which were offering more attractive salaries and conditions of service. The International Civil Service Commission's recommendations were global and were expected to apply to all organizations. The proposed amendments to the Staff Rules did, however, have financial implications arising from the alignment of short-term staff with fixed-term staff, including compensation payments, in order to attract and retain staff members of the highest calibre.

Dr TANGI (Tonga) expressed surprise that the proposed amendments to the Staff Rules had been submitted to the Programme, Budget and Administration Committee at the last minute since, in the context of the reform process, they must have been under consideration for some time. In his view, the Board probably had no choice but to endorse the amendments, but he hoped that in future such decisions would go through the proper channels and be allocated the time they required.

Dr GØTRIK (Denmark) said that, if he had understood correctly, there were insufficient funds in the 2007 budget for the measures proposed. He asked whether by endorsing the proposed amendments to the Staff Rules the Board was endorsing a budget increase, or whether the proposed measures could be covered by the existing budget.

Mr HENNING (Human Resources Services) said that, in accordance with the revised procedures, the administrative and financial implications of the proposed amendments to the Staff Rules had been submitted to the Board. Members had to decide whether the Board wanted to approve a budget increase or whether it wished to recommend, as proposed by the member for Australia, that the proposed amendments to the Staff Rules be covered by economies of scale to be made by the Organization.

Mr AITKEN (Adviser to the Director-General) confirmed that the costs for the current biennium would have to be absorbed through savings and efficiencies related to the current reform process, since any budget increase would have to be approved by the Health Assembly. The cost implications for the 2008-2009 biennium would be presented to the Executive Board and the Health Assembly the following year.

Dr SHANGULA (Namibia) asked whether the measures which, in Mr Henning's view, needed to be taken between then and implementation of the amendments in January 2007 could not be taken in anticipation of the Board's subsequent approval at its meeting in January 2007.

Dr NTAWUKULIRYAYO (Rwanda) agreed in principle with taking a conditional decision, but to implement the amendments to the Staff Rules on that basis would be impossible. The matter should be referred to the Programme, Budget and Administration Committee, which could report to the Board in January 2007, with a corresponding budget. The Board could then make a decision, which could be applied retroactively, as the member for Namibia had suggested.

The ACTING DIRECTOR-GENERAL apologized for the late transmission of the document under discussion to the Programme, Budget and Administration Committee, and explained that it had been hoped to know the outcome of the United Nations General Assembly before submitting the proposals. There was nothing to stop the Board endorsing the proposal without approval by the General Assembly; the Board's decision did not have to be a conditional one. There was a desire, however, for continuity and coherence within the general United Nations reform process, in which WHO had been actively involved. The cost implications were considerable, but in fact they corresponded to an increase Organization-wide of at most 2% in staff costs. There had been constructive cooperation with staff associations on the matter of improving conditions for staff.

The Board could endorse the amendments to the Staff Rules and ask him to report back to the Programme, Budget and Administration Committee in January 2007 on their implementation. The

Board could, at its session in January 2007, endorse the de facto implementation of those amendments. A major factor to be taken into account was the global management system and the need to avoid extra costs in that regard. The 2% maximum increase would have to be absorbed, while safeguarding the functioning of the Organization to the maximum extent possible way.

Ms BLACKWOOD (alternate to Dr Agwunobi, United States of America) said that she was prepared to confirm the amendments to the Staff Rules on condition that the United Nations General Assembly approved the International Civil Service Commission's recommendations. She asked the Secretariat to report back to the Programme, Budget and Administration Committee and to the Executive Board in January 2007 on that matter.

Dr SHANGULA (Namibia), noting that certain processes would have to be completed that would require the Board's approval before the amendments to the Staff Rules could take effect in January 2007, repeated his earlier question: whether, in order to avoid further delays, it would be possible for those processes to be carried out on the assumption that they would be approved.

Dr NTAWUKULIRYAYO (Rwanda) said that as Health Minister he recognized the problems associated with the loss of qualified staff. He therefore agreed that the proposed amendments should be approved in principle, on the understanding that the budgetary implications would be made available to the Board at its session in January 2007, together with an indication of where cuts might be made.

