



WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD

134TH SESSION

GENEVA, 20–25 JANUARY 2014

**SUMMARY RECORDS
LIST OF PARTICIPANTS**

GENEVA
2014

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

ACHR	– Advisory Committee on Health Research	OIE	– <i>Office International des Epizooties</i>
ASEAN	– Association of Southeast Asian Nations	PAHO	– Pan American Health Organization
CEB	– United Nations System Chief Executives Board for Coordination	UNAIDS	– Joint United Nations Programme on HIV/AIDS
CIOMS	– Council for International Organizations of Medical Sciences	UNCTAD	– United Nations Conference on Trade and Development
FAO	– Food and Agriculture Organization of the United Nations	UNDCP	– United Nations International Drug Control Programme
IAEA	– International Atomic Energy Agency	UNDP	– United Nations Development Programme
IARC	– International Agency for Research on Cancer	UNEP	– United Nations Environment Programme
ICAO	– International Civil Aviation Organization	UNESCO	– United Nations Educational, Scientific and Cultural Organization
IFAD	– International Fund for Agricultural Development	UNFPA	– United Nations Population Fund
ILO	– International Labour Organization (Office)	UNHCR	– Office of the United Nations High Commissioner for Refugees
IMF	– International Monetary Fund	UNICEF	– United Nations Children’s Fund
IMO	– International Maritime Organization	UNIDO	– United Nations Industrial Development Organization
INCB	– International Narcotics Control Board	UNRWA	– United Nations Relief and Works Agency for Palestine Refugees in the Near East
ITU	– International Telecommunication Union	WFP	– World Food Programme
OECD	– Organisation for Economic Co-operation and Development	WIPO	– World Intellectual Property Organization
		WMO	– World Meteorological Organization
		WTO	– World Trade Organization

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

PREFACE

The 134th session of the Executive Board was held at WHO headquarters, Geneva, from 20 to 25 January 2014. The proceedings are issued in two volumes. The present volume contains the summary records of the Board's discussions, the list of participants and officers, and details regarding membership of committees. The resolutions and decisions, and relevant annexes are issued in document EB134/2014/REC/1.

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¹ As adopted by the Board at its first meeting (20 January 2014).

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¹ Deleted from the agenda of the 134th session of the Executive Board.

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- A. Global health sector strategy on HIV/AIDS, 2011–2015 (resolution WHA64.14)
- B. Eradication of dracunculiasis (resolution WHA64.16)

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- C. Child injury prevention (resolution WHA64.27)

Promoting health through the life course

- D. Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets (resolution WHA57.12)
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- F. Youth and health risks (resolution WHA64.28)
- G. Implementation of the recommendations of the United Nations Commission on Life-Saving Commodities for Women and Children (resolution WHA66.7)
- H. Climate change and health (resolution EB124.R5)

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- I. Global strategy and plan of action on public health, innovation and intellectual property (resolution WHA61.21)
- J. Availability, safety and quality of blood products (resolution WHA63.12)
- K. Human organ and tissue transplantation (resolution WHA63.22)
- L. WHO strategy on research for health

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- M. WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies (resolution WHA65.20)

Corporate services/enabling functions

- N. Multilingualism: implementation of action plan (resolution WHA61.12)

14. Closure of the session

LIST OF DOCUMENTS

EB134/1 Rev.1	Agenda ¹
EB134/1 (annotated)	Provisional agenda (annotated)
EB134/1 Add.1 and EB134/1 Add.2	Proposal for a supplementary agenda item
EB134/2	Report by the Director-General to the Executive Board at its 134th session
EB134/3	Report of the Programme, Budget and Administration Committee of the Executive Board
EB134/4	Reports of the regional committees to the Executive Board
EB134/5	WHO reform: reform implementation plan and report
EB134/6	Options for improved decision-making by the governing bodies
EB134/6 Add.1	Use of an electronic voting system for the appointment of the Director-General
EB134/6 Add.2	Methods of work of the governing bodies. Draft decision
EB134/7	Streamlining national reporting and communication with Member States
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EB134/10	Strategic resource allocation
EB134/10 Add.1	Strategic resource allocation. Draft decision
EB134/11	Financing of administration and management costs
EB134/12	Global strategy and targets for tuberculosis prevention, care and control after 2015

¹ See page ix.

EB134/13	Global vaccine action plan
EB134/14 and EB134/14 Add.1	Follow-up to the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases
EB134/14 Add.2	Follow-up to the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases. Draft decision
EB134/14 Add.3	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly ¹
EB134/15	Maternal, infant and young child nutrition
EB134/16	Draft WHO global disability action plan 2014–2021: Better health for all people with disabilities
EB134/17	Monitoring the achievement of the health-related Millennium Development Goals
EB134/17 Add.1	Newborn health
EB134/18	Health in the post-2015 United Nations development agenda
EB134/19	Multisectoral action for a life course approach to healthy ageing
EB134/20	[Document cancelled]
EB134/21	Addressing the global challenge of violence, in particular against women and girls
EB134/22	International Code of Conduct on Pesticide Management
EB134/23	Public health impacts of exposure to mercury and mercury compounds: the role of WHO and ministries of public health in the implementation of the Minamata Convention on Mercury
EB134/24	Traditional medicine
EB134/25	Substandard/spurious/falsely-labelled/falsified/counterfeit medical products
EB134/26	Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination

¹ See document EB134/2014/REC/1, Annex 5.

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EB134/27	Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination. Health research and development demonstration projects
EB134/28	Strengthening of palliative care as a component of integrated treatment throughout the life course
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EB134/30	Health intervention and technology assessment in support of universal health coverage
EB134/31	Access to essential medicines
EB134/32	Implementation of the International Health Regulations (2005)
EB134/32 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly ¹
EB134/33	Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits. Pandemic Influenza Preparedness Framework
EB134/34	Smallpox eradication: destruction of variola virus stocks
EB134/35	Poliomyelitis: intensification of the global eradication initiative
EB134/36	Improving the health of patients infected with viral hepatitis
EB134/37	Antimicrobial drug resistance
EB134/38	Evaluation. Update report and proposed workplan for 2014–2015
EB134/39	Second stage evaluation on WHO reform
EB134/40	Confirmation of amendments to the Financial Rules ²
EB134/41	Real estate: update on the Geneva buildings renovation strategy
EB134/42	Hosted health partnerships
EB134/43	Follow-up on the report of the Working Group on the election of the Director-General of the World Health Organization

¹ See document EB134/2014/REC/1, Annex 5.

² See document EB134/2014/REC/1, Annex 1.

EB134/44	Reports of committees of the Executive Board. Standing Committee on Nongovernmental Organizations ¹
EB134/45	Awards
EB134/46	Provisional agenda for the Sixty-seventh World Health Assembly
EB134/47	Appointment of the Regional Director for South-East Asia
EB134/48	Appointment of the Regional Director for the Western Pacific
EB134/49	Human resources. Interim annual report for 2013
EB134/50	Report of the International Civil Service Commission
EB134/51	Amendments to the Staff Regulations and Staff Rules ²
EB134/51 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly ³
EB134/52	Reports of advisory bodies. Expert committees and study groups
EB134/52 Add.1	Reports of advisory bodies. Expert advisory panels and committees and their membership
EB134/53	Progress reports
EB134/54	Contributing to social and economic development: sustainable action across sectors to improve health and health equity (follow up of the 8th Global Conference on Health Promotion)
EB134/55	Follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage
EB134/55 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly ³

Information documents

EB134/INF./1	Statement by the representative of the WHO staff associations
EB134/INF./2	Revised human resources strategy

¹ See document EB134/2014/REC/1, Annex 3.

² See document EB134/2014/REC/1, Annex 2.

³ See document EB134/2014/REC/1, Annex 5.

LIST OF DOCUMENTS

Diverse documents

EB134/DIV./1 Rev.1	List of members and other participants
EB134/DIV./2	Preliminary daily timetable
EB134/DIV./3	Decisions and list of resolutions
EB134/DIV./4	List of documents

COMMITTEES¹

1. Programme, Budget and Administration Committee²

Dr Dirk Cuypers (Belgium, Chairman), Mr Tomás Augusto Pippo Briant (Argentina), Professor Jane Halton (Australia, member ex officio), Dr Martina Baye Lukong (Cameroon, Vice-Chairman), Mr Kim Chang Min (Democratic People's Republic of Korea), Dr Maha Al-Rabat (Egypt), Dr Shigeru Omi (Japan), Dr Vilius Jonas Grabauskas (Lithuania), Dr Sathasivam Subramaniam (Malaysia), Dr Mariyam Shakeela (Maldives), Mr Rodrigo Reina (Mexico), Mr Mohammed Hamad Al-Thani (Qatar), Professor Mandiaye Loume (Senegal) and Ms Precious Matsoso (South Africa, member ex officio).

Nineteenth meeting, 16 and 17 January 2014: Dr Dirk Cuypers (Belgium, Chairman), Mr Tomás Augusto Pippo Briant (Argentina), Professor Jane Halton (Australia, member ex officio), Dr Martina Baye Lukong (Cameroon, Vice-Chairman), Mr Ri Jang Gon (alternate to Mr Kim Chang Min, Democratic People's Republic of Korea), Mr Ahmed Shehabeldin (alternate to Dr Maha Al-Rabat, Egypt), Dr Mitsuhiro Ushio (alternate to Dr Shigeru Omi, Japan), Mr Rytis Paulauskas (alternate to Dr Vilius Jonas Grabauskas, Lithuania), Mr Mazlan Muhammad (alternate to Dr Sathasivam Subramaniam, Malaysia), Dr Mariyam Shakeela (Maldives), Mr Rodrigo Reina (Mexico), Mr Mohammed Hamad Al-Thani (Qatar), Professor Mandiaye Loume (Senegal) and Ms Precious Matsoso (South Africa, member ex officio).

2. Standing Committee on Nongovernmental Organizations³

Dr Walid Ammar (Lebanon), Mr Liow Tiong Lai (Malaysia), Dr Pe Thet Khin (Myanmar), Dr Richard Nchabi Kamwi (Namibia), Dr Zelibeth Valverde (Panama).

Meeting of 21 January 2014: Dr Walid Ammar (Lebanon, Chairman), Dr Noor Hisham Abdullah (alternate to Mr Liow Tiong Lai, Malaysia), Dr Pe Thet Khin (Myanmar), Dr Richard Nchabi Kamwi (Namibia) and Dr Zelibeth Valverde (Panama).

3. Jacques Parisot Foundation Selection Panel⁴

The Chairman of the Executive Board and the Vice-Chairman of the Executive Board, members ex officio.

Meeting of 21 January 2014: Professor Jane Halton (Australia, Chairman), Dr Mohsen Asadi-Lari (Islamic Republic of Iran, Vice-Chairman).

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

² Decision EB133(3). This also reflects the membership as of January 2014, including the change in representatives for Egypt, Malaysia, Maldives, Qatar and Senegal.

³ Decision EB133(4).

⁴ Decision EB123(3).

4. Ihsan Dođramacı Family Health Foundation Selection Panel

The Chairman of the Executive Board, member ex officio, the President of Bilkent University, Turkey, or the President's appointee, and a representative of the International Children's Center, Ankara.

Meeting of 22 January 2014: Professor Jane Halton (Australia, Chairman), Professor Phyllis Erdogan, appointee of Professor A. Dođramacı (President of Bilkent University) and Professor Tomris Türmen, representing the International Children's Center, Ankara.

5. Sasakawa Health Prize Selection Panel¹

The Chairman of the Executive Board, member ex officio, a member of the Executive Board from a Member State of the WHO Western Pacific Region and a representative of the Founder.

Meeting of 22 January 2014: Professor Jane Halton (Australia, Chairman), Mr Jeon Man-bok (Republic of Korea) and Professor Hiroyoshi Endo (representative of the Founder).

6. United Arab Emirates Health Foundation Selection Panel²

The Chairman of the Executive Board, member ex officio, a representative of the Founder, and a member of the Executive Board from a Member State of the WHO Eastern Mediterranean Region.

Meeting of 21 January 2014: Professor Jane Halton (Australia, Chairman), Dr Ziad Ahmed Memish (Saudi Arabia) and Dr Mohammad Salim Al Olama (representative of the Founder).

7. Dr LEE Jong-wook Memorial Prize Selection Panel³

The Chairman of the Executive Board, member ex officio, a representative of the Founder, and a member of the Executive Board from a Member State of the WHO Western Pacific Region.

Meeting of 21 January 2014: Professor Jane Halton (Australia, Chairman), Mr Pascoe Kase (Papua New Guinea) and Dr David Sir (representative of the Founder).

¹ Decision EB133(5).

² Decision EB133(6).

³ Decision EB129(4).

SUMMARY RECORDS

FIRST MEETING

Monday, 20 January 2014, at 09:40

Chairman: Professor J. HALTON (Australia)

- 1. OPENING OF THE SESSION AND ADOPTION OF THE AGENDA:** Item 1 of the Provisional agenda (Documents EB134/1 and EB134/1 (annotated))

The CHAIRMAN declared open the 134th session of the Executive Board and welcomed all participants, in particular the new Board members: Dr Maha Al-Rabat (Egypt), Dr Mohsen Asadi-Lari (Islamic Republic of Iran), Dr Sathasivam Subramaniam (Malaysia), Dr Mariyam Shakeela (Maldives), Mr Sani S. Bala (Nigeria) and Dr Brima Kargbo (Sierra Leone).

Election of Vice-Chairman

The CHAIRMAN noted that Professor Nicknam, the Board member designated by the Islamic Republic of Iran who had been elected as a Vice-Chairman at the Board's 133rd session, had been replaced by Dr Asadi-Lari. The Member States of the Eastern Mediterranean Region proposed that Dr Asadi-Lari should be elected as a Vice-Chairman for the remainder of the term. If there was no objection, she would take it that that proposal was acceptable to the Board.

It was so decided.

Proposal for a supplementary agenda item entitled "Contributing to social and economic development: sustainable action across sectors to improve health and health equity" (Document EB134/1 Add.1)

Ms KAIRAMO (Finland)¹ recognized that the Board had a long and complex agenda for the current session, and that most of the items that were not related to WHO reform dealt with mortality and disease, medical treatments and interventions, and medicines. A more balanced approach was needed, emphasizing health as a resource of individuals and societies. Her country's proposal for an agenda item dealing with the role of health systems in addressing health determinants and health equity across different sectors had not been included on the Board's provisional agenda, nor had that of Brazil, dealing with access to trained health personnel. She hoped that future agendas of the WHO governing bodies would focus on promotion of health as well as treatment of disease.

Dr GRABAUSKAS (Lithuania), Dr VALVERDE (Panama) and Mrs CORDEIRO DUNLOP (Brazil) supported the proposal.

Dr AMMAR (Lebanon) said that the Board should discuss ways of reducing the number of items on its future agendas. It was impossible to discuss items properly if the agenda was as long as the one currently before the Board. At present, the Board took three wide-ranging criteria into account

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

when deciding whether to include an item on its agenda, and often an item satisfied only one of them. In future, an item should satisfy at least two criteria before it was included, and an absolute limit should be set on the number of items considered at any one session. Given the reluctance of Officers of the Board to refuse to include matters proposed by Member States, a technical subcommittee might be set up to screen items in advance.

The CHAIRMAN took it that the member for Lebanon did not support the inclusion of the proposed item.

Dr AMMAR (Lebanon) said that in fact he did support the inclusion of both the item proposed by Finland and the item proposed by Brazil, but reiterated the need to review the criteria used for the inclusion of items for future sessions.

The CHAIRMAN suggested that, since a number of members had supported the inclusion of the additional agenda item, and she understood that the member for Argentina was of the same view, the item should be included as agenda item 8.7.

It was so agreed.

Proposal for a supplementary agenda item entitled “Follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage” (Document EB134/1 Add.2)

The CHAIRMAN noted that the proposal included a draft resolution for consideration by the Board.

Mrs CORDEIRO DUNLOP (Brazil) said that the participants in the Third Global Forum on Human Resources for Health (Recife, Brazil, 10–13 November 2013) had invited the Sixty-seventh World Health Assembly to take into account the Global Forum’s conclusions – expressed in its outcome document, “The Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage” – in its deliberations in May 2014. Her country had proposed the inclusion on the Board’s agenda of an item on the issue, with a view to ensuring that the momentum generated by the Global Forum in the important area of human resources for health was not lost. Many of WHO’s priority objectives, including universal health coverage, the strengthening of health services and the achievement of the health-related Millennium Development Goals, would depend on an adequate supply of well trained and motivated health workers. She hoped that members would support the inclusion of the item and adopt the accompanying draft resolution.

The difficulties the Board had faced in setting its agenda in recent years demonstrated the need for a discussion, led by Member States, of ways of producing a streamlined list of items that would provide added value for public health.

Dr AMMAR (Lebanon), Dr GONZÁLEZ FERNÁNDEZ (Cuba), Dr VALVERDE (Panama), speaking also on behalf of the Member States of the Region of the Americas, Ms MATSOSO (South Africa) and Ms DUPUY (Uruguay) supported the proposal.

The CHAIRMAN suggested that the additional agenda item proposed by the member for Brazil should be included as agenda item 9.8. She suggested further that the issue raised by the member for Lebanon, namely the choice of criteria for the inclusion of an item on the agenda, should be discussed under agenda item 5.2.

It was so agreed.

The DIRECTOR-GENERAL recalled that, at its 133rd session, the Board had adopted a decision¹ requesting her to hold informal consultations with Member States from all regions with a view to reaching consensus on the title and content of a proposed agenda item which, if the Board decided to discuss it at the present session, would become agenda item 8.3. She had duly conducted seven rounds of informal consultations: six regional consultations and one global consultation in which all WHO regions had been represented. Participants had emphasized their desire to avoid another lengthy debate on the issue, but had made it clear that many of them still held opposing views. In accordance with the wishes expressed by Member States, she sought the formal approval of the Board to continue the consultation process.

Dr OMI (Japan) supported the continuation of the consultations.

The CHAIRMAN suggested that item 8.3 should be deleted from the provisional agenda, on the understanding that the Director-General would continue her informal consultations with Member States on the matter.

It was so agreed.

The agenda, as amended, was adopted.²

2. ORGANIZATION OF WORK

Ms VUKOVIĆ (Croatia) said that, as agreed in the exchange of letters in 2000 between WHO and the European Commission on the consolidation and intensification of cooperation, and without prejudice to any future general agreement between WHO and the European Union, the European Union attended sessions of the Board as an observer. However, under Rule 4 of the Board's Rules of Procedure, observers were not automatically invited to participate in the work of subcommittees or other subdivisions of the Board, such as drafting groups and working groups. She requested that, at the 134th session of the Board, as at previous sessions, representatives of the European Union be invited to participate without vote in the meetings of the Board and its committees, subcommittees or other subdivisions that addressed matters falling within the European Union's competence.

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

It was so agreed.

The CHAIRMAN, noting that the "traffic light" system would be used to limit the length of statements, said that agenda items 12.1, Appointment of the Regional Director for South-East Asia, and 12.2, Appointment of the Regional Director for the Western Pacific, would be discussed in an open meeting, attended only by members of the Board, their alternates and advisers, and one representative of each Member State not represented on the Board and of each Associate Member, in accordance with Rule 7 of the Rules of Procedure. No official record would be prepared. She proposed that agenda item 5 on WHO reform should be discussed in three groups of subitems. The first would be item 5.1 on reform implementation; the second would combine items 5.2 (improved decision-making, including the criteria for choosing items for inclusion on the agenda, as proposed by the

¹ Decision EB133(1).

² Document EB134/1 Rev.1.

member for Lebanon), 5.3 (national reporting) and 5.4 (engagement with non-State actors); and the third would comprise items 5.5 (financing dialogue), 5.6 (strategic resource allocation) and 5.7 (financing of administrative and management costs).

It was so agreed.

3. REPORT BY THE DIRECTOR-GENERAL: Item 2 of the Agenda (Document EB134/2)

The DIRECTOR-GENERAL, introducing her report, said that the unprecedented number of items on the agenda of the current session showed the diversity of Member States' concerns and their confidence that WHO was the right agency to address them. However, the heavy agenda had outstripped the capacity of the Secretariat to prepare for and service the session. A lean, effective and flexible Organization must be strategic and highly selective in the work it undertook. She would rather see outstanding performance in a limited number of high-impact areas than a broader approach that might dilute WHO's energy and resources.

The demands on WHO and health ministries would increase further with the rise in noncommunicable disease prevalence, population ageing and the adverse effects of climate change. Public expectations of health care were rising and costs soaring. WHO would have to perform extremely well in order to guide countries through those challenges.

In recent years, the Health Assembly had approved a number of global strategies and action plans to address specific diseases or needs, with highly ambitious goals and clearly defined objectives, targets and indicators. However, they imposed a heavy burden on health systems and created enormous expectations for monitoring and reporting.

She welcomed the emphasis placed by the governing bodies on the strengthening of health systems, including through improvement of the registration of deaths and notifiable diseases, as well as regulatory control and enforcement systems, especially for medicines. In view of the fact that an estimated 2.7 billion people were without any safety net to cover health care costs, she welcomed the strong commitment of Member States and partner agencies to universal health coverage, which she saw as one of the most positive and powerful trends in global health.

Although the humanitarian crises in the Syrian Arab Republic, the Philippines, the Central African Republic and South Sudan were testing the Secretariat's capacity to respond to emergencies, she believed it was performing well. It continued to monitor sporadic cases of disease due to Middle East respiratory syndrome coronavirus (MERS-CoV) infection and avian influenza. There was no evidence of any threat of a serious outbreak of either disease, but their persistence proved the importance of building up countries' capacity to detect, report and respond to cases in accordance with the International Health Regulations (2005).

Turning to WHO reform, she noted that a central aim of the process was to render the Organization more strategic and selective in responding to public health challenges. The two financing dialogues had identified areas where resources could be used more efficiently. A new web portal supporting the programme budget had made a major contribution to transparency. Reforms in human resource management, including streamlined recruitment and selection processes, were being carried out in order to meet operational and staff development needs in the current financial situation.

WHO's achievements in 2013 provided numerous examples of outstanding performance in high-impact areas, including the addition of 62 new products to the WHO List of Prequalified Medicinal Products and the publication in the medical journal *The Lancet* of a study coordinated by WHO on severe complications in pregnancy, as well as the pilot WHO Safe Childbirth Checklist, currently undergoing testing in over 100 hospitals. At country level, there had been some dramatic and measurable improvements in health outcomes. Niger, for example, had succeeded in reducing child mortality by 43%, thanks in large measure to the availability of high-quality data, while Nigeria, which had at one time reported 650 000 cases of dracunculiasis every year, had been certified as free of the disease and was also committed to eradicating poliomyelitis. In India, there had been no

reported cases of poliomyelitis for three years, which paved the way for the certification of the whole of South-East Asia as free of the disease in the very near future.

Dr VALVERDE (Panama) said that in the current climate of austerity and financial difficulty, which had nevertheless seen achievements in international health cooperation and greater involvement by Member States, the Secretariat had to be given the means it needed to do its work and perform more efficiently. WHO reform would definitely help to enhance the Organization's strategies, priorities and results. In order to overcome health challenges and make universal health coverage a reality, WHO had to strengthen its work globally, regionally and locally. Member States must adopt a multisectoral approach to health and health inequalities and use the basic tools for effective public health practice, such as health information systems, which should be strengthened.

Ms VUKOVIĆ (Croatia), speaking on behalf of the European Union and its Member States, said that the report by the Director-General provided a timely and comprehensive update of current global health challenges, many of which would be discussed by the Board. Disconcertingly, however, the length of the present session's agenda was conducive neither to adequate preparation nor to proper discussion. Member States must address that situation if the Organization's governance was to become more efficient.

With respect to WHO reform, the contribution of the first financing dialogue to increased predictability and transparency was encouraging. Continued commitment would be required from all partners to financing of the agreed programme budget for 2014–2015. The entire Organization must take ownership of the programme budget and donors must align themselves with its priorities. Such matters as relations with non-State actors and implementation of the revised human resources evaluation priorities must be rapidly finalized, in the interest of enabling WHO to exercise effective leadership at the global level and deliver results at the country level. The development of close and sustained collaboration with other partners and sectors at the international level, including other organizations of the United Nations system, was likewise crucial to strengthening links in such areas as nutrition, antimicrobial resistance, noncommunicable diseases, tuberculosis and the International Code of Conduct on Pesticide Management.

The European Union and its Member States were committed to the development of a robust post-2015 agenda and to continued efforts to attain the Millennium Development Goals. The re-emergence of various communicable diseases called for health system strengthening and WHO technical support. The effort to highlight the crucial role of those systems in addressing violence, particularly against women and girls, was welcome, as was the emphasis on the need for sustained and concerted global action to counter antimicrobial resistance and its far-reaching effects on health and health systems. On that score, the European Union and its Member States would welcome increased commitment and leadership from WHO in bringing to the global arena a holistic "one-health" approach to the associated human and animal health concerns. They stood ready to engage constructively in finalizing, prior to the upcoming World Health Assembly, the work thus far achieved through WHO's leadership in the area of noncommunicable diseases. Lastly, they welcomed WHO's success in fulfilling its humanitarian role, including as lead agency for the Global Health Cluster, and encouraged full cooperation within the Organization to ensure continued progress and better results on the ground.

