REGIONAL COMMITTEE
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Provisional Agenda item

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EQUITABLE GEOGRAPHICAL DISTRIBUTION OF THE MEMBERSHIP OF THE EXECUTIVE BOARD

The expansion of membership of the South-East Asia (SEA) Region on the WHO Executive Board has been under discussion by SEA Member countries since 2006 in various forums. SEA Member countries have been considering the fact that current understanding of Article 24 of the Constitution (regional membership in the WHO Executive Board based on "equitable geographical distribution" by number of Member countries only) does not adequately reflect developments that have occurred in the last two decades in terms of demographic changes and the health needs of the populations concerned.

Representation in the WHO Executive Board is important as it provides an opportunity for a select number of Member States to set and influence the global health agenda. Whether resolutions are passed in the Executive Board through voting or not, the recommendations and agreed text of resolutions have a direct bearing on the actions taken by WHO. Equitable representation from all regions is necessary to achieve a fair balance.

The Sixtieth Regional Committee proposed the inclusion of an agenda item entitled "Equitable geographical distribution of the membership of the Executive Board" in the provisional agenda of the 122nd Session of the EB. However, during the finalization of the provisional agenda, the item was deferred to a later date. A recent Meeting of the Advisory Committee held in SEARO (30 June–3 July 2008) advised the Regional Director to convene a regional consultation on the subject to chalk out a strategy to move this important issue forward. The consultation was held on 13-14 August 2008 and included participants from both health and foreign ministries representing nine Member countries of the South-East Asia Region. The Sixty-first Regional Committee is invited to consider the Regional Strategy contained in this

paper.

Background

1. Representation in the WHO Executive Board (EB) is important as it provides an opportunity for a select number of Member States to set and influence the global health agenda. Whether resolutions are passed in the Executive Board through voting or not, the recommendations and agreed text of resolutions have a direct bearing on the actions taken by WHO. Equitable representation from all regions is necessary to achieve a fair balance. WHO works for all Member countries and must continue to be perceived as such, as witnessed by its action and rules of governance.

2. The principle currently followed for regional representation is stated as "take into account an equitable geographical distribution" in Article 24 of the Constitution, and assumed to imply representation in proportion of the number of countries in the region. Accordingly, maximum EB seats are allocated to one Region with 53 countries (8 seats) and the minimum are allocated to the South-East Asia Region with 11 countries (3 seats). A new paradigm of governance is needed to set the health agenda by those most affected – those representing large population centres carrying a large burden of disease.

3. The expansion of membership of the South-East Asia (SEA) Region on the Executive Board has been under discussion with SEA Member countries since 2006 in various forums. The Health Secretaries and Consultative Committee for Programme Development and Management (CCPDM) Meeting held in July 2007 agreed to constitute a group of experts to propose a scientific approach in support of the expansion of the SEA regional representation.

4. Consequently, the regional expert group (which consisted of selected renowned biostatisticians and public health experts from Member countries of the South-East Asia Region) met and recommended formulae, in which health needs, size of population and financial contribution, in addition to the number of Member States in each region, played an important and dominant role. The Sixtieth Regional Committee agreed that the recommended formulae best reflected its views to support an increase of SEA Region representation in the Executive Board.

5. The Sixtieth Regional Committee proposed the inclusion of an agenda item entitled "Equitable geographical distribution of the membership of the Executive Board" in the provisional agenda of the 122nd Session of the EB. However, during the finalization of the provisional agenda, the item was deferred to a later date. A recent Meeting of the Advisory Committee held in the South-East Asia Regional Office (SEARO) on 30 June–3 July 2008 advised the Regional Director to convene a regional consultation on the subject to chalk out a regional strategy to move this important issue forward.

6. The consultation was held on 13-14 August 2008 and included participants from both health and foreign ministries representing nine Member countries of the South-East Asia

Region. The regional strategy drafted during the consultation is now presented to the Sixty-first Session of the Regional Committee for its consideration.

Rationale

7. The primary rationale for efforts to redefine equitable geographical distribution in the WHO governing body context is that the allocation of 3 out of 34 EB seats to the SEA Region is extremely low for providing a voice to more than one fourth of the world's population, and to that section of people who are in desperate need of all kinds of health inputs – expertise, infrastructure and operational guidance. To advance this rationale, various options based on a scientific approach were considered.

8. In order to balance this with the existing geographical distribution, the method that takes into account number of Member countries, population, burden of disease and financial contribution is deemed the most appropriate basis for adopting and taking the advocacy strategy forward. This approach would result in the number of Executive Board seats increasing from 34 to 36, one each for the SEA and Western Pacific (WP) regions. This method will also maintain the current position of the EB membership of the regions of Africa, Americas, Eastern Mediterranean and Europe (for detailed analysis, see Annex).

Assumptions and challenges

9. The results of the latest overall review of the issue of regional allocation of seats made by the Executive Board have come into effect in September 2005 (adopted by resolution WHA51.23 in May 1998 on separate proposals from the Cook Islands of the Western Pacific Region and the Regional Committee for Europe). It should thus be expected that any proposal to reallocate the seats or to increase further the size of the board – particularly one coming from a region perceived as already having the highest ratio of seats per governments – will require an in-depth discussion by Member countries and a systematic approach will stand SEA Region countries in good stead.