The CHAIRMAN, speaking as the member for Bolivia, agreed with the member for Tonga that, if the Board did not approve the proposed amendments during the current session, the Organization would suffer as a result. The financial implications would then have to be dealt with at the Board's session in January 2007.

The Secretariat would be unable to move forward without a clear indication that the Board had no objections to the proposed reform. The Board had three options, therefore: to give its approval subject to the conditions mentioned by the members for the United States of America and Namibia; to give its approval unconditionally; or to defer the matter to its session in January 2007.

Mr HENNING (Human Resources Services), replying to the member for Namibia, said that, without the necessary changes to the Staff Rules, even changes to official procedures and manuals could not be implemented. It would also be impossible to define the Rules for the global management system, which were needed to set the parameters of the information technology component of the human resources programme, or to offer staff appointments under the proposed new contract format, as all those changes depended on the changes to the Staff Rules.

Dr SHANGULA (Namibia) clarified that he had asked whether it would be possible to make the necessary changes in anticipation of approval so that the relevant processes could be completed and ready for implementation on the appointed date.

Mr HENNING (Human Resources Services) said that changes to the Staff Rules had to be approved before the procedures could be changed. Any attempt to change the procedures otherwise would not be possible.

Dr NTAWUKULIRYAYO (Rwanda) expressed his support, in principle, for the proposed amendments. However, their implementation would have to wait until after the Board's session in January 2007 when the budgetary implications became clear. If the Board did not approve the amendments at its current session, their implementation would be still further delayed. He therefore proposed that the Board should give its approval subject to the budgetary implications being agreed by the Programme, Budget and Administration Committee and pending a decision by the United Nations General Assembly.

The CHAIRMAN said that he took it that the Board wished to approve the proposed amendments to the Staff Rules subject to approval by the United Nations General Assembly and approval of the budgetary implications by the Health Assembly, following their consideration by the Programme, Budget and Administration Committee.

It was so agreed.

3. MATTERS FOR INFORMATION: Item 8 of the Agenda (continued)

eHealth: standardized terminology: Item 8.4 of the Agenda (Document EB118/8)

The CHAIRMAN said that as it was World No Tobacco Day he wished to take the opportunity to pay tribute to all who worked to reduce tobacco use throughout the world, in particular for the benefit of passive smokers, who were all too often children.

He invited comments on the report on standardized terminology in eHealth.

Dr RAHANTANIRINA (Madagascar) welcomed the valuable information on new developments in health-related information technology and stressed access to reliable data for decision-making. WHO should be involved in the further standardization of terminologies and nomenclatures through participation in an expert working group or independent commission, as outlined in paragraphs 13 and 14 of the report.

Dr GØTRIK (Denmark), endorsing the comments of the previous speaker, expressed the hope that eHealth would be taken up again by the Board at its session in January 2007 and that WHO's role, as outlined in paragraphs 13 and 14, would be further developed.

Ms VALDEZ (alternate to Dr Agwunobi, United States of America) said that she favoured the option set out in paragraph 14, but more details were needed on the role envisaged for WHO in terms of technical requirements and financial implications.

Professor AYDIN (Turkey) agreed that health systems benefited from digitalization, but improvements in the field would depend on the determination of common standards. WHO's expertise in international health systems, health information systems and in establishing international classifications would facilitate such an undertaking which, in turn, could enhance electronic health information systems and activities such as global surveillance and patient safety. WHO's leadership would ensure equal access to a standardized terminology for all Member States. Many countries had eHealth plans and would welcome guidance from WHO. The development of standardized terminologies needed further discussion by the Board. Consideration might also be given to the drafting of a resolution on WHO's involvement in line with the options described in paragraphs 14 or 15.

Ms PATTERSON (alternate to Ms Halton, Australia) said that she was committed to the greater use of eHealth tools and services, and the development and maintenance of international clinical terminology. International progress should be in line with national developments. WHO's approach should neither delay international initiatives nor have substantial financial implications. She supported the call for further information on the technical and financial implications of the report's options.