Ms MATSOSO (South Africa), speaking on behalf of the Member States of the African Region, said that 2013 had been a particularly busy year for WHO with the ongoing consultations on issues such as WHO reform, the financing dialogue and non-State actors. Much had already been accomplished to make WHO a leader in the United Nations family, including with regard to financing reforms and the achievement of greater transparency. The African countries supported the principle of bottom-up planning and welcomed the use of the web portal. Noting the large number of topics before the Board, she highlighted the need to consider the criteria for the acceptance of items onto the provisional agenda.

The African Region continued to grapple with weak health systems and colliding epidemics of communicable diseases and noncommunicable diseases, and required support in order to respond adequately. In that regard, she welcomed the focus on quality of care and the post-2015 development agenda.

Mr REINA (Mexico), agreeing on the importance of the topics highlighted by the Director-General in her report, said that WHO reform, health system strengthening and the inclusion of health in the post-2015 development agenda were particular priorities for his country. With regard to WHO reform, it was important to ensure continuity of the Member State-driven process with a view to achieving a transparent and efficient organization capable of responding to global health challenges. In the post-2015 development agenda, health must be the nexus between sustainable development goals and poverty reduction goals; making the achievement of universal health coverage a development objective of the post-2015 agenda would facilitate attainment of those Millennium Development Goals yet to be achieved.

Mr JEON Man-bok (Republic of Korea) said that WHO reform had enhanced the Organization's performance, which would ultimately lead to better global health. Health was essential for well-being, and health-related goals should be given top priority in the post-2015 development agenda. Universal health coverage and the eradication of communicable and noncommunicable diseases would be the most important goals in the health sector. His Government would, together with WHO and the World Bank, be providing support, including funding assistance, in order to achieve universal health coverage at country level. Noting the many health threats that had emerged over the previous year, including outbreaks of new infectious diseases in China and the Middle East, and the typhoon in the Philippines, he said that WHO's response to emergencies should be more rapid and organized, and he called for strengthened international cooperation in that regard.

Mr BALA (Nigeria) said that Nigeria's groundbreaking success in eradicating dracunculiasis would not have been possible without support and collaboration from WHO and other development partners. Nigeria was pleased that its partners were continuing to offer collaboration in other areas, in particular the eradication of poliomyelitis. His Government was determined to overcome the security challenges in the north-eastern part of the country and achieve further successes with respect to health care delivery, disease eradication and attainment of the Millennium Development Goals.

Dr OMI (Japan) welcomed the Director-General's emphasis on the importance of focusing on areas of high profile and impact. Such an approach should underpin the discussion of reform, including resource allocation. Congratulating Nigeria on its successes, he expressed the hope that efforts would be intensified to overcome the challenges, including serious security issues, that continued to impede global eradication of poliomyelitis.

Dr SHAKEELA (Maldives), also congratulating Nigeria on its achievements, said that India's success in remaining poliomyelitis-free for three years would help the South-East Asia Region to move towards polio-free certification. Although Maldives had been free from poliomyelitis for decades, it remained vigilant, with enhanced surveillance and sustained, high immunization coverage.

Geographical challenges coupled with extreme climate events were affecting the provision of fair access to quality health care for the scattered population of Maldives, and the situation was exacerbated by the burden of noncommunicable diseases. It was a matter of concern that, despite the Region's immense vulnerability to the effects of climate change, its health systems lacked a comprehensive and adequate strategy of resilience and an appropriate public health response. Such a strategy was urgently required, not only because the health community had a duty to counter emerging threats, but also because adaptation to climate change should be seen as a matter of basic public health protection. New and innovative funding mechanisms for prevention programmes were required, given the financial constraints faced with respect to delivery of treatment and care. The opportunity to

strengthen public health offered by the climate change Adaptation Fund could be seized only if the health sector was aware of what it should do differently because of climate change.

Dr MEMISH (Saudi Arabia) thanked the Director-General and all WHO staff for their outstanding efforts to deal with the emergencies arising in Member States, notwithstanding resource limitations, and congratulated Nigeria and India on their success in eradicating important communicable diseases. He supported the proposal by the member for Lebanon to ensure that only subjects of appropriate priority were placed on the agenda of the Board.

Dr HISHAM ABDULLAH (Malaysia) thanked the Director-General and her team for their efforts to respond to the needs of all Member States. The revised, Organization-wide human resources strategy was an essential component of WHO reform that sought to ensure the continued relevance of the Organization in a changing global health landscape. The change management and communication strategies adopted in the context of reform had been exemplary, and Malaysia, whose health care system was also undergoing transformation to meet changing demands, looked forward to learning from WHO's experience. She agreed that the Organization should focus on areas of high impact and priority.

Dr ASADI-LARI (Islamic Republic of Iran), commending the strong efforts of the Director-General in tackling major global health challenges, affirmed the importance of addressing social determinants of health, reducing inequalities and ensuring free access to medication, medical supplies and relevant health technologies for all Member States. Universal health coverage was essential in order to overcome shortcomings at the global and national levels to secure better health for all.

Dr BARBOSA DA SILVA (Brazil) welcomed the priorities established and the leadership shown by WHO and highlighted the importance of achieving universal health coverage and tackling chronic noncommunicable diseases. Efforts must also be made to promote the sharing of high-quality information and mutual support between countries in order to strengthen health and sustainable development and continue to move forward towards the achievement of the Millennium Development Goals and the establishment of goals for the post-2015 period. Other important issues included the right to health, the promotion of equity, access to medicines, and the quality, safety and effectiveness of medical products. The continuation of WHO reform was essential in order to enhance the Organization's transparency, credibility and legitimacy and reduce conflicts of interest. Objectivity and effectiveness should remain the watchwords of the reform process.

Dr DAULAIRE (United States of America)¹ said that, in an increasingly interdependent world, all States relied more than ever on an effective and responsive WHO. The reform process was critical to make WHO an effective twenty-first century institution. His Government supported the priorities outlined by the Director-General and welcomed her recognition of the need for focus. In discussions of the post-2015 development goals, as well, focus and discipline were required. His country was committed to the achievement of universal health coverage, both domestically – as evidenced by its Affordable Care Act – and globally. It was also committed to supporting the collection, analysis and effective use of data through the improvement of programmes and policies. The United States Food and Drug Administration was actively working with the Secretariat and countries around the world in improving and linking regulatory systems in order to protect and improve the health of all citizens. His Government attached high priority to strengthening the International Health Regulations (2005) and had established global health security as a key issue. It was working closely with the Secretariat to scale up international capacity to prevent, detect and respond to infectious diseases of pandemic proportions and to finish the task of global poliomyelitis eradication.

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

Mr MURAV'EV (Russian Federation),¹ expressing support for the WHO reform process and appreciation of the Organization's efforts to improve the health and life of all citizens, said that continued attention must be paid to tackling noncommunicable diseases at the global and regional levels. His country would continue to provide resources for WHO's activities in that regard. In addition, having assumed the Presidency of the Group of Eight (G8) in 2014, it would be placing on the Group's agenda an initiative aimed at reducing the burden of noncommunicable diseases, with a particular focus on prevention of stroke and treatment and rehabilitation of stroke victims. He hoped that the Director-General and other Member States would support that initiative. Particular attention should also be paid to maternal and child health. As a result of a policy to encourage a healthy lifestyle throughout the life course, coupled with better care for mothers and children, infant mortality in the Russian Federation had decreased by nearly 30% and maternal mortality by 35% over the previous five years.

Dr KAKONGE (Kenya)¹ welcomed the Director-General's commitment to ensuring that WHO remained fit for purpose and to the ambitious reform programme. Kenya welcomed the outcome of the financing dialogue and acknowledged the need to expand the donor base. Certainly, the reliance on 20 contributors to provide 80% of voluntary contributions put WHO in a vulnerable position. A multisectoral approach must be taken with regard to noncommunicable diseases, since the effects of such diseases were not confined to the health sector. Efforts should also be made in the area of information-sharing, education and awareness-raising, with governments and partners dispelling myths about noncommunicable diseases and ensuring provision of correct information. Health and the pursuit of universal health coverage should be key elements in the post-2015 development agenda. At the same time, efforts to achieve the unmet Millennium Development Goals, including reducing the burden of major noncommunicable diseases, must continue.

The large number of items on the Board's agenda was a cause of concern, and a way must be found to keep future agendas manageable.

Ms ST LAWRENCE (Canada)¹ said that the significant size and scope of the Board's agenda were a clear indication of the need for Member States to work with the Secretariat to accelerate efforts to enhance the governance of WHO. Member States must seek new ways of conducting their work in order to drive change and ensure that WHO was strategic, forward-looking and focused on addressing global health challenges where the greatest impact could be achieved. In considering the activities to be undertaken by WHO to address those challenges, however, they should be mindful of the budget ceilings established for each programmatic category and also should consider what activities WHO should no longer be doing. Overcommitting the Organization would undermine the efforts to advance reform.

She congratulated Nigeria and Afghanistan on the marked decrease in poliomyelitis infection rates in 2013 but remained concerned about the increase in the number of confirmed cases in Pakistan and the safety and security of vaccination teams in that country. She welcomed the Director-General's efforts to highlight the importance of vital statistics and health information systems, which provided the information necessary for planning and monitoring health systems, making effective decisions on resource allocation, ensuring accountability and improving the quality of health services for women and children. Canada would continue to work with the Secretariat and with other Member States to strengthen that area.

Dr LIU Yue (China),¹ welcoming the positive role played by the Secretariat in addressing health inequity, commended the achievements of some developing countries, including India and Nigeria. Her Government was grateful to the Secretariat for launching *The world health report 2013*² in Beijing

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

² The world health report. Research for universal health coverage. Geneva: World Health Organization; 2013.

and for approving the prequalification of China's Japanese encephalitis vaccine, which would make it possible for Chinese vaccines to contribute to global efforts to prevent and control the disease. She encouraged the Secretariat to develop novel models of cooperation for the sharing of technology and experience and to support the implementation of the Beijing Declaration of the Ministerial Forum of China-Africa Health Development.

Mr HO (Singapore),¹ congratulating India and Nigeria on their achievements thus far, noted with satisfaction that, despite a busy year, the Secretariat had remained focused on reform. Although universal health coverage must certainly be an important element in the post-2015 agenda, the debate should go beyond finance and health insurance to encompass other related policies to ensure good health coverage, including promoting public health, healthy living, active ageing and a robust health care system for countries. Singapore would continue to share its experiences in that regard and learn from those of other countries. Good health care data and information and measurable targets would be crucial in order to gauge success.

Mr MISHRA (India)¹ thanked the Secretariat for its continued support of India's programme to eradicate poliomyelitis. As a result of a team effort led by the Government of India and involving numerous partners across the globe, India had progressed from reporting almost half of the poliomyelitis cases in the world in 2009 to experiencing only one case in 2011 and none over the previous three years. Success had been made possible as a result of the tireless efforts of millions of front-line workers, including vaccinators, social workers, social mobilizers and community and health workers, who continued to implement innovative approaches. India would use the experience it had gained from poliomyelitis eradication in the implementation of other difficult initiatives, for which it sought the support of other Member States.

Dr LUKWAGO (Uganda),¹ expressing thanks to the Director-General for drawing attention to the health implications of conflict situations, said that because of sudden and massive migration of populations from conflict areas, some Member States, notably in eastern and central Africa, were experiencing enormous pressure on their health systems that threatened to undermine national efforts to control outbreaks of disease and implement the International Health Regulations (2005). He called upon the Secretariat to consider interventions aimed at supporting countries such as his that were hosting millions of refugees from conflict countries.

Ms KOCHLEF (Tunisia)¹ said that WHO should continue to pursue reform in order to achieve greater efficiency. She agreed that there should be fewer items on governing body agendas in order to facilitate appropriate discussion and effective decision-making on all items.

The DIRECTOR-GENERAL, thanking speakers for their valuable feedback and guidance, said that several important issues had been highlighted in the discussion, including the importance of health in the post-2015 development agenda, universal health coverage, colliding epidemics of communicable and noncommunicable diseases, health system strengthening, climate change and access to affordable, quality medicines. The eradication of dracunculiasis was encouraging; however, the Secretariat was mindful of the lingering challenge of poliomyelitis eradication and would need to work very closely with Pakistan and other countries to make sure that the task was completed.

Noting that health inequity needed to be addressed within the context of multisectoral collaboration, she pointed out that the Secretariat was already working closely with the staff of other organizations, such as FAO and OIE, not only in the context of the International Health Regulations (2005) but also in the area of antimicrobial resistance. It would also be working with other organizations of the United Nations system to support Member States in improving their health

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

information systems. Certainly action was needed in that area, since without good data results could not be measured.

The spill-over effect of conflicts was a challenge, not only for neighbouring countries but also for the international community and the humanitarian sector, of which WHO was the health cluster lead. She welcomed the recognition of WHO's work in humanitarian crises. The Syrian crisis, in which the Regional Office for the Eastern Mediterranean, headquarters, and the European Region were working together, showed how WHO's entire assets could be used to support neighbouring countries and displaced persons.

She continued to attach great importance to WHO reform. In order to be credible, the Organization must be transparent and pay special attention to bottom-up planning, addressing country priorities and coordinating resource mobilization. She looked forward to hearing the views of Member States on how to tackle the large numbers of agenda items. Although all of them related to important issues, and it was difficult for Member States to opt not to discuss them, it was necessary to focus on high-impact priorities. On behalf of all staff, she thanked Member States for their support of reform and their efforts to make WHO a lean and effective leader in global public health.

4. REPORT OF THE PROGRAMME, BUDGET AND ADMINISTRATION COMMITTEE OF THE EXECUTIVE BOARD: Item 3 of the Agenda (Document EB134/3)

Dr CUYPERS (Belgium), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, drew attention to the report of its nineteenth meeting (document EB134/3). At that meeting, the Committee had considered 18 items, seven of which were not on the agenda of the Board. He had invited the Secretariat to begin including programmatic matters in the Committee's agenda, in order to facilitate strategic reflection and discussion on cross-cutting areas of work that were likely to continue for some time. Of the seven items not forwarded to the Board, one had been a programmatic item on health systems. The other six were an update on implementation of the Programme budget 2012–2013, WHO's internal management control framework, the first annual report on information technology and telecommunications, the report of the Office of Internal Oversight Services, the report of the Independent Expert Oversight Advisory Committee and the reports of the Joint Inspection Unit. He would report on the Committee's discussion of the other items when they were taken up by the Board.

Mr REINA (Mexico) said that the WHO reform process provided a historic opportunity to further enhance transparency and accountability. He looked forward to the Board's discussion of options for ensuring strategic resource allocation in accordance with clear criteria and taking into consideration the need to prioritize technical work at country level. He also looked forward to the discussion of the Board's working methods.

Dr CARBONE (Argentina), referring to paragraph 10 of document EB134/3, said that it was important to consider the possibility of holding an extraordinary meeting of the Committee to continue discussions on strategic resource allocation. She looked forward to hearing the outcome of the Director-General's consultations on the matter.

Dr VALVERDE (Panama) said that strategic resource allocation was a matter of the utmost priority for the Region of the Americas. She, too, looked forward to hearing proposals regarding how best to carry out further consultations with balanced regional representation and a clear mandate. Options included the establishment of an open-ended working group or an extraordinary meeting of the Programme, Budget and Administration Committee to be held before the next World Health Assembly.

Ms LANTERI (Monaco)¹ said that she would welcome further information on paragraph 10 of document EB134/3 and on the mechanism for realistic and equitable allocation of costs mentioned in paragraph 12. She sought clarification from the Secretariat of the Committee's recommendation that sufficient resources should be allocated to evaluation, contained in paragraph 17 of the report.

The CHAIRMAN said that the additional information would be provided when the relevant agenda items were taken up by the Board.

It was so agreed.

5. REPORTS OF THE REGIONAL COMMITTEES TO THE EXECUTIVE BOARD: Item 4 of the Agenda (Document EB134/4)

The CHAIRMAN drew attention to the report that had been prepared pursuant to decision WHA65(9) on governance reforms, as part of the efforts to ensure harmonization and alignment between the global and regional levels of the Organization.

Dr GONZÁLEZ FERNÁNDEZ (Cuba), welcoming the reports of the regional committees, noted that the Regional Committee for the Americas had underscored the need to ensure that engagement with non-State actors was in accord with the priorities and strategic agenda approved by Member States, and the importance of using clear criteria and a fair, equitable and transparent methodology for the allocation of WHO resources to the regions. It had also supported the proposed principles, functions and participants of the global coordination mechanism for follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable diseases, and the proposal that WHO should provide the mechanism's secretariat.

Ms MATSOSO (South Africa) said that it was clear from the reports that a certain degree of harmony was emerging on various topics. However, a standard approach should be adopted for the reporting of data in order to avoid inconsistencies between data contained in regional reports and those presented in reports released at the global level.

Dr NCHABI KAMWI (Namibia), speaking on behalf of the Member States of the African Region, noted with satisfaction that there was a greater alignment between the regional committees and the Executive Board.

Mr JEON Man-bok (Republic of Korea) welcomed the increased cooperation between the global governing bodies of WHO and the regional committees, noting that the provision of information on topics of regional significance offered an opportunity to learn about the interests of other regions and issues that might have been overlooked. Ageing and health, which had been considered by the Regional Committee for the Western Pacific at its most recent session, was a challenge for all regions, and he hoped that there would be further discussion of the impact of population ageing and of response measures at the regional, national and global levels.

Dr CARBONE (Argentina) recalled that the Regional Committee for the Americas had adopted decision CD52(D5) concerning the International Health Regulations (2005). The Regional Committee had expressed concern about the grave problem of noncommunicable diseases, had decided to include

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

on its 2014 agenda an item concerning obesity and overweight, and would be considering the adoption of a specific plan of action to address those risk factors.

The CHAIRMAN invited the regional directors to pass on to the chairmen of the regional committees the Board's thanks for the reports.

The Board noted the report.

The meeting rose at 12:35.

SECOND MEETING

Monday, 20 January 2014, at 14:40

Chairman: Professor J. HALTON (Australia)

1. COMMUNICABLE DISEASES: Item 6 of the Agenda

Global strategy and targets for tuberculosis prevention, care and control after 2015: Item 6.1 of the Agenda (Document EB134/12)

The CHAIRMAN drew attention to the Secretariat report on the global strategy and targets for tuberculosis prevention, care and control after 2015 and to a draft resolution on the subject proposed by Australia, Brazil, Colombia, Costa Rica, Estonia, France, Italy, Japan, Netherlands, Poland, Portugal, Slovakia, South Africa and United States of America, which read:

The Executive Board,

Having considered the report prepared by WHO which presents a global strategy and targets¹ for tuberculosis prevention, care and control after 2015,

RECOMMENDS to the Sixty-seventh World Health Assembly, the consideration and adoption of the following resolution:

The Sixty-seventh World Health Assembly,

(PP1) Having considered the report by the Secretariat which presents a proposed global strategy and targets for tuberculosis prevention, care and control after 2015;

(PP2) Acknowledging the progress made towards the achievement of the Millennium Development Goal 6 for 2015 following the United Nations Millennium Declaration and related 2015 TB targets through the adoption of the Stop TB Strategy and the Global Plan to Stop TB 2006–2015, as well as the financing of national plans based on these frameworks, as called for with resolution WHA60.19;

(PP3) [Concerned with the persisting gaps and the uneven progress made towards current targets, and that some regions, Member States, communities and vulnerable groups require specific strategies and support to accelerate progress in preventing disease and deaths, and to expand access to needed interventions and new tools; (EU)]

(PP4) Noting with concern that even with significant progress, an estimated three million people who develop TB each year will not be detected or will not receive appropriate care and treatment;

(PP5) Cognizant of the serious economic and social consequences of tuberculosis and of the burden borne by many of those affected in seeking care and adhering to tuberculosis treatment;

(PP6) Considering resolution WHA62.15 and its appeal for action on multidrug-resistant tuberculosis, aware that the response to the crisis to date has been insufficient despite introduction of new rapid diagnostic tests, and efforts to scale up disease

¹ Document EB134/12.

management, that the vast majority of those in need still lack access to quality prevention, treatment and care services and alarmed at the grave individual and public health risks;

(PP7) Aware that HIV co-infection is the main reason for the failure to meet TB control targets in high-HIV settings and that TB is a major cause of deaths among people living with HIV, and recognizing the need for substantially enhanced joint actions in addressing the dual epidemics of tuberculosis and HIV/AIDS through increasing integration of primary care services to improve access to care;

(PP8) Recognizing that further progress on tuberculosis and other health priorities addressed within the Millennium Declaration must be made in the decades to come beyond 2015, and that progress on all of these priorities requires overall commitment to health systems strengthening and progress towards universal health coverage;

(PP9) Acknowledging that progress against tuberculosis depends on action within and beyond the health sector to address the social and economic determinants of disease, including expansion of social protection and overall poverty reduction;

(PP10) Guided by resolution WHA61.17 and its appeal for action on the health of migrants, and recognizing the need for increased collaboration between high and low incidence countries and regions in strengthening TB monitoring and control mechanisms, including with regard to the growing mobility of labour;

(PP11) Noting the need for increased investments for accelerated implementation of innovations at country level as well as in research and development of new tools for tuberculosis care and prevention essential to eliminate tuberculosis;

(OP) 1. **ADOPTS** the global strategy for tuberculosis prevention, care and control after 2015 with:

- (a) its bold vision of a world without tuberculosis and its targets of ending the global tuberculosis epidemic by 2035, through a reduction in tuberculosis deaths by 95%, and in tuberculosis incidence by 90%, and elimination of associated catastrophic costs for TB affected households;
- (b) its associated milestones for 2020, 2025 and 2030;
- (c) its principles addressing: government stewardship and accountability; coalition-building with affected communities and civil society; equity, human rights and ethics; and, adaptation to fit the needs of each epidemiological, socioeconomic and health system context;
- (d) its three pillars of: integrated, patient-centred care and prevention; bold policies and supportive systems; and intensified research and innovation;

(OP) 2. **URGES** all Member States¹ to adapt the strategy and implement, with high-level commitment and adequate financing, its proposed tuberculosis-specific, health sector and multisectoral actions, taking into account the local settings and, with full engagement of a wide range of stakeholders, seek to prevent the persistence of high-incidence rates of TB within specific communities or geographic settings;

(OP) 3. **URGES all Member States¹** to adopt and pursue the targets and milestones, as well as monitor the implementation of the strategy and evaluate impact **[fully taking into consideration leaving flexibility to countries with high Tuberculosis burden while setting their respective country targets for post-2015 TB prevention and control. (CHINA)]**;

¹ And, where applicable, regional economic integration organizations.

- (OP) 4. INVITES international, regional, national and local partners from within and beyond the health sector to engage in, and support, the implementation of the strategy;
- (OP) 5. REQUESTS the Director-General:
- (a) to provide guidance to Member States on how to adapt and operationalize the strategy, including the promotion of cross border collaboration to address the needs of vulnerable communities and the threats posed by drug resistance;
 - (b) to co-coordinate and contribute to the implementation of the post-2015 global tuberculosis strategy, working with Member States, The Global Fund to Fight AIDS, Tuberculosis and Malaria, UNITAID and other global and regional financing institutions, all constituencies of the Stop TB Partnership and with additional multisectoral partners required to achieve the goal and objectives of the strategy;
 - [(CANADA) (b BIS) to actively support the development of a global investment plan by the Stop TB Partnership, outlining activities and defining financing requirements to meet the ambitious targets while achieving the stated milestones on the way;]**
 - (c) to further develop and update global normative and policy guidance in tuberculosis prevention, care and control, as new evidence is gathered and innovations develop in the tools and strategic approaches available for ending the global epidemic and moving far more rapidly towards tuberculosis elimination;
 - (d) to support Member States upon request, in the adaptation and implementation of the strategy, as well as in the development of nationally-appropriate indicators, milestones and targets to contribute to local and global 2035 target achievement;
 - (e) to monitor the implementation of the strategy, and evaluate impact in terms of progress towards set milestones and targets;
 - [(f) to promote the research and knowledge-generation required to end the global TB epidemic and eliminate TB, including accelerated discovery and development of new tools, and to pursue the adoption of resulting innovations; (EU)]**
 - [(g) to promote equitable access to new tools and medical products for the prevention, diagnosis, and treatment of TB and MDR TB as they become available; (EU)]**
 - (h) to work with the Stop TB Partnership and, where appropriate, seek out new partners that can leverage effective commitment and innovation within and beyond the health sector to effectively implement the strategy;
 - (i) to report on the progress achieved to the Seventieth and Seventy-third World Health Assemblies and at regular intervals thereafter through its Executive Board.

A report on the financial implications of the draft resolution for the Secretariat was in preparation.

Dr RONSE (Belgium), speaking on behalf of the Member States of the European Region and expressing support for the proposed global strategy, said that despite significant achievements in the Region, multidrug-resistant and extensively drug-resistant tuberculosis remained a threat to elimination of the disease. Tuberculosis mainly affected the poorest and most vulnerable sectors of the population; the success of tuberculosis control efforts depended on timely treatment being made available to all persons with the disease without causing a heavy financial or social burden. Successful prevention strategies, early diagnosis, universal susceptibility testing for the diagnosis of multidrug-resistant cases and the screening of high-risk groups were also vital. Maintaining services for the prevention, diagnosis and treatment of tuberculosis would require the strengthening of health systems and social services as well as sustained financing. It would also be necessary to reach out to persons in vulnerable situations, such as migrants, substance abusers, the homeless and those living with HIV and

AIDS. He therefore welcomed the emphasis placed in the strategy on universal health coverage and a social protection mechanism. A comprehensive, multisectoral and integrated approach to tuberculosis was essential, but turning the ambitious aspirations of the strategy into reality would present challenges. The goals and measures needed to achieve a reduction in incidence should be adjusted for different epidemiological situations. Access to prevention, control and care measures and the full commitment of all stakeholders were key to eliminating tuberculosis.