10. Bearing in mind that the Health Assembly will almost certainly seek the views of the board on any proposal to change either size of the board or the regional allocation of the board's seats, it will be required that any proposal at the global level should first be submitted to the board rather than going directly to the Health Assembly. It can also be expected that as the proposal involves a significant or novel change in the method of allocating seats on the board, considerable time should be allowed for the process. In this respect, it is quite possible that the board would seek the views of each of the regional committees as part of its consideration of the proposal. Extensive informal consultations with as many regions and Member countries within those regions as possible would also go far in reaching the acceptable outcome.

Guiding principles for advocacy

- The current regional membership is loosely based on the number of countries in the Region. However, determining regional representation by the population size, disease burden and extent of poverty should be considered, so that a region representing 26 per cent of the world's population and having almost one third of the world disease burden *proactively sets the global public health agenda*.
- There is a low SEA regional financial contribution to the global WHO budget; however, the region has the *second-highest expenditure*.
- Expanding membership of the EB will make it *more representative*.
- *Increasing load* of communicable diseases and emerging noncommunicable diseases in the Region, the burden of mortality from natural disasters and improving data availability to assess *disease burden* support moving this issue forward.
- *The power to make decisions in this regard rests with:*

  (i) Member countries (heads of governments/health ministers/ministers of foreign affairs); (ii) Regional Committee; and (iii) the World Health Assembly through the Executive Board.
- *The decision of Member countries participating in the World Health Assembly can also be influenced, among others, by:*

  (i) Intergovernmental bodies and international organizations; (ii) civil society, including NGOs and eminent personalities; and (iii) the media.
- *Benefits from the expanded EB membership:*

  (i) more effective spending due to inclusive decision-making; (ii) harmonization of needs and interventions; (iii) the scientific approach introduced to advocate increase in membership is applicable to any region; and (iv) increase in solidarity among Member countries for effective cooperation in addressing the disease burden.

Vision of the regional strategy

11. Addressing the health needs and concerns of all.

Goal

12. Member countries of the SEA Region, by increasing their equitable representation in the Executive Board of WHO, aspire to have a greater voice and more effective role for the people of the Region, reflecting the changing demographic balance and disease burden to

address the health needs and concerns of the people of the Region who are largely below the poverty line.

Objective

13. Secure minimum of two thirds agreement and ratification by Member countries for a change in the WHO Constitution, allowing the adoption of a more systematic approach to determining representation, which will lead to increased representation on the EB for the SEA Region.

Tools and mechanisms for advocating the expansion of the EB

14. The Regional Committee could identify the lead country/countries for taking this regional strategy forward.

15. Formal and informal channels of communication by both the health and foreign ministries of the Member countries could be used to take up the following activities:

- Initiate a dialogue with counterpart ministries;
- bring the matter up in bilateral meetings as well as in multilateral/regional forums;
- activate SEA Region countries' missions in Geneva and world capitals;
- circulate a policy document among Member countries, civil society, NGOs and eminent personalities for strong advocacy;
- focus on the issue in SEA Member countries by the health ministries, foreign ministries, technical forums, research agencies, etc.; and
- facilitate seminars and workshops for intra- and interregional advocacy.

Action Plan for moving the EB expansion forward

For Member countries

- After consideration by the Regional Committee, a resolution may be submitted by the identified lead country of the South-East Asia Region to the Executive Board meeting in May 2009 through the WHO Director-General;
- efforts should be made by the SEA Member countries to place this item in the agenda of the World Health Assembly in May 2010;
- identify focal persons/agencies in Member countries who will take this strategy forward;
- review nationally the implementation of this strategy on a regular basis by the health ministers; and

- collectively assess the progress in the Regional Committee meetings.

For WHO/SEARO

- Support the Member countries in their effort in taking this strategy forward.

16. The Sixty-first Regional Committee is invited to consider this Regional Strategy.

Annex

This model is based on the number of countries, population, disability-adjusted life years (DALYs) per 1000 population, and financial contribution of SEA Member countries to the WHO budget. When equal weights are assigned according to their proportion in the Region out of the world's total, the formula reads as follows:

$$\text{Seats} = \left(\frac{\frac{C}{\Sigma C} + \frac{P}{\Sigma P} + \frac{D}{\Sigma D} + \frac{F}{\Sigma F}}{4} \right) \times 34,$$

where

C = Number of countries in the region; P = Population of the region;

D = DALYs lost in the region per 1000 population; F = a total of financial contribution (assessed) of all Member countries of the region.

This formula gives one extra seat to the SEA and the Western Pacific regions (see Table 1). With the guiding principle that no region should reduce current representation in numbers, all others would maintain their present strength. This would imply an increase of two in the size of the EB from the present 34 seats to 36 seats.

Table 1: *Executive Board representation*

Region	Present seats	Seats as per formula	When the present number of seats is protected
AFR	7	6	7
AMR	6	6	6
EMR	5	3	5
EUR	8	8	8
SEAR	3	4	4
WPR	5	6	6
Total	34	33[a]	36

[a] Calculations are based on 34 seats but the total is different due to rounding-off

The positive features of this formula are that the number of countries continues to be a determinant, while the facts of financial contribution are also considered. At the same time, health needs in terms of population and burden of disease (DALYs lost per 1000 population) also get due recognition. Thus, all four parameters are assigned equal weights under this formula. That is, nearly nine seats are allocated on the basis of number of countries, nine on the basis of population count, nine on the basis of DALYs lost per unit of population, and nine on the basis of financial contribution.