Dr ABEYKOON (alternate to Mr de Silva, Sri Lanka) said that eHealth technologies and the need for consistent terminology were of increasing importance. He therefore supported WHO's participation in that area. He favoured the options set out in paragraphs 13 and 14 of the report and looked forward to further information.

Mrs VELÁZQUEZ BERÚMEN (alternate to Mr Bailón, Mexico) supported the proposals in the report and asked whether a working group would be set up in order to define specific applications: electronic medical records; hospital information and diagnostic imaging systems; confidentiality; patient safety and the security of information. Countries that were considering using electronic administration and hospital information systems and, in particular, telemedicine as part of clinical information systems, could make use of eHealth programmes and systems in order to improve the quality of treatment for patients, as well as their access to information.

Dr HANSEN-KOENIG (Luxembourg) said that WHO should emphasize the development of the new eHealth technologies and a decision on future activities should be taken soon. She favoured the options set out in paragraph 14 and requested further information for a more detailed discussion by the Board at its January 2007 session.

Dr SINGAY (Bhutan) agreed that eHealth technologies had great potential, especially for countries such as his own, and that WHO should play a leading role in that area. He favoured the options set out in paragraphs 13 and 14 and joined in calls for further information to be submitted to the Board at its session in January 2007.

Mr FAHY (European Commission) said that the European Community was undertaking work in the area of standardized terminology and welcomed the reference in the report to the European Committee for Standardization. The European Commission would be pleased to collaborate with WHO in order to avoid duplication of effort. He favoured further consideration of the item by the Board and offered his support in the preparatory work.

Dr EVANS (Assistant Director-General) noted the preference for the options set out in paragraphs 13 and 14 of the report. Work on WHO's future role would continue. Further information on that, the technical requirements and financial implications of the options, the recent survey undertaken by the WHO Global Observatory for eHealth, and the other matters raised during the discussions would be submitted to the Board at its session in January 2007. The offer of support from the European Commission was greatly appreciated.

The Board noted the report.

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

Rational use of medicines: progress in implementing the WHO medicines strategy: Item 5.3 of the Agenda (Documents EB118/6 and EB118/6 Add. 1) (continued from the third meeting, section 1)

The CHAIRMAN said that a drafting group had met in order to consider the proposed amendments to the draft resolution. The group had not completed its work and had suggested deferring the matter for the Board's consideration at its session in January 2007. Rational use of medicines was a wide-ranging topic and the resolution should be given a specific focus rather than repeating aspects covered in previous texts.

Dr GØTRIK (Denmark) said that the Member States of the European Union would also be prepared to defer further consideration.

Dr SOPIDA CHAVANICHKUL (alternate to Dr Suwit Wibulpolprasert, Thailand) expressed a flexible preference for deferring consideration by the Board to its January 2007 session.

Dr SHANGULA (Namibia) said that if the matter was deferred Board members should be provided with further information on the focus of the draft resolution.

The CHAIRMAN said that he took it that the Board wished to defer further consideration of the matter to its session in January 2007, and requested the Secretariat to provide Board members in the meantime with a text of the draft resolution incorporating the amendments, together with the additional information requested.

It was so agreed.

5. CLOSURE OF THE SESSION

The ACTING DIRECTOR-GENERAL recalled that one of Dr Lee's last actions had been to invite the new High-level panel on UN System-wide Coherence in areas of Development, Humanitarian Assistance, Environment to a meeting with the Geneva-based organizations. WHO would host that meeting on 2 June 2006.

After reviewing work during the session, including consideration of the procedure to elect a new Director-General, he said that discussions had already taken place as to how the Secretariat could move ahead as a result of the decisions taken at the Health Assembly, for example in respect of the International Health Regulations (2005). The Secretariat had also taken swift and effective action in response to the recent earthquake in Indonesia, with the involvement of the country office, the Regional Office for South-East Asia and headquarters.

The CHAIRMAN said that the Board had successfully fulfilled its role at the present session in clarifying procedures and must next shoulder the great responsibility of selecting a new Director-General. While remembering the spirit in which the late Director-General had influenced the Organization, the Board should move ahead constructively to meet the important challenges of the forthcoming sessions.

After the customary exchange of courtesies, he declared the session closed.

The meeting rose at 12:00.