Dr BARBOSA DA SILVA (Brazil) said that vulnerable people, who experienced more difficulties in accessing health services, should be the subject of specific detection, diagnostic and treatment measures, in addition to social support. To that end, greater emphasis should be placed on universal health coverage. Progress had been made towards achievement of the Millennium Development Goals, particularly in terms of halting and reversing the increase in the incidence of tuberculosis in his country and the Americas as a whole, but many challenges remained, particularly with regard to drug resistance and shortcomings in case notifications. Despite increased funding to countries endemic for tuberculosis, global control efforts remained underfunded. There should be a focus on achieving adequate coverage, providing high-quality treatment and investing in research and development. The draft resolution sponsored by Brazil was aimed at securing Member States' commitment to post-2015 targets.

Dr BAYE LUKONG (Cameroon), speaking on behalf of the Member States of the African Region, said that the Region continued to notify a disproportionately high number of tuberculosis cases and was not on track to achieve the tuberculosis-related targets of the Millennium Development Goals. However, it should be noted that regional tuberculosis incidence had reached a plateau and had been declining since 2010. Many challenges remained, including low detection rates, low uptake of improved diagnostic technology, HIV coinfection, the emergence of drug-resistant forms of the disease, weak health systems and overreliance on donor funding for tuberculosis control programmes. Nevertheless, progress had been made, with five of the nine high-burden countries in the Region recording a drop in incidence. Two of those nine countries had also reduced tuberculosis prevalence by 50% since 1990, and three had achieved a 50% decline in mortality compared to 1990. The views of the African Region had been adequately taken into account in the preparation of the proposed global strategy and she therefore welcomed that document and supported the draft resolution.

Mr KASE (Papua New Guinea) said that four countries in the Western Pacific Region, including his own, had a high burden of tuberculosis. Despite the progress made in Papua New Guinea in treating, controlling and preventing tuberculosis as a result of consolidated efforts by the Government and a range of partners including WHO, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and Australian Aid, treatment rates remained relatively low because of high default rates. Current efforts were focused on strengthening the capacity of the national tuberculosis control programme and its management of drug-resistant tuberculosis. He welcomed the global strategy and targets proposed in document EB134/12.

Dr NOOR HISHAM ABDULLAH (Malaysia) said that the success of the proposed global strategy would depend on effective implementation of key stewardship responsibilities by governments, in collaboration with stakeholders. In addition, it would be important to strengthen intercountry collaboration in order to prevent the spread of tuberculosis through international travel, trade and migration. Welcoming the amendments proposed by the representative of China to paragraph 3 and the insertion of a new subparagraph 5(b BIS) as proposed by the representative of Canada, he requested clarification from the Secretariat regarding the use of the words "at regular intervals" in subparagraph 5(i). How would that reporting requirement fit in with streamlined reporting under the ongoing governance reform process? Malaysia supported the global strategy proposed by the Secretariat and wished to be added to the list of sponsors of the draft resolution.

Mr COTTERELL (Australia) welcomed the proposed global strategy and the ambitious but achievable targets for 2020, 2025 and 2035. He particularly supported the focus on detection, treatment and prevention of drug-resistant tuberculosis, integration of HIV and tuberculosis services, the expansion of preventive services to at-risk groups and the need to strengthen regulatory frameworks and ensure access to quality medicines. Cross-border collaboration would also be crucial to meeting the challenges posed by tuberculosis. As a sponsor of the draft resolution, he commended it to the Board for adoption.

Mr LUTZOW STEINER (Mexico) said that his country wished to be added to the list of sponsors of the draft resolution. The global strategy should be based on an integrated approach, taking into account the social determinants of the disease and the issue of co-morbidities such as diabetes mellitus. He supported the comments made by the member for Belgium regarding tuberculosis and migrants and other vulnerable groups and urged WHO to provide increased support to Member States in areas such as management of medicines and the integration of specific strategies on drug-resistant tuberculosis.

Dr MEMISH (Saudi Arabia), speaking on behalf of the Member States of the Eastern Mediterranean Region, expressed support for the proposed global strategy and targets. After rising steadily up to 2006, the tuberculosis notification rate in the Region had stagnated but the decline in incidence was slow. There were often long delays in the detection of tuberculosis cases and more attention must be paid to mapping at-risk populations. Increased involvement of all health-related stakeholders was needed to ensure that all cases were reported to national tuberculosis surveillance mechanisms. Multidrug-resistant tuberculosis remained a major threat to tuberculosis control and global health security; health system strengthening would be a key element in efforts to scale up management of drug-resistant forms of tuberculosis. He expressed concern at the funding gap for tuberculosis control. Tuberculosis rates were low in Member States of the Cooperation Council for the Arab States of the Gulf; those countries were working closely with WHO to achieve complete elimination of the disease.

Mr JEON Man-bok (Republic of Korea) said that continuous efforts were needed to maintain the momentum of decreasing tuberculosis infection rates and to prepare the post-2015 development agenda. Tuberculosis should be included among the elements of the realistic reporting mechanism on national health policy and laws called for in document EB134/7. As government resources alone were not sufficient to fight tuberculosis, it was necessary to scale up approaches drawing on a public-private mix. Strong management of latent tuberculosis was also crucial and it was important to ensure that all people, particularly those from vulnerable groups, had access to tuberculosis check-ups.

Dr GRABAUSKAS (Lithuania), recalling that the adoption of the Millennium Development Goals had galvanized the international community to take action on health issues, including tuberculosis, as part of an integrated approach to overall development, said that in his country, clear progress had been made in the diagnosis and treatment of tuberculosis and in the procurement of antituberculosis medicines. However, much more remained to be done, particularly with regard to providing social support for patients from vulnerable populations, increasing public awareness, and coordinating the involvement of nongovernmental organizations in tuberculosis care. The proposed global strategy contained a clear vision for future efforts; its goals and targets were ambitious but achievable.

Ms MATSOSO (South Africa) highlighted the importance of paying due attention to the situation of vulnerable groups, such as health care workers and miners. The latter group was of particular concern in her country, as they faced an increased risk of tuberculosis owing to silica exposure. South Africa was taking steps to strengthen occupational health systems and surveillance to address the issue. She welcomed the ongoing collaboration with affected countries, particularly in the Southern African Development Community, and the support of multilateral agencies.

Dr PE THET KHIN (Myanmar) said that in order to maintain the progress that had been made, more attention should be paid to the control and containment of drug-resistant tuberculosis and the collection of data on the problem. He encouraged the regional offices to share information on the experiences of countries that had initiated programmes in that area. Member States should review their current tuberculosis prevention, care and control programmes in the light of the three pillars of the proposed global strategy. In that connection, he advocated the adoption of a series of end points, rather than a set of milestones for 2025 and targets for 2035. He trusted that the Secretariat would fine-tune the indicators to make them as robust and practical as possible.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) welcomed the new multisectoral strategic approaches and new international targets for the post-2015 period set out in the proposed global strategy and expressed support for the draft resolution. He stressed the importance of expanding universal health coverage and pursuing research and innovation with the ultimate aim of eliminating tuberculosis. More attention should also be paid to associated HIV infection and multidrug resistance. The situation in his country was positive, with low incidence and mortality rates.

Mr BALA (Nigeria) observed that co-morbidities, including HIV and noncommunicable diseases, complicated the clinical management of tuberculosis and constituted a significant challenge. Ending the tuberculosis epidemic would require further expansion of the scope and reach of interventions, the development of policies to create an enabling environment and encourage sharing of responsibilities, and the aggressive pursuit of research and innovation to develop tools for tuberculosis care and prevention. WHO should explore strategies to deal with the underlying determinants of the disease, such as poor nutrition and living conditions, all of which would benefit from economic growth.

Dr VALVERDE (Panama), welcoming the proposed global strategy and targets, said that communicable diseases like tuberculosis were leading causes of illness and death, particularly in children and the elderly, and were associated with the deterioration of the environment and a lack of basic sanitation, together with other social and economic problems such as poverty and a lack of education and access to basic services. The prevalence of sexually transmitted diseases, and especially of HIV, had led to the re-emergence of tuberculosis. Her country welcomed the draft resolution and wished to be added to the list of sponsors.

Dr OMI (Japan), noting that there was room for improvement in cure and detection rates, said that WHO should continue its work in that area. In addition, tuberculosis control efforts should be undertaken in parallel with activities to strengthen health systems and achieve universal health coverage. With regard to multidrug-resistant tuberculosis, a Japanese pharmaceutical company had developed a new antituberculosis medicine, which it was hoped would contribute to efforts to control drug-resistant forms of the disease. Lastly, given the importance of the directly observed treatment, short course (DOTS) strategy in the fight against tuberculosis, a reference to that strategy should be included in the draft resolution.

Dr SHAKEELA (Maldives) said that in 2012, the South-East Asia Region had had the highest number of tuberculosis cases ever detected in a year in any region. In Maldives, the main challenge was the procurement of medicines, as a result of stock-outs and the short shelf life of many antituberculosis products. Despite the progress made globally, challenges remained, including HIV coinfection and multidrug-resistance, and more needed to be done to strengthen laboratory capacity and to establish strict quality assurance mechanisms for pharmaceutical products.

Professor SHIRALIYEV (Azerbaijan) said that his country was seeking to introduce joint strategies involving partnerships with international organizations, donors and the wider medical community. Azerbaijan had recently adopted legislation on tuberculosis control, providing a sound legal basis for its efforts to combat the disease, and it planned to develop standards to govern areas

such as diagnosis and prevention. Fully equipped laboratories were in place and health care personnel had been trained in the treatment of tuberculosis. In addition, all medical centres had been provided with the equipment required to treat the disease. Close collaboration with relevant stakeholders had further contributed to the stabilization of tuberculosis incidence. The goals set out in the proposed strategy were ambitious; to achieve them, an international policy with a clear definition of priorities was needed.

Ms BOTERO HERNANDEZ (Colombia)¹ emphasized the need to intensify research efforts and to ensure that research and innovation were patient-centred rather than commercially motivated. The fact that no new antituberculosis products had been developed in the previous 40 years had contributed to the appearance of drug-resistant forms of the disease. It was important to improve early diagnostic tests and treatments for multidrug-resistant tuberculosis. Increased political commitment was also needed to implement preventive policies with due regard to the social determinants of health.

Mr HU Xiaomeng (China),¹ noting that the Secretariat report proposed innovative measures for the development of national strategies, said that the targets and milestones were ambitious and challenging. The post-2015 global tuberculosis strategy framework should be made more applicable to high-burden countries by allowing them some flexibility in formulating post-2015 targets. Institutional coordination and resource mobilization mechanisms should be developed at the United Nations level, and strong emphasis should be placed on the need for multisectoral cooperation and protection of vulnerable groups. It was also vital to strengthen technical and financial support for high-burden countries, and WHO should support Member States in developing post-2015 strategic targets and surveillance indicators. The Global Plan to Stop TB 2006–2015 had achieved some positive results in recent years. A series of measures had contributed to a decline in tuberculosis prevalence, incidence and mortality in China, where reduction targets had been reached ahead of schedule with financial support from the international community. The Government of China intended to strengthen its commitment to tuberculosis control efforts and to deal with the remaining challenges, such as multidrug-resistant tuberculosis, population movement and HIV coinfection. Tuberculosis control and prevention efforts would be integrated into policies to achieve universal health coverage and strengthen health systems. In the light of the strategic framework to be adopted at the current session of the Board, China would conduct the relevant data analyses to assist in development of the 2015–2020 national strategy and targets.

Mr SOLOVIČ (Slovakia)¹ stressed the need to intensify global efforts to fight tuberculosis; there should be increased collaboration between high- and low-incidence countries and regions in order to strengthen tuberculosis monitoring and control mechanisms and reduce the risk of cross-border transmission. In addition, the importance of taking action on the social and economic determinants of the disease at the global, regional and national levels should not be underestimated.

Ms GABBASOVA (Russian Federation),¹ expressing strong support for the proposed global strategy, observed that the aims of the document were ambitious and that consolidated efforts would be required to attain them, particularly in the areas of multidrug resistance and HIV coinfection. More attention should be paid to vulnerable groups, ensuring that all persons received adequate treatment, reducing the cost of antituberculosis and antiretroviral medicines and assuring the quality of diagnostics. It was also necessary to develop international instruments on the detection and treatment of tuberculosis among migrants. She expressed concern about the achievability of the targets for 2035 contained in the strategy, particularly the one related to the reduction in tuberculosis incidence. A target of a 90% reduction was extremely ambitious: in her country, for example, a drop of 83.3% would still achieve the target figure of fewer than 10 cases per 100 000 population. It would perhaps

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

be more appropriate to adopt the latter figure as the target, instead of a percentage figure. Noting that the proposed global strategy called for the development of novel diagnostic, treatment and prevention tools, she welcomed the initiatives taken by the Secretariat to step up investment in research activities,

Mr MEUNIER (France),¹ expressing support for the proposed global strategy, said that the draft resolution (which his country also wished to sponsor) would help to mobilize all stakeholders, from national authorities to key partners such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Stop TB Partnership and UNITAID, researchers and public and private actors. He stressed the role of national authorities, as well as the need for rapid progress in achieving universal health coverage and adopting effective preventive measures. Additional resources were needed, especially for high-burden countries, and efforts should be made to increase access to high-quality medicines and diagnostic tools. The emphasis placed on intensified research and innovation under the third pillar of the proposed global strategy was highly commendable.

Professor TJANDRA YOGA ADITAMA (Indonesia),¹ drawing attention to the progress made in his country towards achieving the Stop TB and Millennium Development Goal targets for tuberculosis, said that it was important to expand the scope and strengthen the implementation of tuberculosis-related strategies after 2015. In Indonesia, for example, it was estimated that the current national strategy would achieve a reduction of less than 50% in tuberculosis incidence in the period 2015–2035. However, the tuberculosis burden differed from country to country; high-burden countries like Indonesia were likely to require further support from WHO and international partners. Indonesia fully supported the proposed global strategy and wished to be added to the list of sponsors of the draft resolution.

Mr BLAIS (Canada),¹ expressing support for the proposed global strategy and the draft resolution, said that his country also wished to be included on the list of sponsors of the latter. He stressed the importance of collaboration with the Stop TB Partnership on the implementation of the new global strategy.

Ms REITENBACH (Germany),¹ welcoming the emphasis placed on HIV coinfection, monitoring and surveillance in the report, said that the strategy should also highlight the importance of prevention efforts; specific attention should also be paid to surveillance of drug-resistant forms of the disease and the incidence of tuberculosis in children. In addition, rather than referring to one specific diagnostic test, the report should refer to rapid molecular diagnostic tests endorsed by WHO or to all WHO-recommended diagnostic tests, and the operationalization of universal health coverage and social health protection should be encouraged. Although national budget planning was important, it would impose a bureaucratic burden on federal countries like Germany that had an integrated health system. Lastly, she expressed concern that the targets related to the reduction of tuberculosis incidence and mortality were very ambitious: Germany had in place a well-established tuberculosis control programme but had never recorded such a significant reduction in morbidity and mortality, even when the disease had had an incidence of more than 10 cases per 100 000 inhabitants.

Mr ALIMUZZAMAN (Bangladesh)¹ said that, despite making considerable progress, Bangladesh remained a high-burden country for tuberculosis and faced challenges in areas such as notification of smear-negative, extrapulmonary and childhood cases of tuberculosis; maintaining the DOTS strategy and partnerships with nongovernmental organizations and other relevant stakeholders; strengthening laboratory capacity; ensuring an uninterrupted supply of good-quality medicines, and mobilizing sufficient resources. He agreed with other speakers on the importance of dealing with the

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

social and economic determinants of tuberculosis and the need for strategies to mitigate the impact of migration, ageing populations and tobacco smoking. Bangladesh supported the draft resolution.

Dr VALLEJO (Ecuador)¹ said that the proposed global strategy should be adapted to the epidemiological, regulatory, health and socioeconomic situation of individual countries, taking into account the actual availability of resources. The different characteristics of countries should also be taken into account in setting targets that were feasible for all. In the case of Ecuador, the milestone of a 75% reduction in tuberculosis deaths by 2025 could be achieved only if scientific advances, such as new vaccines, rapid diagnostic tests and improved treatment regimes, were available in a timely manner. In the face of growing rates of drug-resistant tuberculosis and HIV coinfection, WHO should broaden the scope of its actions, to better support countries in the development of strategic plans, and should focus on finding alternative (and especially non-reimbursable) forms of funding.

Mr MISHRA (India)¹ endorsed the new multisectoral strategies and approaches set out in the report, which should provide a better platform for national tuberculosis control programmes. However, country-specific innovations and strategies would be needed in order to reach the entire population. Better detection and intensive monitoring would be crucial in that regard. India was a high-burden country, and although the number of new cases reported had fallen, there had been a significant rise in multidrug-resistant tuberculosis. Therefore, country-wide services were being introduced for the better management of that form of the disease. Although new strategies were required, better, more comprehensive and error-free implementation of the DOTS strategy, and tackling the disease at base level would also have an impact on drug resistance.

Ms KUSYNOVÁ (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN and welcoming the proposed global strategy, cited the joint statement on the role of pharmacists in tuberculosis care and control signed in 2011 by her Federation and WHO, which had since been translated into several national policies. The efforts made in that regard by countries such as India clearly demonstrated the relevance of pillars one and two of the strategy, concerning “integrated patient-centred care and prevention” and “bold policies and supportive systems”, respectively, with particular reference to the engagement of all providers, including pharmacists, in public and private care. The global community of pharmacists represented in the Federation renewed its commitment to and support for the adoption, adaptation at national level and implementation of the global strategy.

Dr BRIGDEN (MSF International), speaking at the invitation of the CHAIRMAN, said that as one of the largest providers of care for people with drug-resistant tuberculosis, her organization was concerned at the increasing incidence of the disease. Given that situation, the use of clear targets and indicators in country strategic plans must be emphasized under the proposed global strategy. Welcome as the strategy was, oversights were evident in pillar three relating to “intensified research and development”, including a lack of focus on the development of new drug regimens, the need for increased investment, and the introduction of new innovation models aimed at delinking the cost of research and development from the final product price. The post-2015 strategy must also include measures to ensure the affordability of the response to tuberculosis. Member States were therefore urged to strengthen the research and development pillar in order to give more prominence to those issues.

Dr DI GIROLAMO (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN and also on behalf of the People’s Health Movement, welcomed the inclusion of social determinants of tuberculosis in the strategy and

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

said that strong drivers would be needed to tackle the root causes of the spread of disease, such as marginalization, exclusion and detention in refugee camps. A strong human rights-based approach structured around the principles of primary health care would be vital in that regard, and she encouraged WHO to work with the United Nations Human Rights Council to provide support for the use of the law to advocate for the right to care for people with tuberculosis. In addition, the strategy should place stronger emphasis on cure rates, access to treatment and improved data on service delivery systems. The strategy should also include actions to overcome barriers to access to diagnostics and medicines resulting from intellectual property restrictions and high prices. Such actions should foster the full use of flexibilities under the Agreement on Trade-Related Aspects of Intellectual Property Rights.

Dr NAKATANI (Assistant Director-General), acknowledging the challenges highlighted by speakers, said that providing support to high-risk groups was an important element of pillar one of the proposed global strategy, namely patient-centred care and prevention. Actions to deal with the social determinants of the disease, such as poverty, were included in pillar two. In response to comments on the DOTS strategy, he explained that although the strategy had been used as a basis for the development of pillar one, it was considered by some to be more didactic than patient-centred; specific references to it had therefore been omitted. However, if Member States so wished, references to the DOTS strategy could be included. Another important issue concerned monitoring and periodic reporting: it was currently planned to monitor progress on a three-yearly basis. Guidance on the issue from the Executive Board would be welcome. He acknowledged the challenging nature of the targets contained in the proposed global strategy but explained that they were based on current situations in different regions. For example, the incidence target for 2020 of fewer than 85 cases per 100 000 population was based on current rates in the Western Pacific Region, and the same target for 2035 of fewer than 10 cases per 100 000 population was based on current data from western Europe.

The CHAIRMAN took it that the Executive Board wished to take note of the report.

The Board noted the report.

Ms STRESINA (Romania),¹ expressing support for the proposed global strategy, said that her country wished to be included on the list of sponsors of the draft resolution.

Ms GEBREMARIAM (Ethiopia)¹ asked that her country be included in the list of sponsors of the draft resolution.

(For adoption of the resolution, see the summary record of the fourth meeting, section 1.)

Global vaccine action plan: Item 6.2 of the Agenda (Document EB134/13)

Dr ASADI-LARI (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that efforts to strengthen the global vaccine action plan faced several challenges, including the poor quality of the immunization data currently available in many countries, and low immunization coverage, with only 30% of Member States meeting coverage targets. Eradication and elimination targets were not being met: poliomyelitis remained endemic in some countries and was resurgent in others; and most regions would fail to meet measles and neonatal tetanus elimination targets. Full implementation of the action plan depended on countries' ownership of it. The Region's Member States were working to strengthen the capacity of their respective national immunization programmes in order to implement the recommended strategies. In 2014 and 2015, they

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

would focus on strengthening programme management capacity (including in terms of human resources) and National Immunization Technical Advisory Groups; establishing an optimal programme structure; according higher priority to vaccine-preventable disease surveillance, immunization data quality, and monitoring and evaluation of immunization activities by governments and stakeholders; working with vaccine producers to ensure that the inactivated poliovirus vaccine was available at affordable prices to middle-income countries that had not yet introduced it; soliciting support for national plans to eliminate measles and neonatal tetanus; achieving measles and maternal and neonatal tetanus elimination by updating the plan of action, mobilizing resources and carrying out supplementary immunization activities; and introducing new vaccines, including by advocating for resource allocation and mobilization, applying to the GAVI Alliance for support, and establishing pooled vaccine procurement for middle-income countries. New technologies should be made available to all Member States.

Dr VALVERDE (Panama) said that in 2014 more than US\$ 29 million had been budgeted for vaccines in Panama, as immunization was one of the most cost-effective public health strategies for achieving the Millennium Development Goals, in particular Goal 4 (Reduce child mortality). The Secretariat's report emphasized that high-quality data provided the cornerstone for accountability at all levels. Despite the difficult economic situation, Member States should invest more resources in improving data quality and transparency, so as to be able to implement national immunization programmes effectively and efficiently. The view prevailing in the Region of the Americas was that immunization policies should take into account not only aspects relating to technology, cost-effectiveness and science, but also those of a practical nature relating to viability and long-term sustainability, as well as social issues such as equity.

Dr NOOR HISHAM ABDULLAH (Malaysia) agreed with the recommendations made by the Strategic Advisory Group of Experts on immunization, in particular that the quality of the data used for monitoring and evaluation should be improved. Information and communication technologies had to be used to improve the recording, reporting and analysis of immunization data at all levels. The global anti-vaccination movement was gaining in prominence and could potentially undermine all the public health results obtained in terms of reducing the vaccine-preventable disease burden. All stakeholders, including Member States, the Secretariat and non-State actors such as nongovernmental organizations, should pay special attention to that issue. A proactive approach was critical to understanding the reasons for the negative perception of immunization and to formulating a solution based on that understanding.

Dr AMMAR (Lebanon) said that the alarming figures contained in the Secretariat's report should encourage all stakeholders to make greater efforts to meet the goals of the global vaccine action plan on time, especially in countries experiencing armed conflicts and political unrest. Many middle-income countries that were not eligible for funding by the GAVI Alliance could not afford essential vaccines, such as the pneumococcal, rotavirus and inactivated poliovirus vaccines; the problem was compounded in countries in which immunization efforts relied to some extent on the private sector and where sudden, acute shortages meant that even people who could afford to pay were having difficulty finding vaccines. Such countries needed the support of WHO and the GAVI Alliance to secure vaccines at affordable prices and thus avoid shortages.

Dr PE THET KHIN (Myanmar) said that the recommendations made by the Strategic Advisory Group of Experts on immunization should be given serious consideration so as to improve data quality and the review and analysis of available data. Action taken pursuant to those recommendations had to be properly reflected in the WHO 2014–2015 biennial work plan at regional and country levels. Member States also had to stimulate and support their immunization data-handling units to monitor programme performance effectively. According to the Secretariat's report, three WHO regions would not meet their routine immunization coverage targets by 2015, a point requiring special attention from the regional offices and Member States. Systematic and well planned proactive immunization

activities by civil society, nongovernmental organizations and development partners working on the ground were essential. Timely action based on epidemiological findings was crucial for increasing immunization coverage and controlling or containing vaccine-preventable diseases. Similarly, the three recommendations made in paragraph 10 of the report should be properly reflected in country and regional office 2014–2015 work plans, so as to improve the immunization programme overall. The South-East Asia Region had only recently established an elimination goal and target year for measles and therefore urgently requested the Regional Office to review the overall epidemiological situation for measles and provide appropriate support during the first half of 2014.

Mr LUTZOW STEINER (Mexico) acknowledged the progress made by national immunization programmes but noted, with regard to the quality of data on immunization coverage and epidemiological surveillance, that it was important for countries to continue working to establish mechanisms that generated timely and reliable information for decision-making. Efforts should be made at all administrative levels to improve and maintain effective and population-based immunization coverage. Mexico, for its part, continued to carry out epidemiological surveillance activities and was implementing the recommendations of PAHO so as to eradicate diseases such as poliomyelitis, measles, rubella/congenital rubella syndrome and neonatal tetanus. He urged all Member States to strengthen their activities so that they remained free of those diseases and to continue working to achieve autonomy in the financial, operational and strategic management of their national immunization programmes.

Mr RI Jang Gon (Democratic People's Republic of Korea) noted the progress made towards eradicating polio and reducing mortality and morbidity rates for vaccine-preventable diseases, including through the use of new vaccines. Thanks to immunization programmes, the South-East Asia Region was to be declared polio-free, a major public health achievement. Immunization was a cost-effective public health measure. His country had introduced new vaccines, including pentavalent vaccines, and carried out various activities to improve immunization coverage, with the support of WHO and its partners. As a result, immunization coverage of more than 97% had been achieved and a good cold chain system and capacity for vaccine storage, management and transportation at various levels had been established. Increased production and dissemination of existing vaccines should continue to be given importance, and research work had to be strengthened to develop new vaccines, especially against malaria and HIV infection. Developing countries with a high burden of those diseases should be supported to establish and strengthen their research and development capacities, so as to lessen their reliance on outside supplies.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) noted that the global vaccine action plan for 2011–2020 contained a series of challenging objectives – polio eradication, rapid progress towards the elimination of measles, rubella and neonatal tetanus, and ensuring that most vaccine-preventable diseases ceased to be a health issue. WHO continued to advise United Nations bodies on the acceptability of the vaccines they planned to procure and guaranteed that the vaccines met established standards for quality and safety. In 2009, it had prequalified 10 single or combined vaccines produced in Brazil, Bulgaria, Cuba, India, Indonesia, the Russian Federation and Senegal. Under its national immunization programme, Cuba had eliminated poliomyelitis, diphtheria, pertussis, measles, rubella/congenital rubella syndrome, neonatal tetanus and tuberculous meningitis; the incidence of other vaccine-preventable diseases had dropped by more than 98%. Of the 11 immunobiologicals used in the programme, eight were manufactured in the country and complied with WHO quality and safety standards. The Strategic Advisory Group of Experts on immunization had rightly recommended that the quality of data on immunization coverage should be improved, because without good information there could be no good decisions. It was essential, therefore, that countries formulate policies and strategies and improve their immunization practices; they should promote political commitment, accountability and the self-sufficiency of national immunization programmes and obtain solid and sustained financial support for immunization activities.

Ms MATSOSO (South Africa), welcoming the Secretariat's report and noting that monitoring and evaluation were key issues, said that she shared the concern about data quality. Many countries faced similar challenges, particularly with regard to routine data quality, making it difficult to assess programme performance and prioritize critical areas. WHO and other United Nations agencies should therefore help countries to integrate their child survival strategies and other related programmes, with a view to increasing immunization coverage; fragmentation undermined long-term sustainability. The timelines were ambitious, and WHO should review them and support countries in the organization of their specific disease control efforts and systems. She agreed that it was necessary to enhance country ownership of national immunization programmes, including in the area of financing. She urged all countries to pledge to implement the activities of the global vaccine action plan so as to ensure that, as a global community, they realized the vision of the Decade of Vaccines and the world it promised.

Dr BARBOSA DA SILVA (Brazil) agreed that countries had to give higher priority to the quality of immunization coverage data and the surveillance of vaccine-preventable diseases. Immunization was one of the most cost-effective public health measures for the population in general, and for mothers and children in particular. Under Brazil's national immunization programme, which would mark its fortieth anniversary in 2014, a coverage rate of 95% had been achieved, with 96% of vaccines, or 300 million doses, provided by the public health system being produced in the country. The aim remained to improve the programme and increase vaccine availability. WHO should provide specific support to countries on questions of vaccine accessibility and individual cost. Brazil was committed to promoting the PAHO vaccination week in the Americas, an idea that was spreading to other regions. He reaffirmed Brazil's pledge to provide clear, transparent and good-quality information for the WHO review process and its willingness to cooperate with other countries in that regard and to continue its involvement in polio eradication activities at various levels.

Professor SHIRALIYEV (Azerbaijan) noted that programmes to eliminate diseases such as poliomyelitis, measles and rubella were a major global, regional and national priority of WHO. However, the problem of the immunization process itself, which was at the very heart of those disease control programmes, was often ignored, while other elements of the programmes were made a priority. It was logical to consider immunization as a single unified system. An immunization programme must be implemented as a whole, along with the necessary epidemiological surveillance, if its component targets were to be achieved. Immunization programmes should be enhanced by introducing new vaccines, updating basic regulations and laws, increasing political commitment, adopting a differentiated approach to social mobilization and strengthening human resources capacity. WHO should organize and coordinate the efforts of countries, donors and international organizations in order to ensure that all children, wherever they lived and whatever their race or social status, were protected by immunization. It was the priority that united the efforts of all, and its success would be heralded by a continuous increase in immunization coverage and the introduction of new and effective vaccines at all levels.

Ms ALGOE (Suriname) expressed support for the global vaccine action plan and endorsed the views of previous speakers. As suggested in the Secretariat's report, new information and communication technologies should be used to improve data collection. Mobile telephones were available worldwide but were insufficiently utilized in public health programmes. She urged WHO's regional offices to provide Member States with more technical support relating to mobile health and data collection, notably by sharing best practices between Member States. She concluded by asking two questions. What would be the impact in terms of cost of the switch from the trivalent to the bivalent polio vaccine? By what date would the removal from circulation of vaccine-derived poliovirus be confirmed?

Dr USHIO (Japan), noting that the global vaccine action plan was an important strategy for improving public health worldwide, in particular in terms of Millennium Development Goal 4 (Reduce child mortality), welcomed the first report drafted in accordance with the proposed framework for

monitoring, evaluation and accountability endorsed at the Sixty-sixth World Health Assembly. WHO was to be congratulated on its steady implementation of the action plan and its focus on developing, managing and monitoring the resources allocated to the plan at both global and country levels. Those efforts were contributing to a significant reduction in infant mortality. WHO should further analyse the challenges at each level and clarify what measures should be taken, and what support was required by Member States, to improve data quality, which was one of the most important elements in the fight against infectious diseases. The same approach should be taken to improve immunization coverage, on the basis of detailed analyses of the challenges at each level, including the district level, such as poor access to immunization activities and low awareness of immunization. Diseases close to being eliminated or eradicated, such as poliomyelitis, measles and rubella, required a strong political commitment in addition to the strengthening of routine and supplementary immunization activities. Japan had been cooperating on numerous immunization activities for developing countries and stood ready to continue working with Member States in that field.

Dr BEJTJA (Albania) said that a good information system was the key to achieving the targets set in the global vaccine action plan. Good models existed but they had to be replicated. Mobile health approaches had to be considered and better explored. Particular attention should be paid to new, or non-traditional, vaccines and their affordability, especially in middle-income countries that were not eligible for funding by the GAVI Alliance.

Dr SHAKEELA (Maldives) said that, as the Decade of Vaccines moved forward, a balanced approach should be adopted to the task of implementing concrete solutions to the problems faced in communities. Timely and precise immunization coverage and disease surveillance data were critical for better programmatic decisions, attainment of immunization targets and progress towards disease reduction. Administrative coverage figures were known to be woefully inaccurate, yet they remained primary decision-making tools. Maldives had a very high immunization coverage rate – above 95% – but it also faced several challenges, chief among them procurement. Maldives being a small country that depended entirely on imports for vaccines, rising costs and restricted availability and accessibility threatened the successful implementation of its immunization programme. Maldives had to cope daily with high wastage, distribution problems between islands and possible stock-outs in supplies. The global vaccine action plan should serve to improve vaccine availability and accessibility through appropriate monitoring and price controls, failing which countries like Maldives would struggle to keep immunization accessible on an equitable basis for their peoples.

Dr CARBONE (Argentina) said that Argentina recognized the importance of having a vaccination strategy and had developed a national vaccination registration system, known as NOMIVAC, under the national programme to control vaccine-preventable diseases. The system registered the names and addresses of persons who had been vaccinated in each department and sent out alerts when individuals failed to receive the vaccinations for which they were due. The system was part of Argentina's computerized health system, which aimed to establish a single database of real-time information on, inter alia, provincial and national coverage rates, doses applied, progress made and population concerned. Argentina promoted strategies for the systematic detection of viral hepatitis and universal hepatitis B immunization: hepatitis A and B immunization had been incorporated in the national schedule of free vaccinations. She expressed satisfaction at the global fall in morbidity and mortality rates following the introduction of new vaccines into the national programmes of low- and middle-income countries but considered that national governments and international bodies should make a greater investment in meeting the objectives of vaccine design. Argentina was committed to continuing to make a contribution in that area.

Ms MEL'NIKOVA (Russian Federation)¹ said that immunization was the most effective method for preventing disease and promoting health through the life course. Her delegation supported the view expressed in the Secretariat report that more investment in immunization programmes was needed in order to meet the goals of the Decade of Vaccines. Low-income countries faced a particular challenge, one that they would be unable to overcome without international assistance. WHO and other public organizations should make the greatest possible effort to contribute to the strengthening of immunization programmes in those countries, as the Russian Federation had done for other countries of the Commonwealth of Independent States in respect of poliomyelitis and measles. She endorsed the reference in the report to the vital importance of accurate data on immunization coverage and disease surveillance for improved programmatic decision-making, meeting immunization targets and monitoring progress towards disease reduction. Strict national controls would be needed in order to guarantee the quality of data: Member States should adopt appropriate measures at all administrative levels, improve data collection and analysis methodology and evaluate the effectiveness of their programmes.

Ms BOTERO HERNANDEZ (Colombia)¹ commended the considerable progress that had been made at global level with regard to vaccination plans. It was important to build on those efforts and to devise, disseminate and monitor a method for following up the plans and implementing expanded immunization programmes at community level. Expressing concern that the report contained little information on the high cost of including new vaccines in immunization programmes, an aspect that constituted a serious financial risk for national health systems, she requested the Secretariat to provide more information on the subject.

Dr DAULAIRE (United States of America)¹ expressed support for the global vaccine action plan. The accountability framework had been effectively defined but some indicators would require further definition and clarification of targets. In that regard, it would be important to identify how countries would use the results for action and how regional committee recommendations would be implemented. In addition, a global dashboard should be developed, to monitor progress on key indicators by all Member States on a year-by-year basis. The dashboard should indicate which countries were meeting the targets and which were not. The Secretariat should be more ambitious with regard to the target of developing and introducing new, improved and underutilized vaccines and technologies by 2020, in order to accelerate progress during the Decade of Vaccines. He concurred with the previous speaker that greater attention should be paid to the issues of costing, effective delivery and affordability of the entire vaccination package, which was not merely a technological matter. In that context, he stressed the importance of monitoring global vaccine supply and pricing to ensure equitable access.

Mr HU Xiaomeng (China)¹ endorsed the recommendations of the Strategic Advisory Group of Experts on immunization. The global vaccine action plan had a long implementation cycle involving many stakeholders; communication across regions and between Member States therefore had to be stressed and cooperation increased. The Secretariat should provide more technical support to Member States and raise more funds to help developing countries use new information and communication technologies. In the matter of switching polio vaccines, WHO should take into consideration how countries actually used the vaccine, so as to make the switch more operational. A transition period should be established for countries, especially developing countries, that wished to introduce the inactivated poliovirus vaccine. WHO should coordinate the work of multiple parties in promoting research and development and manufacturing the inactivated poliovirus and bivalent attenuated vaccines; it should help developing countries carry out risk assessments of vaccines, and only

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

implement a vaccine switch when there was an adequate supply and the risks were fully understood and controlled.

Professor TJANDRA YOGA ADITAMA (Indonesia)¹ said that the global vaccine action plan had the potential to enhance the global immunization programme. Its four sets of activities were suitable for implementation worldwide, and monitoring, evaluation and accountability of the immunization programme were important to meet its targets. In order to maintain the progress made and sustain routine immunization coverage, Indonesia had joined the Intensification of Routine Immunization initiative launched by the Regional Office for South-East Asia to ensure that every child was vaccinated. Most of the vaccines used in Indonesia and in the Region's other countries were produced by an Indonesian company. Indonesia was implementing specific strategies for areas that were hard to reach and had high drop-out rates. Media campaigns were being conducted on the importance of complete immunization for the health and welfare of children. In some remote districts, however, obstacles were still encountered in meeting the 80% coverage target. In 2013, Indonesia had introduced the fully liquid pentavalent vaccine into the national immunization programme and was giving young children booster doses to complete their immunization. The capacity of national and provincial committees to deal with adverse events following immunization was being strengthened, and consideration was being given to the possibility of introducing new vaccines in the framework of the comprehensive multi-year plan promoted as part of the Decade of Vaccines. Indonesia would do its utmost to achieve the targets set out in the plan.

Mr ALIMUZZAMAN (Bangladesh)¹ agreed that the quality of data on vaccination was inadequate in many cases and that innovative approaches to achieving full immunization coverage, both nationally and globally, would ensure progress. Bangladesh had achieved most of the global targets for routine immunization and vaccine-preventable disease control. Thanks to successive campaigns under the national immunization programme, 84% of children aged 12 to 23 months had been fully vaccinated, 89% had been vaccinated against measles, 92% had been given the oral polio vaccine and 92% had received all three doses of the pentavalent vaccine. There had been no case of poliomyelitis in Bangladesh since November 2006. Bangladesh had introduced the hepatitis B, *Haemophilus influenzae* type b and rubella vaccines, and was planning to introduce the pneumococcal conjugate vaccine in 2014 with the help of its development partners. It would continue to implement appropriate and affordable immunization and surveillance strategies aimed at reducing the vaccine-preventable disease burden. The affordability and regular availability of vaccines were key to further progress. It was hoped to increase the domestic supply of vaccines and to strengthen the capacity of the national regulatory authorities with the help of development partners.

Dr FABBRI (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN and also on behalf of the People's Health Movement, said that the inclusion of mixed public-private health systems in universal health coverage should perhaps be reconsidered in the light of the difficulties highlighted in that context in the report of the Strategic Advisory Group of Experts on immunization. The disadvantages of vertical programmes and the attendant challenges with respect to coordination were also emphasized in the report, as was the role of National Immunization Technical Advisory Groups. National vaccination strategies should respond to local epidemiology, institutional capacity and local health system priorities, as had been found in the context of efforts to ensure immunization coverage against the human papillomavirus, rotavirus, diphtheria, tetanus and pertussis (DTP3), and rubella. For example, in countries where infant immunization coverage was low and there was a risk of partial population immunity, it might be advisable to allocate additional resources to primary health care and adolescent

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

immunization. Consideration of opportunity costs must also be central to national decision-making, in order to avoid potential long-term distortions in health system expenditures.

Dr COHN (MSF International), speaking at the invitation of the CHAIRMAN, welcomed the recommendations set out in the report and said that improving the availability and quality of vaccination data should be a priority in the global vaccine action plan, bearing in mind the lack of clarity regarding the vaccine prices paid by the majority of countries. The cost of fully vaccinating a child had risen by 2700% over the past decade. It was therefore critical to monitor vaccine prices, particularly in countries set to lose GAVI Alliance support and middle-income countries faced with increasingly unaffordable vaccine costs. Member States must play their part in the accurate and timely collection of data, by reporting annually the prices paid for vaccines and ensuring that the Secretariat was able to secure essential price information from all sources, the aim being to build a full picture of the global vaccine market and provide benchmark prices to enable easier comparison and better procurement decisions.

Dr OKWO-BELE (Immunization, Vaccines and Biologicals) said that the issues raised in speakers' comments would be conveyed to the Strategic Advisory Group of Experts on immunization. He commended the excellent work being done by the regional offices, which had taken numerous initiatives to accelerate progress in rolling out the global vaccine action plan. As several speakers had pointed out, countries requiring support for efforts to implement the plan should have ready access to such support. The stronger linkages between WHO efforts to eradicate polio and those of the GAVI Alliance and other partners were starting to bear fruit, especially in countries with low immunization coverage. Data quality was crucial to enhancing understanding of what needed to be done and where action was required; good quality data were particularly important at subnational level, in order to enable timely action to be taken in areas lagging behind in terms of coverage. The Strategic Advisory Group of Experts on immunization would take up the issue of anti-vaccination groups at its April 2014 meeting, at which it would discuss the best practices that countries could implement to reduce the negative impact some of those groups were having. Referring to the need for up-to-date equipment to maintain the cold chain, he said that key partners were working together at global level to find solutions. In order to avoid fragmentation in programme delivery, diligent work was being done to ensure that infants received not only preventive but also curative care and rehabilitation in an integrated strategy aimed at reducing the burden of major killer diseases such as pneumonia and diarrhoea. The same approach was being applied to other age groups; for example, the human papillomavirus vaccine for adolescents was being rolled out with a view to expanding other interventions for that target group. Regarding the switch from the trivalent to the bivalent oral polio vaccine, he stressed that WHO was actively ensuring that the regional offices were working with all Member States to ensure that the latter were ready to make the switch by the target date of 2016. All agencies were carefully analysing the impediments and risks arising as efforts to eradicate polio entered their final phase. He expressed appreciation for the proactive manner in which many small countries were dealing with issues of vaccine procurement and supply, and suggested that WHO and UNICEF might support them in finding solutions to the problems they faced. He also expressed appreciation for suggestions regarding how all organizations and Member States could work together to collect experiences and improve electronic vaccination registries, which would serve to assess immunization programmes in the future. Resources had been secured in the Programme budget for the collation of those experiences and for initiating work on standardization, but the task was a complex one and would take time.

The DIRECTOR-GENERAL, noting that almost all of the speakers had referred to the importance of data quality, said that good data were predicated on the registration of every single birth and death. Registration was also a key factor of the right to health and a prerequisite for the right to immunization, based on possession of a trackable identity; she therefore urged all development partners to support countries, under the Every Woman Every Child initiative, in strengthening their registration processes. WHO, for its part, was working with ITU to support the efforts of countries to

use digital data platforms to improve their health information systems. In the context of interagency collaboration and discussions, WHO was urging the GAVI Alliance and other entities with a track record of negotiating with the vaccine industry to help middle-income countries to obtain more affordable vaccines. Under its mandate, the GAVI Alliance focused first and foremost on eligible countries, but WHO was encouraging it to find solutions for middle-income countries as well. WHO did not engage in procurement of vaccines and had very little access to data on vaccine prices. However, the Secretariat stood ready to discuss the matter with Member States if they wanted WHO to provide information on vaccine prices.

The CHAIRMAN took it that the Executive Board wished to take note of the report.

The Board noted the report.

2. NONCOMMUNICABLE DISEASES: Item 7 of the Agenda

Follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases: Item 7.1 of the Agenda (Documents EB134/14, EB134/14 Add.1, EB134/14 Add.2 and EB134/14 Add.3)

Mr COTTERELL (Australia) congratulated the Secretariat on the significant amount of work accomplished and agreed that a second formal meeting of Member States should be convened to finalize the terms of reference for the global coordination mechanism. It was critical that the mechanism should complement rather than duplicate the work of the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases. It might also be useful for the Secretariat to identify priority areas for the global coordination mechanism before the meeting, as that would help clarify the terms of reference. He welcomed the report of the formal meeting of Member States to complete the work on the terms of reference for the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases, including a division of tasks and responsibilities for United Nations funds, programmes and agencies and other international organizations, and the report of the consultation with Member States to conclude work on the limited set of action plan indicators for the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020, contained in Annexes 3 and 4, respectively, to the Secretariat's report. He agreed that they should be forwarded to the Sixty-seventh World Health Assembly in May 2014 for consideration. Australia was committed to supporting implementation of the Global Action Plan 2013–2020 and urged the Secretariat to work with Member States to ensure its implementation by strengthening national surveillance and monitoring systems, which would also facilitate accurate reporting under the global monitoring framework.

Dr PE THET KHIN (Myanmar) commended the Secretariat's work on the global action plan for 2013–2020, the terms of reference for the global coordinating mechanism and the Inter-Agency Task Force, and the limited set of action plan indicators. The division of tasks and responsibilities for the Inter-Agency Task Force was comprehensive and technically relevant. However, consideration should also be given to whether that division of tasks was feasible, given the number of partner agencies involved. WHO should lead and coordinate the areas of work suggested under Objective 6 of the division of tasks. He suggested that WHO headquarters should work closely with the regional offices to prioritize the areas of work suggested under each objective in the light of the epidemiological situation with regard to noncommunicable diseases in each country. Implementation of those activities would also directly and indirectly strengthen the health system. Success depended on close and careful monitoring of the work done, using simple and viable monitoring mechanisms at country level. Many of the proposed areas of work should be incorporated in the Programme budget 2014–2015.

Dr FEISUL IDZWAN MUSTAPHA (Malaysia), noting the report on progress made in implementing the 2008–2013 action plan for the global strategy for the prevention and control of noncommunicable diseases,¹ said that past achievements had laid the groundwork for further intensified action by the Secretariat, and especially by Member States, using multisectoral, whole-of-government and whole-of-society approaches. It was gratifying that work had been completed on the terms of reference for the Inter-Agency Task Force and the limited set of action plan indicators, which should be submitted to the Health Assembly in May 2014 for consideration and adoption. Much work remained to be done, however, before a consensus was reached on the terms of reference for the global coordination mechanism, and he therefore endorsed the proposal to convene a second formal meeting of Member States before the World Health Assembly in May 2014.

Dr AL-THANI (Qatar), speaking on behalf of the Member States of the Eastern Mediterranean Region, noted that the four areas of action and corresponding strategic interventions specified in Annex 6 to document EB134/14 were in line with the regional Framework for Action on the commitments of Member States to implement the United Nations Political Declaration on Noncommunicable Diseases endorsed by the Regional Committee for the Eastern Mediterranean at its fifty-ninth session.² He further noted with satisfaction that substantive progress had been made towards setting up the Inter-Agency Task Force and developing the limited set of action plan indicators. More work was required, however, to finalize the global coordination mechanism and to prepare for the United Nations General Assembly comprehensive review and assessment in 2014. The need for strong engagement by Member States in the review and assessment was stated in a resolution adopted by the Regional Committee at its sixtieth session,³ thereby demonstrating the active engagement of Member States of the Region in global efforts to implement the commitments made under the United Nations Political Declaration. The Regional Committee called on the Secretariat to coordinate closely with the United Nations Secretariat in preparing for the General Assembly review.

Mr BALA (Nigeria), speaking on behalf of the Member States of the African Region and noting that the Sixty-sixth World Health Assembly had adopted a comprehensive global monitoring framework that included a set of indicators and voluntary targets, said that it was urgently necessary to operationalize and implement the global action plan for 2013–2020. The Member States had participated in consultations on the status of noncommunicable diseases around the world and in Africa, helping to draft the terms of reference for the global coordination mechanism and the Inter-Agency Task Force. They remained concerned, however, that progress was being hampered by inadequate political commitment, low levels of national funding and poor enforcement of national policies to prevent and control key risk factors for noncommunicable diseases such as tobacco and alcohol use, unhealthy diet and physical inactivity. The commercialization of risk factors and the financial implications for governments in the Region were among the challenges they faced, and mechanisms should therefore be developed to compel Member States and other stakeholders to demonstrate greater commitment to the Political Declaration. They also encouraged the Secretariat to work with them to step up investment in the Region, in order to reduce the economic and other effects of those risk factors.

Mr LUTZOW STEINER (Mexico), acknowledging the efforts made by the Secretariat and working groups to guide action on noncommunicable diseases, agreed that a second formal meeting of Member States should be convened before the Sixty-seventh World Health Assembly in May 2014. In the light of its national priorities, and with regard to the recommendations made by various PAHO and WHO working groups, Mexico had in 2013 launched a national strategy for the prevention and control

¹ See document EB134/14, Annex 1.

² See resolution EM/RC59/R.2.

³ Resolution EM/RC60/R.4.

of overweight, obesity and diabetes. The President of the Republic had publicly explained the programme's multisectoral strategies and activities involving the education sector, the country's sports institutions and the regulation of food advertising, especially when directed at children. The programme was therefore in line with the global action plan for 2013–2020. It was to be hoped that the indicators set out in the Secretariat's report would be approved by the Health Assembly in May 2014. Noting the list of potential members of the Inter-Agency Task Force, he trusted that they would continue to be guided by WHO.

Mr JEON Man-bok (Republic of Korea) said that the four progress reports contained in the Secretariat report (document EB134/14) were essential to the successful implementation of the global action plan for 2013–2020. Implementation of the 2008–2013 action plan should be reviewed to make up for any shortcomings. He fully supported the arrangements agreed by Member States with regard to the Inter-Agency Task Force and the indicators for the global action plan for 2013–2020, and suggested that the Executive Board should submit them to the Health Assembly in May 2014. Implementation reports should not only describe performance but also evaluate progress and describe limitations, and he therefore suggested that evaluation should be added to the report on implementation of the 2008–2013 action plan. Member States continued to have conflicting views on the global coordination mechanism, and he therefore agreed on the need to convene a second formal meeting before the Sixty-seventh World Health Assembly in May 2014.

Dr OKABAYASHI (Japan), referring to the report on implementation of the 2008–2013 action plan, noted that significant progress had been made during that period: two high-level meetings had been held and the new global action plan for 2013–2020, including nine voluntary targets and indicators, had been drafted. He trusted that the Secretariat and the Member States would maintain that momentum, and he expected WHO to continue providing technical support for steady and effective implementation of initiatives in each country. The multisectoral approach was important for noncommunicable disease prevention and control, and effective ways should be found of promoting the involvement of stakeholders. He therefore appreciated the Secretariat's proposal to hold a second formal meeting of Member States after the current session of the Executive Board.

Dr CAPAK (Croatia), speaking on behalf of the European Union and its Member States, noted that, a few months before the United Nations General Assembly comprehensive review and assessment, significant progress had been made in implementing the 2008–2013 action plan and that the Sixty-sixth World Health Assembly had adopted the global action plan for 2013–2020. The European Union supported the proposed terms of reference for the Inter-Agency Task Force to be submitted to the Health Assembly in May 2014, and the nine action plan indicators; it would continue to contribute to work on the terms of reference for the global coordination mechanism, with a view to finalizing them before the Health Assembly. WHO should continue to spearhead the global response to noncommunicable diseases. It was clear, however, that sustainable results could only be achieved through commitment and action across all sectors, at the national and international levels. Engagement with non-State actors, including nongovernmental organizations and businesses, would make it possible to tap into the potential for all partners to make a significant contribution to reducing the noncommunicable disease burden; at the same time, WHO and public health had to be shielded from undue influence by any form of real, perceived or potential conflict of interest. As engagement with non-State actors through the global coordination mechanism could not be decided in isolation from the ongoing debate on WHO reform, it was urgently necessary to reach agreement on Organization-wide principles at the Health Assembly in May 2014.

(For continuation of the discussion and adoption of a decision, see the summary record of the third meeting, section 2.)

The meeting rose at 17:35.

THIRD MEETING

Tuesday, 21 January 2014, at 09:00

Chairman: Professor J. HALTON (Australia)

1. STAFFING MATTERS: Item 12 of the Agenda

The meeting was held in open session until 10:10, when it resumed in public session.

Appointment of the Regional Director for South-East Asia: Item 12.1 of the Agenda (Document EB134/47)

At the request of the CHAIRMAN, Dr VALVERDE (Panama), Rapporteur, read out the following resolution adopted by the Board in open session:¹

The Executive Board,

Considering the provisions of Article 52 of the Constitution of the World Health Organization;

Considering the nomination made by the Regional Committee for South-East Asia at its sixty-sixth session,

1. APPOINTS Dr Poonam Khetrpal Singh as Regional Director for South-East Asia as from 1 February 2014;
2. AUTHORIZES the Director-General to issue to Dr Poonam Khetrpal Singh a contract for a period of five years from 1 February 2014 subject to the provisions of the Staff Regulations and Staff Rules;
3. AUTHORIZES the Director-General to amend the conditions of employment of Dr Poonam Khetrpal Singh as follows: “You will not participate in the United Nations Joint Staff Pension Fund but will instead receive as a monthly supplement the contribution that the Organization would have paid each month to the Pension Fund had you been a participant”.

The CHAIRMAN congratulated Dr Poonam Khetrpal Singh on her appointment and conveyed the Board’s best wishes for her success in her post.

At the invitation of the CHAIRMAN, Dr KHETRAPAL SINGH took the oath of office contained in Staff Regulation 1.10 and signed her contract.

Dr KHETRAPAL SINGH (Regional Director-Elect for South-East Asia) thanked the Executive Board and the Member States of the South-East Asia Region for trusting her to lead one of the most dynamic regions of WHO at such a demanding time. Her passion for public health had begun in 1975 on joining the Indian Administrative Service, a government institution responsible for one fifth of the world’s population, where she had formulated policy and developed and implemented health-related

¹ Resolution EB134.R1.

strategies. Later she had become Health Secretary of the state of Punjab. After three years with the Health Population and Nutrition Department of the World Bank, she had joined WHO in 1998 as Executive Director for Sustainable Development and Healthy Environments, and subsequently had served as Deputy Regional Director for South-East Asia. Since retiring in February 2013, she had been Adviser on International Health to the Ministry of Health and Family Welfare in India.

Over the previous decade, she had worked with the Member States of the South-East Asia Region to overcome extreme challenges and celebrate victories. The Region had coordinated a multi-country rapid response to the 2004 tsunami, containing the health impact of that disaster and supporting the reconstruction of national health systems. The South-East Asia Region Health Emergency Fund, the first of its kind, had strengthened countries' response to natural disasters and emergencies. Lessons had been learnt from Thailand's progress towards universal health coverage and Timor-Leste's post-conflict reconstruction of its health systems. Bangladesh and Nepal had received international acknowledgement for achievements in meeting Millennium Development Goals 4 (Reduce child poverty) and 5 (Improve maternal health). Maldives continued to be malaria-free. India's landmark achievement in becoming polio-free was an historic milestone, and the Region looked forward to the certification of polio eradication in March 2014.

Significant health challenges remained in the Region as the nature of public health continued to evolve. The Region was undergoing unprecedented demographic, epidemiological, economic and social transition and would require a bold strategy to tackle the unfinished agenda of Millennium Development Goals 4, 5 and 6 (Combat HIV/AIDS, malaria and other diseases), noncommunicable diseases, and health systems and emergencies, under the strong leadership of the Regional Office. Type 2 diabetes, cardiovascular diseases, hypertension and strokes were becoming more prevalent in the Region, across all income groups and among the young. Such chronic problems called for new types of care and caregivers, as the increasing cost of care was a key driver of inequities and poverty. The complex causes and consequences of noncommunicable diseases influenced the health of the Region's people, further stretching already weakened health systems.

Despite technological advances, universal health coverage had not yet been achieved. Heart and kidney transplants were possible, but diseases were still not being prevented. Tuberculosis and malaria were re-emerging, and were becoming drug-resistant and coinfectious. Vaccines for childhood diseases were not reaching the most vulnerable populations. Climate change-related natural disasters and health emergencies were on the rise. The multisectoral nature of those challenges required new health partnerships and consolidated support from all health-related sectors in a new era of universal health development.

WHO must undergo wide-ranging organizational reform to meet countries' growing needs and become more effective, efficient, responsive, accountable and transparent; to fulfil that core mandate, it must define and meet country priorities, joining hands across the three levels of the Organization. The South-East Asia Region had some of the best public health experts, medical facilities and centres of excellence, and a leading pharmaceutical industry that was already improving the health of populations within and beyond the Region. Steadfast in her resolve to bring change, explore new avenues, and build partnerships for a technically sound, committed and dynamic effort to meet all public health challenges, she would lead the Region without fear or favour.

She would bring to that task the benefit gleaned from working with many experts during her 15 years of service in WHO, and she particularly thanked her predecessor, Dr Samlee Plianbangchang, in that regard. She looked forward to Member States' support in rapidly and substantially improving the health of the population of South-East Asia and beyond.

The DIRECTOR-GENERAL welcomed the appointment of Dr Khetrupal Singh, who was known for her leadership and managerial capacities and who had extensive experience in WHO at the regional level and at headquarters. She would build on the strong legacy of Dr Samlee Plianbangchang, who had led the Region's successful effort to eradicate poliomyelitis. Moreover, as a result of her appointment, WHO had achieved gender equality in its team of regional directors.

Expression of appreciation to the outgoing Regional Director for South-East Asia

At the invitation of the CHAIRMAN, Dr VALVERDE (Panama), Rapporteur, read out the following resolution adopted by the Board in open session:¹

The Executive Board,

Desiring, on the occasion of the retirement of Dr Samlee Plianbangchang as Regional Director for South-East Asia, to express its appreciation of his services to the World Health Organization;

Mindful of his lifelong devotion to the cause of international health, and especially recalling his 10 years of service as Regional Director for South-East Asia;

Recalling resolution SEA/RC66/R2, adopted by the Regional Committee for South-East Asia, which designates Dr Samlee Plianbangchang as Regional Director Emeritus of the World Health Organization;

1. EXPRESSES its profound gratitude and appreciation to Dr Samlee Plianbangchang for his invaluable contribution to the work of WHO;
2. ADDRESSES to him on this occasion its sincere good wishes for many further years of service to humanity.

The DIRECTOR-GENERAL recognized Dr Samlee Plianbangchang's devoted service to WHO over more than 26 years, including 10 years as Regional Director. He left a legacy of multiple achievements, many of enduring public health significance. With the support of Member States and development partners, he had achieved polio eradication in the South-East Asia Region. She wished him all the best for the future.

Ms MATSOSO (South Africa), speaking on behalf of the Member States of the African Region, congratulated Dr Khetrupal Singh on her appointment and the Executive Board on creating a gender-sensitive Organization. Acknowledging Dr Khetrupal Singh's acumen, wisdom and commitment to global health, she welcomed her statement regarding how she would work to shape health in South-East Asia. The challenges Dr Khetrupal Singh had mentioned were of global importance, and she would make a significant contribution to WHO reform. The Member States of the African Region thanked the outgoing Regional Director, Dr Samlee Plianbangchang, for his commitment.

Dr EZZAT (Egypt), speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed the appointment of Dr Khetrupal Singh. Noting her long years of experience within WHO and her leadership abilities, he was sure that she would contribute efficiently and effectively to improving the health of people in the Region.

Mr PIPPO BRIANT (Argentina), speaking on behalf of the Member States of the Region of the Americas, thanked Dr Samlee Plianbangchang for his long career of service and his work as Regional Director for South-East Asia. He had been a strong defender of primary health care and a good friend of the Region of the Americas. He congratulated Dr Khetrupal Singh on her election as the first female Regional Director for South-East Asia. Her experience in sustainable development and her commitment to primary health care and South-South cooperation would benefit the Region and the world.

¹ Resolution EB134.R2.

Dr CUYPERS (Belgium), speaking on behalf of the Member States of the European Region, congratulated Dr Khetrupal Singh on her appointment. Her rich and varied experience and expertise would enable her to contribute to improving the health of people in South-East Asia and globally, as well as meeting the Region's goals. He thanked Dr Samlee Plianbangchang for his services to WHO.

Dr OMI (Japan), speaking on behalf of the Member States of the Western Pacific Region and congratulating Dr Khetrupal Singh on her appointment, noted her rich experience and proven leadership capacity that would contribute to improving health globally and in the Region. He recalled that Dr Samlee Plianbangchang had been one of the most dedicated and hard-working staff members and regional directors in the history of WHO, and thanked him for his service.

Dr SHAKEELA (Maldives), speaking on behalf of Member States of the South-East Asia Region, congratulated Dr Khetrupal Singh on her appointment. She had an impressive record of accomplishments, experience and skills. Most importantly, she had a vision for the Region, one that incorporated the public health priorities of individual Member States, regional perspectives and global dynamics. Maldives, like the other Member States of the Region, was confident that her appointment would strengthen the Director-General's promotion of the global health agenda and WHO reform.

The Region had made great strides in public health, through the efforts of Member States and partners and with technical support from WHO, especially with regard to attaining the Millennium Development Goals. She thanked Dr Samlee Plianbangchang for his untiring and dedicated leadership during his tenure as Regional Director, and wished him success in his future endeavours.

Dr PE THET KHIN (Myanmar) thanked Dr Samlee Plianbangchang for his contribution to the Region and to Myanmar, including the establishment of the University of Public Health in Myanmar. He congratulated Dr Khetrupal Singh on her appointment and wished her success in leading the Regional Office and working with Member States to achieve the Organization's goals in the Region.

Mr MISHRA (India)¹ thanked the Member States of the South-East Asia Region for nominating Dr Khetrupal Singh to serve as Regional Director and the Executive Board for electing her, noting that she was the first woman to hold that post and the first Indian in 44 years. She brought to the post a wealth of experience at the global, regional and national levels. The Government of India was confident that she would serve as a dynamic, able and committed leader, whose clear vision would contribute to protecting and improving the health of the 1.8 billion inhabitants of the Region, and that she would take the Region forward without fear or favour. He thanked Dr Samlee Plianbangchang for his leadership and commitment to the health and well-being of the people of South-East Asia; he had overseen historic achievements during his tenure, including polio eradication in the Region.

Dr SAMLEE PLIANBANGCHANG (Regional Director for South-East Asia) congratulated Dr Khetrupal Singh on her appointment and wished her every success. As Regional Director, he had witnessed many landmark achievements in health in the Region, which had been made possible by Member States' unwavering commitment to ensuring the accelerated improvement of health for all their peoples. WHO's contribution to those achievements had been significant and was appreciated by Member States. He was honoured to have led the South-East Asia Region, and thanked those inside and outside WHO who had supported his work.

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

Appointment of the Regional Director for the Western Pacific: Item 12.2 of the Agenda (Document EB134/48)

At the request of the CHAIRMAN, Dr VALVERDE (Panama), Rapporteur, read out the following resolution adopted by the Board in open session:¹

The Executive Board,
Considering the provisions of Article 52 of the Constitution of the World Health Organization;

Considering the nomination made by the Regional Committee for the Western Pacific at its sixty-fourth session,

1. REAPPOINTS Dr Shin Young-soo as Regional Director for the Western Pacific as from 1 February 2014;
2. AUTHORIZES the Director-General to issue to Dr Shin Young-soo a contract for a period of five years from 1 February 2014 subject to the provisions of the Staff Regulations and Staff Rules;
3. AUTHORIZES the Director-General to amend the conditions of employment of Dr Shin Young-soo as follows: “You will not participate in the United Nations Joint Staff Pension Fund but will instead receive as a monthly supplement the contribution that the Organization would have paid each month to the Pension Fund had you been a participant”.

The CHAIRMAN congratulated Dr Shin Young-soo on his reappointment and conveyed the Board’s best wishes for his continued success in the South-East Asia Region.

Dr SHIN Young-soo (Regional Director for the Western Pacific) said that his reappointment as Regional Director for the Western Pacific for a second term was not only an honour for himself but a recognition of his staff’s hard work and close collaboration with Member States. As the first Regional Director for the Western Pacific to have been appointed from outside WHO, he had been surprised by the complexity of the Organization’s work, but had found the past five years to be the most fulfilling of his professional life. The work of the Regional Office was country-focused and constantly reoriented to support countries’ needs. The performance of the regional and country offices had been evaluated by external experts, whose recommendations were being implemented.

In a dynamic and rapidly changing Region, many health outcomes had been achieved since his appointment in 2009. The Region had already achieved targets under Millennium Development Goals 4, 5 and 6 or anticipated achieving them by 2015. The measles elimination initiative in the Region had been successfully concluded and the Regional Verification Commission, established in 2012, was to verify measles elimination in each country, one by one. The Region had reached its 2012 interim milestone for the reduction of hepatitis B surface antigen seroprevalence in young children, and the Regional Committee had established a further target for 2017. Nine out of 10 malaria-endemic countries had changed their national goal from control to elimination.

Another major task for the future was that of supporting Member States in the strengthening of health systems with a view to achieving universal health coverage. The long-term success of efforts in areas such as disaster preparedness and combating communicable and noncommunicable diseases depended on accessible and effective health systems. It was important that WHO constantly reinvent itself, the better to serve Member States as their health needs changed. Work in the Region over the following five years should be country-needs oriented and people-centred, focusing on vulnerable

¹ Resolution EB134.R3.

groups. The Region should build on its successes, tackle emerging challenges and recognize unfinished business; and it should be flexible and adaptable, engaging actors inside and outside the health sector. The Secretariat should manage financial and human resources better, provide value for money at every level, and improve service to Member States.

He congratulated Dr Khetrapal Singh on her appointment as Regional Director for South-East Asia, and looked forward to continued collaboration with that Region. He extended his best wishes to the outgoing Regional Director, Dr Samlee Plianbangchang.

The DIRECTOR-GENERAL said that Dr Shin Young-soo would continue to build on the strong foundation of his earlier achievements. The Western Pacific Region had seen significant reductions in disease burden and was on track to attain Millennium Development Goals 4, 5 and 6. His leadership had focused on country needs, while remaining sensitive to expectations of accountability and transparency. The Regional Office had led some areas of WHO reform, particularly in human resources and financial management and accountability. The reappointment of Dr Shin Young-Soo was a wise decision.

Dr ASADI-LARI (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, congratulated Dr Shin Young-soo on his reappointment. During his successful first term, he had contributed to public health globally and in the Region, and he wished him further success.

Dr BARBOSA DA SILVA (Brazil), speaking on behalf of the Member States of the Region of the Americas, welcomed the reappointment of Dr Shin Young-soo. The Region of the Americas would continue to work with him to tackle joint challenges, namely implementing the mandate of WHO, supporting and collaborating with Member States, and promoting and protecting health.

Mr BALA (Nigeria), speaking on behalf of the Member States of the African Region, congratulated Dr Shin Young-soo on his reappointment, which demonstrated the Western Pacific Region's appreciation of his achievements during his first term. Given his administrative acumen and commitment to accountability and transparency, he would undoubtedly record further successes during his second term.

Ms ALI (Maldives), speaking on behalf of the Member States of the South-East Asia Region, said that following his reappointment Dr Shin Young-soo would be able to build on the foundations he had previously laid. She wished him success in the further development of health in the Western Pacific Region.

Ms PENEVEYRE (Switzerland), speaking on behalf of the Member States of the European Region, thanked Dr Shin Young-soo for the work he had done thus far and wished him success and a fruitful second term.

Dr NOOR HISHAM ABDULLAH (Malaysia), speaking on behalf of the Member States of the Western Pacific Region, congratulated Dr Shin Young-soo on his reappointment, assured him of the Region's full support and looked forward to working closely under his strong leadership to improve health and health care in the Region.

Mr JEON Man-bok (Republic of Korea), welcoming Dr Shin Young-soo's reappointment, said that his expertise and leadership had had a significant public health impact, making the Region one of the most transparent and accountable within WHO. He commended the goals attained under his stewardship and his contributions to WHO reform. He extended his country's gratitude to the members of the Executive Board for their support.

Dr OMI (Japan) congratulated Dr Shin Young-soo and said that he had done excellent work in technical areas and on WHO reform. He would remain a strong leader and the Government of Japan would continue to support him over the next five years.

2. NONCOMMUNICABLE DISEASES: Item 7 of the Agenda (continued)

Follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases: Item 7.1 of the Agenda (Documents EB134/14, EB134/14 Add.1, EB134/14 Add.2 and EB134/14 Add.3) (continued from the second meeting, section 2)

Dr GRABAUSKAS (Lithuania), commending the comprehensive report by the Secretariat (document EB134/14), said that a few additional points were relevant to the prevention and control of noncommunicable diseases in the context of the advancement of national health systems. Lithuania had recorded mixed success in recent years in reversing noncommunicable disease mortality trends; that showed that even industrially advanced countries faced a need for further investment in areas such as: research on prevention and control of noncommunicable diseases; risk reduction through healthier lifestyles and environments; control of the social determinants of health, including reduction of existing inequities; and developing sustainable health systems.

Lithuania commended the Secretariat's resolve to keep noncommunicable diseases high on the global health agenda, including through promoting implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020 by the whole international community.

Dr BARBOSA DA SILVA (Brazil) said that combating noncommunicable diseases remained a priority for Brazil, whose national strategic action plan included several cross-cutting interventions in respect of those diseases. Brazil welcomed the terms of reference for the United Nations Inter-Agency Task Force on the Prevention and Control of Noncommunicable Diseases and the limited set of action plan indicators but believed that further discussions were needed to finalize the terms of reference for the global coordination mechanism. He agreed that those discussions should be held at a second formal meeting of Member States before the Sixty-seventh World Health Assembly, preferably in April 2014, in order to allow sufficient time for regional consultations beforehand. Defining the objectives of the mechanism would be a necessary but complex and challenging task, not least because those discussions should not prejudice or pre-empt the work currently being done, as part of the WHO reform process, on the Organization's engagement with non-State actors.

Dr AMMAR (Lebanon) welcomed the comprehensive report, which showed the importance of the multifaceted, synchronized efforts made to date, but felt that more information was needed on the United Nations General Assembly comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases to be undertaken later in the year. Regarding the proposal for a second formal meeting on the terms of reference of the global coordination mechanism, he requested information from the Secretariat on the issues on which there was currently no consensus and whether it would be advisable to conduct informal consultations before that meeting.

Regarding the Inter-Agency Task Force, the willingness of United Nations agencies to coordinate efforts for implementing the Political Declaration was not yet echoed at country level, where noncommunicable diseases were not a clear priority.

Given the differences in national capacity to measure progress regarding the various indicators, the Secretariat needed to provide more guidance and relevant tools to countries, to assist them in taking the necessary measures to implement the Political Declaration.

Dr EZZAT (Egypt) said that, in cooperation with the Secretariat, measures for the prevention and control of noncommunicable diseases should be pursued in six areas: improving noncommunicable disease surveillance and monitoring systems; tackling the underlying causes; ensuring early detection and interventions through primary health care; allocating human and financial resources to curb the prevalence of noncommunicable diseases; improving coordination with all stakeholders; and implementing the recommendations of the Political Declaration and the resolutions adopted by the Regional Committee for the Eastern Mediterranean at its sixtieth session, held in Muscat in 2013.

Dr SHAKEELA (Maldives) welcomed the Secretariat report contained in document EB134/14 but pointed out that progress in global health depended on ensuring that the required reports were not based on generalized assessments. She was deeply concerned by the mismatch in the global action plan for 2013–2020 between national and global targets, because the former were based on what a particular Member State had already achieved and what it hoped to achieve as a next step, while the latter were based on the desire to raise the lowest existing global indices. That meant that global targets were often set at a lower level than that already achieved by a number of countries.

Maldives itself had suffered, in its graduation from least developed country status, from the use of such generalized global benchmarks to deal with regional or local issues, and its experience in that regard was a cautionary tale of numerous health issues that had gone unrecognized and misunderstood and were now leading to hardships. The entire Region would suffer the same fate if flexibility was not built into customized global indices to fit regional vulnerabilities and priorities.

Dr VALVERDE (Panama) welcomed the progress made in implementing the 2008–2013 action plan for the global strategy for the prevention and control of noncommunicable diseases, as detailed in Annex 1 to document EB134/14. Implementation of the global strategy would consolidate WHO's leadership in the promotion of public health and the enjoyment of the highest attainable standard of health by all peoples. The multisectoral vision of the global strategy required effective collaboration with the private sector and nongovernmental organizations. In that regard, however, WHO needed to remain protected from potential conflicts of interest and to take account of principles relating to engagement with non-State actors.

Panama was focusing on implementation of the action plan, using an information system to register data in a timely and reliable manner for comparison with the proposed indicators. She supported the proposed terms of reference and membership of the United Nations Inter-Agency Task Force and the adoption of the nine action plan indicators.

Ms POLACH (Argentina) expressed support for the idea of setting national targets for noncommunicable diseases for 2025, taking into account the nine voluntary global targets that had been established. Monitoring progress towards attainment of those targets would benefit all Member States, but it would also be important to monitor risk factors, determinants, outcomes and health system responses.

It was essential to introduce regulatory measures aimed at increasing levels of physical activity and consumption of fruit and vegetables and reducing the amounts of salt, sugar, saturated fats and *trans*-fatty acids in food products. It was also important to protect children from advertising of unhealthy foods and drinks, and to promote smoke-free environments and reduce harmful consumption of alcohol through taxation policy. Tackling noncommunicable diseases required the committed efforts of all sectors, for which reason States should strengthen their leadership role in protecting the population and building healthier physical and social environments with less exposure to risk.

Dr BEJTJA (Albania) welcomed the progress made in implementing the 2008–2013 action plan and expressed support for concluding the work on the terms of reference for the global coordination mechanism before the next Health Assembly. The terms of reference for the United Nations Inter-Agency Task Force had been skilfully drafted, and there should be no ambiguity regarding WHO's

leading role in its work. Approaches at the local and regional levels should be tailored to the specific needs of countries.

Dr ASADI-LARI (Islamic Republic of Iran) strongly supported the Political Declaration but expressed concern about the global indicators, which suffered from the limitations of the national and regional indicators on which they were based. The limited set of action plan indicators were not sufficient to enable Member States to track progress in implementing priority actions. More specific indicators were needed, and both health and non-health sectors should focus on key priorities in implementing the national and global plans.

Mr LEWIS (Canada),¹ noting the considerable progress achieved in follow-up to the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, highlighted WHO's leadership in establishing ambitious plans to give impetus to the global agenda on those diseases. The global coordination mechanism was an unprecedented, innovative entity. In Canada's experience, an inclusive approach was essential for success in multisectoral action on noncommunicable diseases. He supported the proposal to convene a second formal meeting of Member States to finalize the terms of reference for that mechanism before the next Health Assembly.

Dr HENG (Singapore),¹ recalling the Director-General's description of noncommunicable diseases as a "slow-motion disaster", underscored the need to act quickly to deal with the unhealthy lifestyles that fuelled those diseases. Far-sighted policies were needed that promoted healthy habits and reduced risk factors. Since the watershed event of the High-level Meeting in 2011, considerable progress had been made, including through the adoption of an ambitious set of global targets and the establishment of the United Nations Inter-Agency Task Force. However, more still needed to be done, not least finalizing the terms of reference of the global coordination mechanism. To that end, Singapore welcomed the proposal for a second formal meeting of Member States to be held before the next Health Assembly.

Dr GULDVOG (Norway)¹ said that one of the remaining challenges regarding the global coordination mechanism related to defining the important role to be played by non-State actors in the fight against noncommunicable diseases. The mechanism must provide a genuine platform for non-State actors to engage and participate, on the basis of their expertise, without compromising the integrity and independence of WHO or the role of Member States. Norway had already begun collaborating with civil society and other actors and understood that the issue of their engagement was a complex one, involving a disparate set of government and non-government stakeholders.

As the sum of knowledge about noncommunicable diseases increased, the global response should evolve accordingly. One example was the area of black carbon emissions and the short-lived climate pollutants, which were responsible for more than six million deaths annually, a number comparable to that of tobacco-related deaths. The magnitude and seriousness of that growing health problem called for more attention from Member States and the Secretariat.

Mr KOLKER (United States of America)¹ said that much had been accomplished through the 2008–2013 action plan but that Member States and partners needed to redouble their efforts in that area in the period 2013–2020. He called for the formal meeting to finalize the terms of reference of the global coordination mechanism to take place ahead of the Sixty-seventh World Health Assembly but after the next consultation on WHO's engagement with non-State actors. The terms of reference should facilitate appropriate participation by multiple stakeholders and inspire broad engagement, as called for in the Political Declaration of the 2011 High-level Meeting. Further, the mechanism should

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

promote accountability in the implementation of the global action plan for 2013–2020 by assessing progress, reporting results and adjusting activities where improvement was needed. A process should be established for updating the menu of policy options set out in Appendix 3 of resolution WHA66.10 as the evidence for and cost–effectiveness of prevention and control interventions evolved over time. The global coordination mechanism could provide recommendations in that regard.

Dr VALLEJO (Ecuador)¹ said that the Secretariat’s comprehensive report would be of great strategic value to the health authorities in Ecuador. There were still gaps in the country’s institutional response to noncommunicable diseases, but significant progress had been made in recent years in the areas of policy and strategy. Ecuador was working to overcome the challenge of developing an integrated strategic plan that would guide promotion, prevention and care, as well as to build capacities for intersectoral action on health policies for noncommunicable disease control. Systematic responses to the new global health challenges could not be made without the leadership of health authorities.

There was mounting statistical evidence of the magnitude of the problem and of the risk factors, but the latter were being countered by advances in the regulatory framework for healthy food, food labelling, advertising and food in schools, which involved combating powerful interests within the food industry. A proposal for cooperation on noncommunicable diseases had been developed, covering two areas of intersectoral cooperation. The United Nations Inter-Agency Task Force would play an important role in managing joint actions by agencies at the national and global levels, particularly with regard to healthy food, physical activity and healthy environments. WHO should continue to exercise leadership in that regard.

Mr MURAV’EV (Russian Federation)¹ expressed appreciation of the progress made by WHO in implementing the Political Declaration, which was a priority issue for the Russian Federation. The discussions that had been held on the terms of reference for the global coordination mechanism had been constructive. The mechanism should be established under the auspices of WHO, which had the appropriate mandate and tools to implement the global action plan for 2013–2020.

The global coordination mechanism could be a forum open to Member States, representatives of nongovernmental organizations and the private sector, with a view to promoting good practice. The results of the work of the mechanism could be submitted to subsequent Health Assemblies for consideration and to support decision-making on implementation of the global action plan for 2013–2020. A small secretariat, formed by existing WHO Secretariat staff members, could support the mechanism, and a special trust fund, under the auspices of WHO, could be set up to finance the mechanism and future technical cooperation projects.

He expected the Executive Board to organize another formal meeting of Member States on the terms of reference for the mechanism in March or April 2014, so that they could be adopted at the Sixty-seventh World Health Assembly. He also looked forward to the forthcoming adoption of terms of reference for the Inter-Agency Task Force, which would ensure a global approach to noncommunicable disease control, encompassing funds and programmes already managed by other specialized agencies in the United Nations system.

Following the consultation with Member States, in November 2013, on the nine action plan indicators, he believed that monitoring of the health system response to the noncommunicable disease epidemic could be carried out more effectively in the future. Given the effect of those diseases on socioeconomic development, it was essential that control of noncommunicable diseases was given priority in the post-2015 agenda, either as a specific objective or as part of the overall goal of universal health coverage.

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

Professor KULZHANOV (Kazakhstan)¹ said that WHO documentation and the work of the Secretariat were essential support for national efforts to combat noncommunicable diseases. A strong legislative base was required, but not all countries had laws that worked effectively: in some cases, powerful lobbies prevented the successful adoption or implementation of legislation. Early screening, detection and prevention of noncommunicable diseases were very important, and an intersectoral approach would ensure a greater degree of success.

There was also a need to tackle the issue of noncommunicable diseases at the primary health-care level, and the use of multidisciplinary teams, with the involvement of nurses, social workers and psychologists had already proven successful in that context. In Kazakhstan, there was active cooperation with nongovernmental organizations and the wider population, which was seen as essential to achieving success. It was important to provide the general public with information obtained through scientific research, making the most of innovative technology. Ubiquitous smart technology could be harnessed to the fight against noncommunicable diseases.

Dr ELOAKLEY (Libya)¹ commended the efforts made to date on the global action plan for 2013–2020, the targets and indicators, the Inter-Agency Task Force and the terms of reference for the global coordination mechanism but expressed reservations about whether enough had been done to achieve a 25% reduction in premature mortality from noncommunicable diseases by 2025. Greater efforts were needed to ensure that the numerous resolutions adopted by the governing bodies were translated into appropriate action to prevent and control those diseases on the ground. The Secretariat should consult regularly with country representatives to find out whether and how resolutions had been implemented and, if necessary, what could be done to improve implementation.

Ms KUSANO (International Council of Nurses), speaking at the invitation of the CHAIRMAN, said that the terms of reference of the global coordination mechanism urgently needed to be finalized. The proposed advisory group for the mechanism, consisting of multisectoral partners including nurses, would facilitate the successful implementation of coordinated actions on noncommunicable diseases. Cost-effective nursing interventions were available and had been recommended as a priority for Member States in the global action plan for 2013–2020; the expansion of nurses' role would help to support equitable access to health services. Health promotion and disease prevention were essential to lighten the increasing burden of noncommunicable diseases, and attention should be paid to removing the regulatory barriers that restricted nurses in delivering an effective and efficient service at the primary health care level. Nurses should be fully involved in the global coordination mechanism and the United Nations General Assembly comprehensive review of the progress achieved in the prevention and control of noncommunicable diseases.

Mrs GROVES (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, said that although good progress had been made globally in preventing and controlling noncommunicable diseases, Member States needed to ensure that that progress was sustained at country level. National action plans should invoke the principle of the global action plan for 2013–2020, that people and communities needed to be empowered and involved in preventing and controlling those diseases.

The draft terms of reference for the global coordination mechanism would provide a means of strengthening global and regional coordination. The objectives of the mechanism should be closely aligned with those of the global action plan for 2013–2020 and progress should be measured in accordance with the global monitoring framework, to ensure coherence across WHO's noncommunicable disease strategy.

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

Non-State actors should be able to participate in the global coordination mechanism, as equity and diversity were important principles and all partners should have an equal voice in such a forum. The Alliance looked forward to further clarification on how the mechanism would be financed.

Dr LEGGE (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN and on behalf of the People's Health Movement, expressed regret that the draft terms of reference for the United Nations Inter-Agency Task Force made no mention of the need to preserve policy space for action on noncommunicable diseases in the provisions in new trade agreements for settlement of investor-State disputes. The threat of such disputes – in relation to tobacco legislation, for example – could deter countries, especially low- and middle-income ones, from taking effective regulatory action on noncommunicable diseases and other public health issues. He strongly urged that giving guidance on trade and investment rules be included in the terms of reference of the Task Force.

Mr ADAMS (Union for International Cancer Control), speaking at the invitation of the CHAIRMAN and on behalf of the NCD Alliance, encouraged all Member States to maintain the current momentum in fulfilling their commitments on noncommunicable diseases outlined in document EB134/14. Member States should not delay in establishing a robust global coordination mechanism that incentivized action on noncommunicable diseases. They should also support the comprehensive review and assessment by the United Nations General Assembly of the progress achieved in preventing and controlling those diseases. The review should be held at the highest political level and should result in an action-oriented outcome document that included time-bound commitments.

Ms WANJAU (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, said that WHO should take care not to open its doors without restraint to the alcohol, unhealthy food and beverage industries, as unregulated engagement could lead to weak policies or risk undue influence or conflicts of interest. Many risk factors for noncommunicable diseases were spread through cross-border trade, and the Secretariat should support Member States in protecting their ability to regulate trade in unhealthy products through appropriate taxation, labelling or warning measures, without fear of public health objectives being undermined by economic interests.

Access to treatment should be ensured for everyone who needed it and, to that end, renewed discussions were required on intellectual property rights and flexibilities for medicines under the Agreement on Trade-Related Aspects of Intellectual Property Rights.

Dr CHESTNOV (Assistant Director-General) welcomed Member States' comments and guidance and thanked them for their continued efforts to tackle the problem of noncommunicable diseases. Much progress had already been made: there were now nine specific global targets; the comprehensive global monitoring framework had been established, which included 25 indicators; work on the global action plan for 2013–2020 had been completed; indicators were in place to measure progress; the United Nations Inter-Agency Task Force had been established; and efforts were now aimed at establishing the global coordination mechanism. Member States had made many useful suggestions regarding that mechanism, which would all be studied further; however, it would not be possible to meet every demand, and it would be important to choose from the tools available and consider how to remain accountable if other actors were involved in the process. He confirmed that a second formal meeting would take place to finalize the terms of reference of the mechanism.

The DIRECTOR-GENERAL acknowledged and welcomed the substantial progress made on the issue of noncommunicable diseases, and the guidance and support that the Secretariat had received from Member States. She confirmed that a second formal meeting could be held to finalize the terms of reference of the global coordination mechanism. Many had spoken of the importance of multisectoral collaboration; without such an approach, it was clear that full implementation of the

global action plan for 2013–2020 would not be possible. She urged Member States to strengthen safeguards against conflicts of interest, which were essential to transparency. She agreed with the comments that had been made about the need to preserve policy space, which should remain the prerogative of Member States, without influence from industry or other parties. At the same time, the normative or standard-setting space should remain the prerogative of WHO, working in collaboration with scientific experts from countries. Member States needed to decide what sort of engagement they wanted WHO to have with civil society and industry, both within and beyond the health sector, and she looked forward to further guidance from Member States on that matter.

Several speakers had drawn attention to the importance of the United Nations General Assembly comprehensive review and assessment of the progress achieved that was due to take place later in the year. Member States were being consulted on the matter, and she was working with the regional directors, the Deputy Director-General and other senior Secretariat officials to develop a roadmap on how best to support countries and meet their expectations for that review.

The CHAIRMAN took it that the Board wished to take note of the reports contained in documents EB134/14 and EB134/14 Add.1 on the follow up to the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases.

The Board noted the reports.

The CHAIRMAN drew attention to a draft decision on the item, and its financial implications, set out in documents EB134/14 Add. 2 and EB134/14 Add.3, respectively.

Dr BARBOSA DA SILVA (Brazil) proposed that, in paragraph (3) of the draft decision, “March” should be replaced by “April” in order to allow more time for regional consultations.

The CHAIRMAN took it that the Board wished to adopt the draft decision, as amended by the member for Brazil.

The decision, as amended, was adopted.¹

The meeting rose at 12:55.

¹ Decision EB134(1).

FOURTH MEETING

Tuesday, 21 January 2014, at 14:35

Chairman: Professor J. HALTON (Australia)

1. COMMUNICABLE DISEASES: Item 6 of the Agenda (continued)

Global strategy and targets for tuberculosis prevention, care and control after 2015: Item 6.1 of the Agenda (Document EB134/12) (continued from the second meeting, section 1)

The CHAIRMAN drew attention to the following revised draft resolution that incorporated amendments proposed by Board members. The revised draft resolution, proposed by Australia, Brazil, Canada, Colombia, Costa Rica, Estonia, Ethiopia, France, Indonesia, Italy, Japan, Libya, Lithuania, Malaysia, Mexico, Netherlands, Panama, Poland, Portugal, Romania, Slovakia, South Africa and United States of America, read:

The Executive Board,

Having considered the report prepared by WHO which presents a global strategy and targets¹ for tuberculosis prevention, care and control after 2015,

RECOMMENDS to the Sixty-seventh World Health Assembly, the consideration and adoption of the following resolution:

The Sixty-seventh World Health Assembly,

(PP1) Having considered the report by the Secretariat which presents a proposed global strategy and targets for tuberculosis prevention, care and control after 2015;

(PP2) Acknowledging the progress made towards the achievement of the Millennium Development Goal 6 for 2015 following the United Nations Millennium Declaration and related 2015 TB targets through the adoption of DOTS and then the Stop TB Strategy and the Global Plan to Stop TB 2006–2015, as well as the financing of national plans based on these frameworks, as called for with resolution WHA60.19;

(PP3) Concerned with the persisting gaps and the uneven progress made towards current targets, and that some regions, Member States, communities and vulnerable groups require specific strategies and support to accelerate progress in preventing disease and deaths, and to expand access to needed interventions and new tools;

(PP4) Noting with concern that even with significant progress, an estimated three million people who develop TB each year will not be detected or will not receive appropriate care and treatment;

(PP5) Cognizant of the serious economic and social consequences of tuberculosis and of the burden borne by many of those affected in seeking care and adhering to tuberculosis treatment;

(PP6) Considering resolution WHA62.15 and its appeal for action on multidrug-resistant tuberculosis, aware that the response to the crisis to date has been insufficient

¹ Document EB134/12.

despite introduction of new rapid diagnostic tests, and efforts to scale up disease management, that the vast majority of those in need still lack access to quality prevention, treatment and care services and alarmed at the grave individual and public health risks;

(PP7) Aware that HIV co-infection is the main reason for the failure to meet TB control targets in high-HIV settings and that TB is a major cause of deaths among people living with HIV, and recognizing the need for substantially enhanced joint actions in addressing the dual epidemics of tuberculosis and HIV/AIDS through increasing integration of primary care services to improve access to care;

(PP8) Recognizing that further progress on tuberculosis and other health priorities addressed within the Millennium Declaration must be made in the decades to come beyond 2015, and that progress on all of these priorities requires overall commitment to health systems strengthening and progress towards universal health coverage;

(PP9) Acknowledging that progress against tuberculosis depends on action within and beyond the health sector to address the social and economic determinants of disease, including expansion of social protection and overall poverty reduction;

(PP10) Guided by resolution WHA61.17 and its appeal for action on the health of migrants, and recognizing the need for increased collaboration between high and low incidence countries and regions in strengthening TB monitoring and control mechanisms, including with regard to the growing mobility of labour;

(PP11) Noting the need for increased investments for accelerated implementation of innovations at country level as well as in research and development of new tools for tuberculosis care and prevention essential to eliminate tuberculosis;

(OP1)1. ADOPTS the global strategy for tuberculosis prevention, care and control after 2015 with:

(a) its bold vision of a world without tuberculosis and its targets of ending the global tuberculosis epidemic by 2035, through a reduction in tuberculosis deaths by 95%, and in tuberculosis incidence by 90% (or less than 10 tuberculosis cases per 100 000 population), and elimination of associated catastrophic costs for TB affected households;

(b) its associated milestones for 2020, 2025 and 2030;

(c) its principles addressing: government stewardship and accountability; coalition-building with affected communities and civil society; equity, human rights and ethics; and, adaptation to fit the needs of each epidemiological, socioeconomic and health system context;

(d) its three pillars of: integrated, patient-centred care and prevention; bold policies and supportive systems; and intensified research and innovation;

(OP2)2. URGES all Member States¹ to adapt the strategy, implement, **monitor and evaluate** with high-level commitment and adequate financing, its proposed tuberculosis-specific, health sector and multisectoral actions, taking into account the local settings and, with full engagement of a wide range of stakeholders, seek to prevent the persistence of high-incidence rates of TB within specific communities or geographic settings;

(OP3)3. INVITES international, regional, national and local partners from within and beyond the health sector to engage in, and support, the implementation of the strategy;

¹ And, where applicable, regional economic integration organizations.

- (OP4)4. REQUESTS the Director-General:
- (a) to provide guidance to Member States on how to adapt and operationalize the strategy, including the promotion of cross border collaboration to address the needs of vulnerable communities and the threats posed by drug resistance;
 - (b) to co-coordinate and contribute to the implementation of the post-2015 global tuberculosis strategy, working with Member States, The Global Fund to Fight AIDS, Tuberculosis and Malaria, UNITAID and other global and regional financing institutions, all constituencies of the Stop TB Partnership and with additional multisectoral partners required to achieve the goal and objectives of the strategy;
 - (c) to further develop and update global normative and policy guidance in tuberculosis prevention, care and control, as new evidence is gathered and innovations develop in the tools and strategic approaches available for ending the global epidemic and moving far more rapidly towards tuberculosis elimination;
 - (d) to support Member States upon request, in the adaptation and implementation of the strategy, as well as in the development of nationally-appropriate indicators, milestones and targets to contribute to local and global 2035 target achievement;
 - (e) to monitor the implementation of the strategy, and evaluate impact in terms of progress towards set milestones and targets;
 - (f) to promote the research and knowledge-generation required to end the global TB epidemic and eliminate TB, including accelerated discovery and development of new or improved diagnostics, treatment and preventive tools, in particular, efficient vaccines, and to stimulate the uptake of resulting innovations;
 - (g) to promote equitable access to new tools and medical products for the prevention, diagnosis, and treatment of TB and MDR TB as they become available;
 - (h) to work with the Stop TB Partnership, including to actively support the development of the global investment plan, and, where appropriate, seek out new partners that can leverage effective commitment and innovation within and beyond the health sector to effectively implement the strategy;
 - (i) to report on the progress achieved to the Seventieth and Seventy-third World Health Assemblies and at regular intervals thereafter through its Executive Board.

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

1. Resolution: Global strategy and targets for tuberculosis prevention, care and control after 2015	
2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)	
Category: 1. Communicable diseases	
Programme area(s): Tuberculosis	Outcome: 1.2 Output: 1.2.1
How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?	
This resolution fully adopts the global strategy for tuberculosis prevention, care and control after 2015. It therefore supports a majority of the Secretariat's tuberculosis control efforts during the biennium, including: preparing normative guidance and operational tools for implementing the strategy; providing support to Member States to develop and adapt their national plans in line with the strategy, and build country level capacity to implement the strategy, together with related monitoring and evaluation. The resolution and strategy will inform the preparation of future biennium work plans from 2016 to 2035.	
Does the programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)	
Yes.	

3. Estimated cost and staffing implications in relation to the Programme budget**(a) Total cost**

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

Costs and staffing in relation to this strategy will be included in each of the biennial budgets during the lifespan of the strategy based on a realistic costing of outputs and deliverables related to the work planned for each of the respective programme budget periods starting with the programme budget for 2016–2017.

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3 (a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

A substantial amount of work identified as deliverables in the Programme budget 2014–2015 will contribute to the development and future implementation of the post-2015 strategy, as there is continuity between the two approaches (current and new), and the transition work will start during the current biennium.

Total: US\$ 98.5 million (staff: US\$ 52.0 million; activities: US\$ 46.5 million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

All levels of the Organization.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

If “no”, indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

Yes.

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

The Secretariat is currently undertaking a thorough analysis of available funding for the work related to the implementation of this resolution in 2014–2015 and will identify funding shortfalls. This funding gap will be tackled as part of the Organization-wide coordinated resource mobilization plan to resolve funding shortfalls in the Programme budget 2014–2015.

Mrs CADGE (United Kingdom of Great Britain and Northern Ireland),¹ acknowledging the revision of the text, asked for the United Kingdom to be included as a sponsor.

The draft resolution, as amended, was adopted.²

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

² Resolution EB134.R4.

2. NONCOMMUNICABLE DISEASES: Item 7 of the Agenda (continued)**Maternal, infant and young child nutrition: Item 7.2 of the Agenda (Document EB134/15)**

Dr BEJTJA (Albania) welcomed the report and said that the Vienna Declaration on Nutrition and Noncommunicable Diseases in the Context of Health 2020 adopted at the WHO European Ministerial Conference on the subject (Vienna, 4 and 5 July 2013) had clearly set out the need to coordinate and harmonize regional actions on nutrition. The United Nations interagency model, which fostered interinstitutional cooperation and alignment at a national level, had already proved to be beneficial in that regard. His country had conducted a series of broad-ranging interventions to improve nutrition over the previous five years through programmes supported by WHO, UNICEF and FAO. The opportunity for further discussions on the issue at the Second International Conference on Nutrition, scheduled to be held in Rome in November 2014, was welcome.

Ms MATSOSO (South Africa), speaking on behalf of the Member States of the African Region, observed that the report demonstrated clear progress towards the global targets and described actions taken to improve maternal, infant and young child nutrition. In the African Region at least 40 countries had already revised their policies on nutrition and some 15 countries had enacted national legislation to regulate breast-milk substitutes. Nevertheless, shortages of human resources, inadequate monitoring and reporting systems and other health system requirements remained a major concern. She supported ongoing work to develop a monitoring framework and legislation on the marketing of breast-milk substitutes and complementary foods, and work on tools for risk assessment and management of conflicts of interest in nutrition. She endorsed the proposed actions and the development of an action plan to support that work. Countries in the African Region would participate actively in the Member State-driven process to implement previous Health Assembly resolutions, but sought support from WHO at all levels in order to achieve the relevant goals.

Dr SUGIURA (Japan) commented that nutrition issues could not be solved solely by the health sector and welcomed the highlighting of collaboration with other sectors in the report. Good coordination within the health sector, in particular with both mother and child health programmes and noncommunicable disease programmes, would be essential for the implementation of any nutrition programme as the providers and recipients of services would be the same. At present, there were not enough health care professionals globally, and care should be taken to avoid increasing their workloads and competition for scarce human resources between different programmes working towards the targets of the implementation plan. Member States must take full ownership of their national maternal, infant and young child nutrition programmes, and development partners should have the flexibility to accept coordination and to adjust their programmes accordingly. A global monitoring framework must be established in order for progress to be assessed, but the number of indicators should be limited.

Ms DUSSEY-CAVASSINI (Switzerland) emphasized the need for WHO to retain its independence in developing risk assessment and management tools for conflicts of interest in nutrition. The Organization should coordinate its work on noncommunicable diseases and nutrition, and in particular avoid overburdening Member States with requirements on data and reporting. Governments should seek to counter the inappropriate promotion of complementary foods for infants and young children, taking into account the standards developed by the Codex Alimentarius. She welcomed the proposed approach to the Second International Conference on Nutrition and urged WHO and FAO to provide proactive leadership and support for the Member State-driven process. Non-State actors should be included in the discussions at a later stage.

Dr NOOR HISHAM ABDULLAH (Malaysia) expressed concern that the lack of sufficient data on breastfeeding precluded calculation of a regional average for the Western Pacific Region. He endorsed the need for Member States to accept a framework of engagement with non-State actors (as would be discussed under agenda item 5.4) in order to manage conflicts of interest relating to both maternal, infant and young child nutrition and noncommunicable diseases. He agreed with the principle of establishing two sets of indicators and the proposals for finalizing the monitoring framework on them, but sought clarification on the decision not to include body mass index data disaggregated by age in either set of indicators.

Dr MEMISH (Saudi Arabia), speaking on behalf of the Member States of the Eastern Mediterranean Region, underlined the public health implications of good maternal, infant and young child nutrition for future generations. Most countries in the Region lacked sufficient information on the scope and effectiveness of child and infant feeding activities, and current data revealed no significant progress on infant and child nutrition, particularly in low- and middle-income countries, despite the support and guidance of the international community (for instance, through the International Code for Breast-milk Substitutes). The Secretariat should give higher priority to providing countries with support for implementing the Code and monitoring progress globally towards reaching breastfeeding targets.

Dr GONZÁLEZ FERNÁNDEZ (Cuba), welcoming the progress reported, said that work on reaching the global targets must be aligned with other development programmes. A series of measures must be taken in order to increase the scope and quality of health services, to provide information on nutrition and to establish multisectoral policies based on scientific data. Attaining those objectives could improve the evaluation and monitoring of maternal, infant and young child nutrition and enable the international community to formulate a set of development priorities. In Cuba, efforts had been made to strengthen the national programme to protect, support and promote breastfeeding, and nutrition guidelines had been prepared for children under the age of two years. He welcomed the Second International Conference on Nutrition being organized by FAO and WHO as a crucial opportunity to increase international coordination of best practices for maternal, infant and young child nutrition.

Mr COTTERELL (Australia) recognized the difficulties of managing competing interests when engaging with the private sector. He supported the Secretariat's work to engage non-State actors in the development of risk assessment and management tools for conflicts of interest concerning nutrition continuing in the context of WHO's broader work on guidelines for engagement with non-State actors. He supported the global monitoring framework but observed that some of the targets seemed over-ambitious. He requested further information on the scope of, and proposed process for preparing, the outcome document of the Second International Conference on Nutrition; Member States should be closely involved in that work and non-State actors should be consulted appropriately.

Mr LUTZOW STEINER (Mexico) agreed with the proposals in the report. In order to increase the rate of exclusive breastfeeding, local communities must be engaged, the relevant health benefits must be communicated effectively, and training for health care workers must be improved. His country had sought to promote breastfeeding through the designation of specific breastfeeding areas for mothers in the workplace and an increase in the number of banks of pasteurized human breast milk for premature babies with feeding difficulties. Further efforts, however, were required to strengthen the impact of those activities on vulnerable groups of the population, and an integrated approach would be adopted in future to reduce the overall national morbidity and mortality rates of newborn infants.

Mr JEON Man-bok (Republic of Korea) commended WHO's efforts to promote the implementation plan and monitoring progress. Governments should identify the risk factors of vulnerable groups and provide comprehensive support through dietary supplements and nutritional

information. They should share their experiences of such an approach in devising a global monitoring framework. In his country, a project had been launched to reduce anaemia in low-income families. In light of the broad scope of policies designed to counter malnutrition, all concerned ministries needed to cooperate in order to promote effectiveness and consistency in policies. Governments needed to prioritize malnutrition and establish a legal basis for promoting action plans.

Dr CARBONE (Argentina) said that her country had been working consistently over the years to design integrated policies on maternal, infant and young child nutrition. Argentina had incorporated the proposed core set of indicators in its first national nutrition survey in 2004 and 2005 and would continue to refer to them in its forthcoming survey. In addition, the Government had drafted several national nutrition guidelines in an attempt to counter the promotion of inappropriate foods for infants and young children.

Dr BARBOSA DA SILVA (Brazil) underlined the importance of putting the comprehensive implementation plan on maternal, infant and young child nutrition into practice. He welcomed the work on revising the set of indicators and recognized the need for a multidisciplinary and multistakeholder approach. He supported the process for completing the work on the sets of indicators but emphasized the need to guarantee transparency and guard against any conflicts of interest in the working group to be established. The Second International Conference on Nutrition would present a great opportunity to strengthen working relations with other United Nations organizations, such as FAO and UNCTAD.

Dr THAN ZAW MYINT (Myanmar) welcomed the report. The commendable progress in implementing resolution WHA65.6 should be echoed in responding to the resolutions of regional committees. Noting the progress made towards the six global targets, he requested that temporal trends be tabulated or illustrated graphically. Further research should be undertaken into the reasons behind the improvement in nutrition indicators in the South-East Asia Region through increasing the ratio of community health workers in the population, in order to determine whether other factors could accelerate progress. He commended WHO for hosting several databases in the Nutrition Landscape Information System and urged Member States to support the inclusion of data from other technical areas into similarly integrated databases. He expressed support for the indicators in Annex 1 but urged caution when interpreting prevalence rates. He underlined the importance of coordinated action between all relevant agencies at the country level. Member States' ownership of the action points would be essential to achieving the proposed targets.

Ms ALGOE (Suriname), noting the greater global prevalence of overweight than malnutrition, commented on the clear link between maternal, infant and young child nutrition and noncommunicable diseases and their risk factors. Developing principles and practices for engaging with civil society on such issues was imperative, and careful attention should be paid to establishing the composition and procedures of the global coordination mechanism on noncommunicable disease prevention and control. The five criteria for determining whether the promotion of foods for infants and young children was inappropriate (Annex 2) should be further explained, especially in the context of the prevention and control of noncommunicable diseases.

Dr CAPAK (Croatia), speaking on behalf of the European Union and its Member States, said that he would like to propose a draft decision on maternal, infant and young child nutrition. A conference paper would be circulated soon.

Mr SIDIKOV (Uzbekistan) welcomed the report. The approaches and indicators it described were reflected in the national nutrition programme in Uzbekistan. A multisectoral approach was imperative in order to meet the global targets and had proved invaluable to the success of the Uzbek nutrition programme. In an effort to continue work to improve national nutrition standards, his President had declared 2014 as the year of the healthy child.

Dr VALVERDE (Panama) welcomed the report. Adequate nutrition was a basic human right, and integrated nutrition policies should be implemented in order to safeguard such rights. Breastfeeding should be prioritized and encouraged through effective public health policies at a global level. Her country had already established a regulatory framework that promoted exclusive breastfeeding and would be marking World Breastfeeding Week in August 2014 with an emphasis on a multidisciplinary and multisectoral approach and the coordination of policies and legislation in order to prevent the inappropriate promotion of foods for infants and young children. International cooperation was vital, and the Second International Conference on Nutrition was welcome. The leadership of WHO and FAO was essential for defining future policies.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland)¹ welcomed the increased global efforts to tackle malnutrition and urged that a solid monitoring mechanism and robust accountability framework be established to ensure that progress could be effectively tracked and recorded. Her country was keen to expedite progress in designing a core set of indicators; she asked for a draft set to be submitted to the Executive Board in January 2015. She urged the organizers of the Second International Conference on Nutrition to ensure close collaboration between concerned parties, with agreed remits and, wherever possible, harmonization of the language used.

Dr AL-DOUWAIRI (Kuwait)¹ said that efforts should be made to ensure that the Second International Conference on Nutrition focused primarily on the pressing need to align and harmonize agricultural and food security policies with health development plans, particularly to prevent and control noncommunicable diseases; otherwise, many countries would not make significant progress in tackling those diseases. He welcomed initiatives to align national and international policies and legislation in all concerned sectors. The Second International Conference on Nutrition would be important for health and agricultural leaders, and adequate preparatory information should be sent to Member States without delay.

Mr BLAIS (Canada)¹ called for the rapid establishment of a working group to complete work on the core set of indicators. In order to prevent confusion, he recommended proposing only a core list of indicators for Member State consultation. Civil society and the private sector should be fully engaged, alongside Member States and organizations in the United Nations system, in the preparations for the Second International Conference on Nutrition. He strongly encouraged WHO to establish frameworks for engagement of non-State actors and to draw from the extensive work undertaken by the Scaling Up Nutrition (SUN) movement in order to avoid conflicts of interest.

Monsignor VITILLO (Holy See), speaking at the invitation of the CHAIRMAN, thanked the Secretariat for its report and called for organizations with strong links in local communities to be involved in the implementation of the global strategy for infant and young-child feeding. The inclusion of breastfeeding as a global target and proposed key indicator was a welcome step, in view of the low rate of exclusive breastfeeding in most parts of the world.

Ms SMITH (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN, expressed appreciation of WHO's commitment to the global strategy and the comprehensive implementation plan. The report was both informative and sobering in light of the poor figures cited for adoption of the International Code of Marketing of Breast-milk Substitutes and bans on advertising for those substitutes. She therefore urged WHO to reinvigorate and strengthen observance of the Code, which would render the five other global targets unnecessary. It would also promote attainment of the Millennium Development Goals and fulfilment of the Every Newborn

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

action plan. WHO must recognize that breastfeeding concerned not only infant nutrition but mother-infant bonding and the health of the community.

Ms ARENDT (Consumers International), speaking at the invitation of the CHAIRMAN, underlined the need to ensure that no commercial conflicts of interest were entailed in establishing the working group proposed in Annex 1 of the report. In that regard, the argument of intellectual bias and fixed policy positions articulated in the report on the framework of engagement with non-State actors (document EB134/8) was distorted and confusing. Much work remained to be done to ensure implementation of the International Code of Marketing of Breast-milk Substitutes, as was dramatically portrayed in the legal analysis of national measures conducted by the International Baby Food Action Network. Guidance on application of the five criteria set out in Annex 2 of the report would be welcome, as the poor rates of exclusive and continued breastfeeding and the double burden of malnutrition were clearly exacerbated by the inappropriate promotion of foods for infants and young children, which also undermined confidence in local foods and harmed local food security. WHO should ensure the participation of public-interest nongovernmental organizations and social movements in the upcoming Second International Conference on Nutrition.

Mr DIOP (Helen Keller International), speaking at the invitation of the CHAIRMAN, suggested that, on the basis of preliminary findings of work conducted in four countries by the Assessment and Research on Child Feeding project led by his organization, WHO should prepare specific guidelines on each of the five criteria set out in Annex 2 of the report, in order to support countries to operationalize and enforce measures for ensuring the appropriate marketing of complementary foods. Governments must furthermore implement and strengthen monitoring of the International Code. The latter should be expanded to include follow-up formulas and growing-up milks. He urged the Board to include the topic on the provisional agenda of the Sixty-seventh World Health Assembly.

Ms BAUMGARTEN (The Save the Children Fund), speaking at the invitation of the CHAIRMAN and on behalf of World Vision International, expressed continuing commitment to ensuring that attainment of the nutrition targets endorsed by the Health Assembly remained high on the global agenda, including the post-2015 development agenda. Welcoming the proposed establishment of a working group for completion of the global monitoring framework, she called for continued consultation with civil society, including links with the monitoring and evaluation work of the SUN movement and the accountability framework being developed for commitments made at the Nutrition for Growth summit (London, 8 July 2013). She also urged the collection of robust disaggregated data. In all intergovernmental dialogues on the post-2015 development targets, high priority should be accorded to reducing malnutrition, in particular stunting, and to nutrition targets and indicators across multiple sectors. Preparations for the Second International Conference on Nutrition should be a participatory and inclusive process.

Professor LOUME (Senegal) welcomed the recent research undertaken by Helen Keller International into food labelling practices, the results of which should help his country to strengthen national legislation and regulations on infant and young child nutrition.

Dr CHESTNOV (Assistant Director-General) thanked Member States for their constructive comments. The comprehensive implementation plan and the six global targets had been approved and generally accepted by the global nutrition community. Numerous initiatives had been taken in 2013 to support attainment of the global targets. There was a clear intention to include nutrition as part of food security and health in the post-2015 agenda. It would be important to ensure that infant foods met all the requisite standards. To prevent the obesity epidemic, the marketing of complementary foods must not give rise to unhealthy dietary habits at an early age. The Secretariat wished to reiterate its commitment to strengthening its support to Member States in drawing up and carrying out effective policies and programmes on nutrition, as well as in monitoring attainment of the global targets and implementation of measures to that end. WHO would work with agencies in the United Nations

system and other global partners on drawing up a more detailed report in 2014. WHO would also work closely with FAO in the year ahead on preparing the initial draft of the outcome document of the Second International Conference on Nutrition, one aim of which would be to determine the approach to be taken to ensure an uninterrupted supply of and easier access to healthy food for the whole of the world's population.

The DIRECTOR-GENERAL said that she shared Member States' concern at the slow progress made on tackling nutrition issues and the resulting implications for attainment of the six global targets. She also expressed concern at the high number of children under five years of age at risk of stunting, the number of low birth weight babies and the high rates of wasting, as well as rising rates of obesity; action must be taken to protect future generations. WHO and its partners would continue to work to close the gap in data and to seek to understand the epigenetic and environmental factors at play. She called on Member States to focus on prevention, particularly primary prevention, and said that she needed to consider what additional steps could be taken to advance maternal, infant and child nutrition.

The CHAIRMAN said that the draft decision mentioned by the member for Croatia would be circulated in the meeting room. Consideration of item 7.2 would consequently be resumed at a later date.

It was so agreed.

(For continuation of the discussion, see the summary record of the eighth meeting, section 2.)

Disability: Item 7.3 of the Agenda (Document EB134/16)

Dr KARGBO (Sierra Leone), speaking on behalf of the Member States of the African Region, said that 37 of them had acceded to the Convention on the Rights of Persons with Disabilities and more than half those countries had established disability policies and strategic plans. He urged Member States to set up a regional action plan and take a multisectoral approach to disability issues in order to break down communication barriers and highlight the central role of persons with disabilities in society, particularly women and children. The regional focus was on coordinated preventive strategies and he urged the finalization of the draft global disability action plan.

Mr COTTERELL (Australia) commended the draft global disability action plan. He suggested that reporting requirements, in particular those for actions 2.6 and 2.7, be aligned with those for the Convention on the Rights of Persons with Disabilities in order to avoid duplication. The wording of some of indicators of success (for instance, 1.4 and 2.2) should be clarified to reflect success rather than failure. His country was committed to working with governments in the Indo-Pacific region to ensure that its development assistance reached people with disability.

Mr AL-MARRI (Qatar), acknowledged the holistic social perspective of disability and the need to include persons with disabilities in mainstream multisectoral policies and services, but said that more investment must be directed to disability-specific programmes, such as rehabilitation and support services. In so doing, the importance of health as a predetermining and enabling factor for inclusion in all areas of life must be emphasized.

Dr THAN ZAW MYINT (Myanmar) welcomed the consultative process through which the draft global disability action plan had been developed but requested information on the extent of participation by all WHO regions. The proposed specific inputs for all parties could reduce duplication of work and define each partner's remit. Some of the proposed indicators of success, however, could not be obtained from routinely collected data and further discussions should be held in order to devise methods of capturing the required information that did not place undue burden on national health

systems. The entire framework of the action plan should be reviewed in order to combine similar activities and identify those that could be done sequentially, given the limited human resources at the country level. In that regard, coordinated implementation of the proposed actions would be essential.

Dr KAMALIAH MOHAMAD NOH (Malaysia) welcomed the comprehensive draft action plan and commended the clear statement of its elements and the formatting of indicators and actions for each objective. Mainstreaming disability issues was essential as a multisectoral approach would be required to combat the multiple barriers faced by persons with disabilities. She fully supported the submission of the draft action plan to the Sixty-seventh World Health Assembly for consideration.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) welcomed the objectives of the draft global disability action plan. His country had introduced its first national action plan, which was multisectoral and multidisciplinary, in 1995. Following a national survey on persons with disabilities, Cuban health professionals had conducted similar studies covering 1.2 million people with disabilities in several other countries in the Region, resulting in the proposal of different actions and services. All persons with disabilities should have access to equal rights and live dignified and fulfilling lives; Objective 1 of the draft action plan captured that sense.

Ms ALGOE (Suriname), speaking on behalf of the Member States of the Union of South American Nations, expressed appreciation of the draft action plan and acknowledged the incorporation of the outcomes of the consultation of the Region of the Americas into the plan. Those included a series of recommendations to take into account the respective situation of each country and to offer the best approach for each scenario. She noted the inclusion of several indicators of success to ensure effective evaluation of attainment of the proposed objectives and commended the consideration given to “integral” and “inclusive” health for persons with disabilities. The frequency of evaluation of the implementation of the plan must, however, be increased so as to provide Member States with timely feedback on how best to proceed. She urged all Member States to adopt the draft action plan and work towards attaining its objectives, regardless of whether they were signatories of the Convention on the Rights of Persons with Disabilities.

Dr SINGH (South Africa) welcomed the extensive consultation process for developing the draft action plan and the inclusion of a broad range of stakeholders. She commended the alignment of the draft action plan with the Convention on the Rights of Persons with Disabilities and the outcomes of the High-level Meeting of the United Nations General Assembly on disability and development. She concurred with the aims and objectives of the draft action plan and, as South Africa was a developing country with limited resources and could not afford to continue with expensive rehabilitation services, she strongly recommended the coordination of preventive strategies and action plans of Member States on disability issues.

Mr JEON Man-bok (Republic of Korea) expressed support for the draft action plan but asked for clarification of the relevance of indicator of success 2.2. Further attention should also be paid to Objective 3, which called for a uniform definition of disability, in light of the varying cultural, social and economic situations of respective Member States. When carrying out the action plan, it must be acknowledged that each country used its data on disability primarily as a tool for monitoring progress in implementing national policy; such data were not designed for comparison between countries.

Ms RUÍZ VARGAS (Mexico), welcoming the report, emphasized the importance of prevention, particularly in respect of conditions with increasing incidence rates, as effective early detection could help to manage some conditions and delay or avoid disability.

Dr SHAKEELA (Maldives) welcomed the recognition of disability as a global public health concern and development priority and urged WHO to strengthen the efforts made at country level to translate that priority into national policy. Her Government had endorsed a national disability policy in

October 2013 in order to mainstream the fulfilment of rights and the provision of service accessibility to persons with disabilities across all sectors. She therefore fully supported the draft action plan, which would greatly help to improve the living conditions of persons with disabilities globally.

Dr VALVERDE (Panama) commended the draft action plan with its clear objectives and concrete actions, and recommended its adoption by the Sixty-seventh World Health Assembly. Disability policy in Panama reflected the provisions contained in international declarations and conventions to which the country was a party, and the Government had focused on adopting a multisectoral approach when attempting to overcome the barriers faced by persons with disabilities.

Dr CARBONE (Argentina) welcomed the draft action plan. Its provisions aligned well with her country's policies on including persons with disabilities in society and safeguarding their rights. Her country was fully committed to the success of the action plan, and she supported a multisectoral and multidisciplinary approach to the issue as practised in Argentina.

Dr AL LAMKI (Oman),¹ speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed the report and draft action plan, which provided technical guidance on translating the health-related provisions of the Convention on the Rights of Persons with Disabilities into concrete action at country level. Specific attention needed to be paid to integrating disability in disaster risk reduction plans and humanitarian responses in view of the growing number of conflicts and natural disasters across the world. He supported submission of the draft action plan to the Sixty-seventh World Health Assembly; its adoption should stimulate and guide further efforts by Member States to improve conditions for persons with disabilities in the health and other sectors. Global endorsement should be regarded as a first step on the road to implementation, which would require significant financial and human resources, as well as action at national, regional and international levels.

Mr HOLM (Sweden)¹ welcomed the draft action plan and its three objectives, in particular the collection of data on disability and the incorporation of the principles laid down in the Convention on the Rights of Persons with Disabilities and articulated in the report of the High-level Meeting of the United Nations General Assembly on disability and development. However, before it was submitted to the Health Assembly, more emphasis should be placed on the rights of children and the specific needs of children with disabilities. There should also be a more consistent application of a gender perspective that took into account the needs of both men and women with disabilities. Due consideration should be given to decentralized health systems in some Member States and the fact that other bodies besides national governments bore responsibility for the delivery of health services. Therefore, follow-up efforts needed to be focused on the objectives to be achieved, rather than on the actions to be taken. He commended the consultative process and the involvement of Member States and other stakeholders in drafting the action plan.

Ms VINUESA SEBASTIAN (Spain)¹ commended the human rights-based approach of the draft action plan and its emphasis on improving access by persons with disabilities to health services, generating data that would allow policies to reflect their needs, and evaluating the progress made in achieving the Millennium Development Goals in order to ensure the inclusion of disability in the post-2015 development agenda. However, it should place more emphasis on countering sexual discrimination against women and girls with disabilities and supporting the contribution of people with disabilities in the workplace. Her Government had introduced the previous month legislation to ensure that people with disabilities were able to find work and thereby participate fully in society.

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

Mr KOTALWAR (India)¹ endorsed the three objectives contained in the draft action plan. His Government had recently introduced legislation to remove barriers and improve access to services by those with mental health disorders and other disabilities, by raising awareness, providing training for physicians and mental health support staff, and integrating mental health care into primary health care. Centres of excellence were being established in order to enhance training, services and research for mental and neurological disorders. The specific health needs of the elderly were also being addressed in national policy. Internationally comparable data on disability and mental disorders were being collected through a national survey. The new legal framework and scaling up of current policies and programmes should make it possible to meet the three objectives contained in the draft action plan.

Dr JIAO Yahui (China)¹ concurred with the report's analysis of the status, needs and challenges of people with disabilities. Recent legislation in China ensured that persons with disabilities and mental health disorders had access to social security, education, medical care, rehabilitation and employment. The health of persons with disabilities, as well as measures to raise awareness of the nature of disability, would continue to be integrated in the work of the health, education and transport sectors. Revision of the International Classification of Functioning, Disability and Health should make it easier for countries to carry out surveillance through the use of information technology and sharing of international data.

Mr KOLKER (United States of America)¹ noted the draft action plan and commended its expeditious preparation. He proposed five suggestions for clarifying and strengthening certain points. The targets shown as "X%" under all three objectives needed to be specified. As his country had not ratified the Convention on the Rights of Persons with Disabilities, it was important that the phrasing did not give the impression that national action was only being taken to fulfil responsibilities under the Convention; the United States would conduct actions that were consistent with the Convention but had merit in their own right. The words "rehabilitation" and "habilitation" had different meanings and should not be used interchangeably. It might be more appropriate to talk about "disabilities throughout the life course" rather than "persons with disabilities, including children". Under indicator of success 2.2, the use of "graduates" required further clarification.

The CHAIRMAN said that the member for Australia indicated that he seconded those proposals.

Dr MAKASA (Zambia)¹ supported the comments by previous speakers concerning the need for the Secretariat to support Member States in the African Region in implementing preventive strategies to minimize the burden of disabilities. He recorded with concern the increasing burden of disability in Zambia, resulting particularly from road traffic accidents and other injuries; most of those injuries could be managed adequately by strengthening health systems. He signalled his intention to submit a draft resolution on reinforcing essential and emergency surgical care at the primary level for consideration by the Board at a subsequent session.

Professor BRINTNELL (World Federation of Occupational Therapists), speaking at the invitation of the CHAIRMAN, endorsed WHO's broad view of disability, adding that disability could also be transient, changing and responsive to constantly fluctuating societal circumstances. Occupational therapists understood the barriers to participation and engagement created by the growing comorbidity of noncommunicable disorders. Concerning implementation of the draft action plan, she advocated grass-roots consultations and participation of service providers. National disability policies must be data-driven, requiring an interdisciplinary systems approach, the identification of indicators, and analysis. Occupational therapy stood ready to assist in that exercise. The range of

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

opinions, ideas and innovations unveiled during the broad consultative process augured well for a progressive and forward-looking action plan, to which end further dialogue should be pursued at the national level. Her organization was eager to cooperate in the attainment of the objectives encapsulated in that plan.

Professor GUTENBRUNNER (International Society of Physical and Rehabilitation Medicine), speaking at the invitation of the CHAIRMAN, strongly supported the draft action plan. He emphasized the need to include the concept of functioning in the context of enabling the full participation of persons with health conditions that would or could lead to disability, and highlighted such issues as access to appropriate rehabilitation services; the need for substantial government funding of service delivery, data collection and research; specialist education and training for rehabilitation workers on the basis of the needs of persons with disabilities; inclusion of primary care and access to specialized services in the concept of community-based rehabilitation; and research trials on the outcome of rehabilitation inventions as a basis for scientifically sound guidelines. Concerted efforts would be needed to realize the objectives of the draft action plan, which nonetheless promised to be a strong tool for improving the life situation of persons with disabilities worldwide.

Ms MULLIGAN (CBM), speaking at the invitation of the CHAIRMAN, applauded the inclusion of organizations of persons with disabilities in the consultation on the draft action plan. The proposed plan would serve as a framework for implementing the recommendations of the *World report on disability*, the provisions of the Convention on the Rights of Persons with Disabilities, and the outcome document of the High-level Meeting of the United Nations on disability and development. The consultative process had revealed the expectations of the relevant stakeholders: technical support for the inclusion of persons with disabilities in national health systems and the development of appropriate and affordable national rehabilitation services; development of normative standards and tools; support in filling gaps in national health and rehabilitation workforces; and improved access to good-quality disability data. She pledged continuing support for the implementation process.

Dr CHESTNOV (Assistant Director-General) thanked Member States for their guidance, which would be taken into account before submission of the draft action plan to the Sixty-seventh World Health Assembly. In particular, he praised the speed with which they had provided recommendations, which had facilitated preparation of the document.

The Board noted the report.

3. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 10 of the Agenda

Hepatitis: Item 10.5 of the Agenda (Document EB134/36)

The CHAIRMAN drew attention to a draft resolution on hepatitis proposed by Brazil, Colombia, Costa Rica, Egypt and Republic of Moldova, which read:

The Executive Board,
Having considered the report on hepatitis,¹

¹ Document EB134/36.

RECOMMENDS to the Sixty-seventh World Health Assembly the adoption of the following resolution:

The Sixty-seventh World Health Assembly,

(PP01) [~~Reaffirming~~ ~~Recalling~~ (United States)] resolution WHA 63.18, adopted in 2010 by the World Health Assembly, which recognised viral hepatitis as a global public health problem and the need for governments and populations to take action to prevent, diagnose and treat viral hepatitis and that called upon WHO to develop and implement a comprehensive global strategy to support these efforts, **[and expressing concern at the slow pace of implementation (USA)]**;

(PP02) Recalling also resolution WHA45.17 on immunization and vaccine quality which urged Member States to include hepatitis B vaccines in national immunization programmes and concerned that currently the global hepatitis B vaccine coverage for infants is estimated at 75% and is therefore below the 90% global target;

(PP03) Noting with deep concern that viral hepatitis is now responsible for 1.4 million deaths every year (compared to 1.5 million deaths from HIV/AIDS and 1.2 million deaths from each of malaria and TB), that around 500 million people are currently living with viral hepatitis and some 2 billion have been infected by the hepatitis B virus, and considering that most people infected with chronic hepatitis B or C are unaware of their infection and are at serious risk of developing cirrhosis or liver cancer ~~[(Brazil)]~~ ~~and of mother to child transmission~~; **[contributing to global increases in both of these chronic diseases, that millions of acute infections with hepatitis A and hepatitis E occur annually that result in tens of thousands of deaths almost exclusively in lower and middle income countries and often afflict the most vulnerable refugee populations; (USA)]**

(PP04) Considering that while hepatitis C is ~~still~~ not preventable by vaccination, current treatment regimens ~~already~~ offer **[high 70% cure rates and these will improve significantly thanks to further therapeutic advances which are expected to further improve with upcoming new treatments (Brazil)]**; **[will improve significantly in the very near future thanks to recent therapeutic advances and that while hepatitis B is preventable with a safe and effective vaccine, there are 240 million living with hepatitis B virus (HBV) infection and available effective therapies could prevent cirrhosis and liver cancer among many of those infected, and that through generics and other mechanisms access to treatments for both HBV and HCV are becoming increasingly available, but still out reach for most of those living with chronic viral hepatitis, and that therapy will play an increasingly important role in control of viral hepatitis globally, and that elimination of chronic viral hepatitis, with a combination of prevention and treatment strategies should play an important role as it has with HIV control programs; (USA)]**

(PP05) **[Expressing concern (Egypt)] [that preventive measures are not universally implemented and that (EU) Acknowledging that]** access to and availability of reliable, ~~[low cost]~~ **affordable (Brazil & USA)]** and safe diagnostics and treatment regimens for both hepatitis B and C is lacking in many parts of the world, **[particularly in developing countries (Egypt and USA)]**; ~~[expressing concern]~~ **noting (Brazil)]** that ~~[(USA) only less]~~ than half of Member States have a policy to provide hepatitis B vaccine at birth and only 27% of newborns globally received vaccine birth dose;

[(PP05 bis) Acknowledging also that in Asia and Africa hepatitis A and E continue to cause major outbreaks while a safe effective hepatitis A vaccine has been available for nearly 2 decades and that hepatitis E vaccine candidates have been developed but not yet certified by the WHO, and that lack of basic hygiene and sanitation promotes the risks of hepatitis A virus (HAV) and hepatitis E virus (HEV) transmission and the poorest countries and most vulnerable populations

including refugees and displaced persons do not have this access resulting in repeated epidemics of HEV in refugee camps in recent years; (USA)]

(PP06) Taking into account that injection overuse and unsafe practices accounts for a substantial burden of death and disability worldwide, with an estimated 21 million hepatitis B infections and 2 million hepatitis C infections occurring in 2000;

(PP07) Recognising the need for safe blood to be available to blood recipients, as established by resolution WHA28.72, on utilization and supply of human blood and blood products, which recommended the development of national public services for blood donation, and in resolution WHA58.13, which agreed to the establishment of an annual World Blood Donor Day, and considering that one of the main routes of transmission of hepatitis B and C viruses is parenteral;

(PP08) Further recognising the need to strengthen health systems and integrate approaches and the collaborative linkages between prevention and control measures for viral hepatitis and those for infectious diseases such as HIV and other related sexually transmitted and blood-borne infections, other mother to child transmitted diseases, as well as for cancer and noncommunicable disease programmes;

(PP09) Noting that [**HBV and particularly HCV (USA)**] ~~hepatitis-C~~ disproportionately impacts upon people who inject drugs (PWID) and that of the 16 million PWID around the world, an estimated 10 million are living with [**HCV and 1.2 million are living with HBV** ~~the disease, (USA)~~] and that harm reduction measures to ensure access to sterile injection equipment, opioid substitution treatment and other evidence based treatments are essential components for both [**HBV and HCV** ~~hepatitis-C~~ (USA)] prevention and aftercare, and that access to these critical components remain limited or absent in many countries of high [**HBV and HCV** ~~hepatitis-C~~ (USA)] burden;

(PP10) Cognizant of the fact that 4–5 million people living with HIV are coinfecting with ~~HIV and~~ [**HCV and over 3 million are coinfecting with HBV** ~~hepatitis-C~~ (USA)] has become a major cause of disability and mortality amongst those taking Highly Active Anti-Retroviral Treatment;

~~(PP11) Taking into account that viral hepatitis is a major problem within indigenous communities and is in some cases a threat to their existence;~~

(PP11) Welcoming the development by WHO of a global strategy, within a health systems approach, on prevention and control of viral hepatitis infection;¹

(PP12) Considering that most Member States lack adequate surveillance systems [**for viral hepatitis (Chile)**] to enable them to take evidence-based policy decisions;

(PP13) Taking into account that a periodic evaluation of implementation of the WHO strategy is crucial to monitor the global response to viral hepatitis and that the process was initiated with the 2013 publication of the *Global policy report on the prevention and control of viral hepatitis in WHO Member States*;

(PP14) Acknowledging the need to reduce liver cancer mortality rates and that viral hepatitis are responsible for 78% of cases of primary liver cancer [**and welcoming the inclusion of an indicator on hepatitis B vaccination in the comprehensive global monitoring framework adopted in resolution WHA 66.10 on noncommunicable diseases; (USA)**]

(OP) 1. URGES Member States:²

- (1) to develop and implement [**integrated/coordinated (Chile & EU)**] multisectoral national strategies for [~~combating~~ **preventing and controlling** (EU & USA)] viral hepatitis;

¹ “Prevention and control of viral hepatitis infection: framework for global action”.

² And, where applicable, regional economic integration organizations.

- (2) to promote the involvement of civil society in all aspects of the ~~[response~~ **preventing and controlling** (EU)] to viral hepatitis;
- (3) to put in place an adequate surveillance system **[for viral hepatitis (Chile)]** to support decision-making on evidence-based policy;
- (4) to ~~[strengthen the control on the use of blood that has not been screened~~ **for ensure the universal screening of blood for** (EU)] HIV, hepatitis B, hepatitis C and syphilis;
- (5) ~~to aim to~~ reduce **[the prevalence of** (New Zealand)] chronic hepatitis B infection to less than 2% in children by 2021, or some earlier date as may be proposed by WHO Regional Committees, as an interim milestone towards a global goal of less than 1%;¹
- (6) to make special provision in policies for the **[equitable** (USA)] prevention, diagnosis and treatment of viral hepatitis for indigenous people and other vulnerable populations;
[ALT (6) to incorporate in their specific contexts the policies, strategies and tools recommended by WHO in order to define and implement preventive actions, diagnostic measures and the provision of assistance to the population affected by viral hepatitis including migrant and vulnerable populations (Egypt);]
- (7) to consider, as necessary, national legislative mechanisms for the use of the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights in order to promote access to specific [pharmaceutical products;² (USA)]
[(7bis) to consider, whenever necessary, using existing administrative and legal means in order to promote access to preventive, diagnostic and treatment technologies against viral hepatitis; (USA)]
- (8) to establish national harm reduction policies based on [WHO standards;³ (EU)]
- (9) to aim to ensure ~~[that less than 50% of where appropriate~~ **(Brazil)]** all therapeutic injections are **[given by syringes that prevent reuse on patients (RUPs) by 2017, as an interim milestone towards the global use of both reuse prevention and needle stick injury prevention syringes given by syringes capable of multi use by 2021 as an interim milestone towards the complete elimination of their use;** (Brazil)]
- (10) to give viral hepatitis due consideration in the discussions of the post-2015 development agenda **[to include increased access to effective therapies for HBV and HCV infection.** (USA)]

¹ WHO Hepatitis B Position Paper (2009) states: “All regions and associated countries should develop goals for hepatitis B control appropriate to their epidemiologic situations. At Regional level, several Regions have adopted elimination goals: In October 2013, Western Pacific Region has adopted the goal of reducing hepatitis B infections in children to less than 1% by 2017; Eastern Mediterranean Region 2009 Resolution (RC56.R5) for HBV control “reduction in prevalence of chronic HBV infection to less than 1% among children below 5 years of age by 2015”.

² The WTO General Council in its Decision of 30 August 2003 (i.e. on Implementation of paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health) decided that “‘pharmaceutical product’ means any patented product, or product manufactured through a patented process, of the pharmaceutical sector needed to address the public health problems as recognized in paragraph 1 of the Declaration. It is understood that active ingredients necessary for its manufacture and diagnostic kits needed for its use would be included.”

³ Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva: World Health Organization, United Nations Office on Drugs and Crime, Joint United Nations Programme on HIV/AIDS 2009.

- (OP) 2. REQUESTS the WHO's Director-General:
- (1) to provide the necessary technical support to enable countries to develop robust national **[hepatitis prevention and control (USA)]** strategies with time-bound goals;
 - (2) to develop specific guidelines on adequate, effective, affordable algorithms for diagnostics in developing countries;
 - (3) **[in consultation with Member States, to develop a system for regular monitoring and reporting on the progress in hepatitis prevention and control (EU & Brazil) to conduct a biennial survey of Member States to measure the response to viral hepatitis;]**
 - (4) to provide technical guidance on cost-effective ways to integrate the prevention, testing, care and treatment of viral hepatitis into existing health care systems and make best use of existing infrastructure and strategies;
 - (5) to work with appropriate national authorities to ensure commitment to needle and syringe programs and OST or other evidence-based drug treatment in national plans, and to assist in assessment and removal of policy or programmatic barriers to these services;
 - (6) to examine the feasibility of and provide technical guidance for the **[eradication control and elimination (USA)]** of both hepatitis B and hepatitis C;
 - (7) to improve the assessment of global and regional economic impact of viral hepatitis;
 - (8) to support Member States with technical assistance in the use of TRIPS Flexibility when needed **[in accordance with the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property and in consultation with relevant international organizations including the WTO and WIPO; (USA)]**
 - (9) to lead a discussion with key stakeholders, to facilitate **[affordable access to quality, safe, efficacious, and affordable (USA)]** the best hepatitis **[B and C (USA)]** treatments as well as to necessary diagnostic tests and **[hepatitis B treatments and in the interim to assist Member States to promote (EU)]** **[affordability and to improve access for the poorest populations(USA) to achieve medicine cost reductions;]**
 - (10) to prepare an assessment on the burden of viral hepatitis on domestic and economic growth;
 - (11) to report to the Sixty-ninth World Health Assembly, through the Executive Board, on the implementation of this resolution.
 - [(12) to incorporate fully viral hepatitis prevention priorities into ongoing work to implement the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020; (USA)]**
- (OP) 3. CALLS upon all relevant United Nations funds, programmes, ~~and~~ specialized agencies **[and other stakeholders (Brazil)]**:
- (1) to include viral hepatitis in their respective work programmes and work in close collaboration with agencies
 - (2) to identify mechanisms to assist countries in the provision of sustainable funding for diagnostics and treatment of viral hepatitis.

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

1. Resolution: Hepatitis**2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)**

Category: 1. Communicable diseases

Programme area: HIV/AIDS

Outcome: 1.1

Output: 1.1.2

Programme area: Vaccine-preventable diseases

Outcome: 1.5

Output: 1.5.2

Category: 4. Health systems

Programme area: Integrated, people-centred health services

Outcome: 4.2

Output: 4.2.3

Programme area: Access to medicines and health technologies and strengthening regulatory capacity

Outcome: 4.3

Output: 4.3.1

Category: 5. Preparedness, surveillance and response

Programme area: Alert and response capacities

Outcome: 5.1

Output: 5.1.1

Programme area: Epidemic-prone and pandemic-prone diseases

Outcome: 5.2

Output: 5.2.1

How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?

The key actions called for in the resolution directly support attainment of outputs formulated in the above programme areas, in particular by way of increasing commitment and capacities for an appropriate hepatitis prevention and treatment response.

Does the programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget**(a) Total cost**

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) The resolution is not time-bound and it is anticipated that many activities outlined in the resolution will be ongoing.

(ii) An overall costing for the full implementation of the resolution across the Organisation will be completed in the process of preparation of the programme budget for 2016–2017.

(iii) The resolution includes elements that go beyond the previously-agreed framework for action on hepatitis, particularly with regard to accelerating access to hepatitis treatment and the assessment of the economic impact and burden of the disease at global and regional levels.

(iv) An indicative costing for the biennium 2016–2017 currently estimates the work to be performed by the secretariat of the Global Hepatitis Programme at headquarters at US\$ 7.4 million (staff: US\$ 5.8 million; activities: US\$ 1.6 million). It does not include yet costs incurred at regional and national levels.

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 3.3 million (staff: US\$ 2.1 million; activities: US\$ 1.2 million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

In support of the initial implementation of the resolution, priority is given to covering core activities at headquarters, including the elaboration of diagnostic and treatment guidelines, reporting, support to national strategy development, and the initiation of an access initiative.

<p>Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no) Yes.</p> <p>If “no”, indicate how much is not included.</p> <p>(c) Staffing implications</p> <p>Could the resolution be implemented by existing staff? (Yes/no) No.</p> <p>If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.</p> <p>For the biennium 2014–2015, existing staff within the Global Hepatitis Programme, other departments and in the regional offices will initiate implementation of the resolution. However, this will not be sufficient and, in the medium term, additional staff needs will be determined in collaboration with regional offices.</p>
<p>4. Funding</p> <p>Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no) No.</p> <p>If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).</p> <p>Funding gap: US\$ 1.7 million.</p> <p>This funding gap will be tackled as part of the Organization-wide coordinated resource mobilization plan for making good funding shortfalls in the Programme budget 2014–2015.</p>

Dr AL-RABAT (Egypt), speaking on behalf of the Member States of the Eastern Mediterranean Region and welcoming the report, introduced the draft resolution. Viral hepatitis was a leading cause of morbidity and mortality worldwide. Although all types of viral hepatitis occurred in the Region, some countries (Egypt and Pakistan) had the highest incidence rates in the world for hepatitis C. In the Region, an estimated 17 million people were living with hepatitis C virus infection (between 6 million and 8 million in Egypt alone) and some 800 000 new infections occurred every year. Egypt had worked with Brazil on drafting the text, and various amendments had been proposed in subsequent discussions. She sought the continued support and active engagement of Member States in further negotiations on the text.

Dr BARBOSA DA SILVA (Brazil) commended the report. The draft resolution represented the commitment of several countries to combating a major public health problem. The time was right to expand current actions with support from governmental and nongovernmental organizations under the leadership of WHO in order to overcome numerous obstacles, including unequal access to health services and to new, low-cost technologies for diagnosing and treating hepatitis. Under the leadership of WHO, Member States needed to cooperate and strengthen policies on, for instance: coordinating work on the social determinants of hepatitis A, given its prevalence in developing countries; increasing knowledge about hepatitis B, and in particular the existence of low-cost diagnostic techniques and treatments; making vaccination affordable with support from PAHO's Revolving Fund and the GAVI Alliance; and meeting the challenges posed by hepatitis C. The response should be to strengthen national strategies, reinforce WHO's mandate, involve civil society, guarantee affordable prices, improve surveillance and raise awareness about prevention and treatment.

Dr NCHABI KAMWI (Namibia), speaking on behalf of the African group, welcomed the report. Viral hepatitis continued to be a major public health problem in the African Region, compounded by the fact that 37% of the population had no access to clean drinking water and more than 50% had no proper sanitation facilities. Other risk factors included lack of screening of donated blood for hepatitis B and C viruses, unsafe health care practices, and failure to vaccinate health workers at risk of contracting hepatitis B despite WHO's recommendations. Vaccination against

hepatitis B could also prevent cancer and cirrhosis. He urged WHO to provide support to those Member States with low hepatitis B vaccination coverage rates and weak surveillance systems and where treatment of hepatitis B and C was unaffordable.

Dr THAN ZAW MYINT (Myanmar) endorsed WHO's framework for global action to prevent and control viral hepatitis infection with its four strategic axes.¹ Given the need to strengthen the data base on viral hepatitis infection, he requested the Secretariat to undertake estimations of the burden of viral hepatitis for different countries on the basis of available data. He also requested more information on the Secretariat's action plans for each strategic axis, especially at the regional level, so that Member States could align and extend their activities. The unmet need for training materials for primary health care workers could be remedied through collaboration with relevant WHO collaborating centres and the World Hepatitis Alliance. Marking World Hepatitis Day should not be a one-off annual event but rather the trigger for further action, such as raising awareness and mobilizing resources. He had noted that the Secretariat was drafting technical guidance on strengthening national hepatitis surveillance programmes but he urged the proactive involvement of country programme managers for hepatitis prevention and control. The impact of hepatitis was exacerbated by the number of undetected cases, which could result in many cases of chronic disease and hepatocellular carcinoma. It was particularly important for developing countries to strive to reduce unsafe injection practices, especially in rural areas. The integrated management of communicable diseases should be promoted in order to save resources and increase cost efficiency.

Dr FEISUL IDZWAN MUSTAPHA (Malaysia) commended the framework for global action to prevent and control viral hepatitis and its balanced approach. He urged WHO to accord priority to making preventive interventions, such as vaccination and eliminating needle-stick injuries, more affordable for Member States. He supported the draft resolution.

Mr HIRAOKA (Japan) recognized that hepatitis B and C placed a high burden on national health services, economies, families and communities. Vaccination against hepatitis B was a central preventive element, but attention should also be paid to early detection, treatment and long-term care in the context of prevention and control of noncommunicable diseases. In addition to the hepatitis B immunization programme, initiatives that included preventive measures focused on people considered to be at high risk should be continued, and blood safety measures at health centre facilities should be strengthened. Limited access to treatments and medical devices were not the only challenges; human resources development and improved medical infrastructure from primary care to tertiary emergency care levels should also be part of a comprehensive approach to strengthening health systems. Increasing access to medicines and medical devices alone could lead to increased drug resistance.

Mr RI Jang Gon (Democratic People's Republic of Korea) said that his Government was giving priority to preventing and controlling all viral hepatitis in the context of combating communicable diseases. A national strategic plan to reduce both the seroprevalence rate of hepatitis B surface antigen to less than 1% in children aged under one year and prevalence of the disease had been prepared and was being implemented. All newborn babies were vaccinated against hepatitis B, with a vaccination coverage rate of 97.5% in 2008. In addition, research was being conducted on diagnosing and treating viral hepatitis, including hepatitis C. Given the crucial role of a diagnostic system in preventing and treating hepatitis, he urged the Secretariat to provide support to Member States in building their diagnostic capacity.

Ms ALI (Maldives) acknowledged the establishment of the global hepatitis programme and the production of the framework for global action to prevent and control viral hepatitis infection. In the

¹ Document WHO/HSE/PED/HIP/GHP 2012.1.

South-East Asia Region the estimated number of deaths from viral hepatitis and its complications exceeded the mortality estimates for malaria, dengue and HIV/AIDS combined. In view of the high cost of treatment and care, she asked for information about the progress in updating the list of WHO-prequalified serological tests for hepatitis B and C. She welcomed the resource mobilization efforts that had been made to build the capacity of countries in the Region to implement the regional strategy. Her country's immunization programme included vaccination against hepatitis B in the infant immunization schedules and coverage rates of more than 95% for three subsequent doses had been sustained. She supported the draft resolution and planned to submit some amendments for consideration by the Board.

Dr CARBONE (Argentina) commended the report. Since 2012, Argentina had been putting into practice its national plan for controlling viral hepatitis, in particular hepatitis A, B and C, by facilitating diagnosis, and access to treatment and improving care. Her country had been a pioneer in preventing and controlling hepatitis by including free, compulsory vaccination against hepatitis A and B in the national vaccination schedule. In 2005, Argentina had been the first country to introduce a single-dose hepatitis A vaccination programme and to demonstrate that the regimen was effective in practical and cost terms. In 2004, hepatitis A had been the main cause of liver disease and liver transplants among children, but following the introduction of the vaccination programme in 2007, no further transplants for liver disease due to hepatitis A had been carried out. In 2012, the Strategic Advisory Group of Experts on immunization had endorsed the strategy, allowing other countries, including Colombia and Paraguay, to follow Argentina's example. The national hepatitis B vaccination schedule was among the most complete in the world, beginning at birth and with catch-up among adults where necessary in order to ensure coverage. In addition, free and universal transplants were available. She recognized the need to strengthen surveillance, as well as promotion, prevention and awareness-raising.

Dr BEJTJA (Albania) supported the draft resolution. Because of the causal link between hepatitis B and C and cancer, viral hepatitis control should be carried out under the global action plan for the prevention and control of noncommunicable diseases 2013–2020. Inclusion of improving access to effective treatments for hepatitis B and C within the framework of discussions on the post-2015 development agenda held particular significance for middle-income countries.

Mr AL-MARRI (Qatar) recalled the decision of the Member States of the Eastern Mediterranean Region, including Qatar, to be sponsors of the draft resolution.

Dr VALVERDE (Panama) commended WHO's framework for global action and its four strategic axes, which underlined the need for monitoring and evaluation mechanisms to prevent and control viral hepatitis. In recent years, the inclusion of vaccination of newborn infants in Panama's immunization programme had served to increase coverage. Her country wished to be included in the list of sponsors of the draft resolution.

Ms MEL'NIKOVA (Russian Federation)¹ recalled the shortcomings identified in hepatitis control, including: insufficient training of primary health care workers in the diagnosis, treatment and prevention of viral hepatitis; lack of access to medicines in countries with limited resources; weak surveillance and consequent inaccurate assessment of the disease burden; and inadequate preventive programmes. The report noted the development of new medicines and the prospect of successfully treating chronic hepatitis as a result, but they would be accessible only to a few people in developed countries. The reluctance of pharmaceutical companies to reduce the price of new medicines meant that governments had to assume heavy responsibilities in order to ensure access to them. In the

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

absence of a forum for discussing the provision of medicines and pricing policy with the pharmaceutical companies, WHO was the appropriate body to organize and coordinate such work in order to ensure a clear focus and consistency. She supported the proposed actions for Member States aimed at enhancing surveillance, developing screening tools, testing and treatment, and improving access to antiviral agents. In particular, countries needed to introduce preventive programmes focusing on the safety of injections and blood transfusions, and to work with target groups, including health professionals. She therefore welcomed the Secretariat's intention to produce technical papers on such subjects. She supported the draft resolution even though it needed some refinement.

Mr HU Xiaomeng (China)¹ welcomed the report and commended WHO's work in preventing and controlling hepatitis B and C, in particular the attention paid to people coinfecting with HIV and hepatitis B or C virus. The undertaking by some pharmaceutical companies to reduce the price of medicines in low- and middle-income countries was also welcome. After years of unremitting effort, China had succeeded in reducing its own burden of the disease by introducing routine vaccination and other measures. In May 2012, the Regional Office for the Western Pacific had confirmed that the carrier rate of hepatitis B surface antigen in children aged under five years had been maintained below 1% since 2006. Viral hepatitis among people aged over 15 years was the current focus of its prevention and control efforts. In continuing to cooperate with the Secretariat, his Government would welcome both an increase in its financial and technical support to developing countries with a high burden of disease and closer coordination with pharmaceutical manufacturers in order to reduce the cost of medicines.

Mr ALIMUZZAMAN (Bangladesh)¹ observed that hepatitis A virus infection¹ was common in Bangladesh, with a prevalence rate of between 2% and 7%. Prevalence of hepatitis C infection was less than 1%. Hepatitis E virus caused sporadic outbreaks of disease. The statistics showed that about 3.5% of pregnant women carried hepatitis B virus, among whom 22% to 38% were at risk of transmitting the virus to their newborn babies. Hepatitis B vaccine was given to all children aged under one year through the Expanded Programme on Immunization. There were no accurate data on hepatitis D. The high price of vaccines and a lack of regular supplies, as well as of adequate screening facilities, were major challenges. Vaccine supply could be met by establishing manufacturing plants and he invited WHO and other development partners to work with Bangladesh to that end. He supported the draft resolution.

Dr DAULAIRE (United States of America)¹ welcomed the report as the size of the disease burden imposed by viral hepatitis had been significantly underappreciated. He concurred with the assessment of the epidemiological situation and the challenges it presented, and his Government was committed to global viral hepatitis prevention and control. Efforts so far had been only partially successful, being hampered by a fragmented approach. More attention should be paid to implementing the global strategy, and in particular to universal early immunization against hepatitis B and improvement of the medical practices that often led to hepatitis C virus infection. WHO must provide strong leadership and proactive guidance to Member States in support of the actions needed to establish and maintain effective national viral hepatitis prevention and control, including appropriate treatment. He supported WHO's hepatitis prevention and control programme and urged other countries to promote and reinforce their efforts.

Ms BOTERO HERNANDEZ (Colombia)¹ endorsed the report and said that Colombia had added its name to the list of sponsors of the draft resolution. She called on WHO to strengthen primary care programmes in remote areas. The report lacked recommendations on vaccination of travellers in

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line with the provisions of the International Health Regulations (2005). The question of transplantation in cases of chronic hepatitis also needed to be discussed at greater length.

Dr JAIRSIRI (Thailand)¹ welcomed the draft resolution and the fuller attention being paid to viral hepatitis. She urged WHO to support the development of affordable diagnostic tools, essential medicines and treatment and to increase access to screening and affordable treatment for patients living with chronic viral hepatitis in developing countries.

Mr GORE (World Hepatitis Alliance), speaking at the invitation of the CHAIRMAN, commended the broad sweep of the draft resolution and the higher priority being given to viral hepatitis. WHO might consider renaming its HIV/AIDS department by including the word hepatitis in order to counteract the impression that the main significance of viral hepatitis was in the context of HIV coinfection. In addition to national goals, WHO should set global goals, such as the elimination of mother-to-child transmission of hepatitis B. Every opportunity should be exploited to raise funding, both by the Secretariat and by Member States, and to ensure inclusion of viral hepatitis in the post-2015 development agenda. The therapeutic advances for hepatitis C were important drivers of action to ensure affordable access.

Dr ANDRIEUX-MEYER (MSF International), speaking at the invitation of the CHAIRMAN, said that the new oral treatments which should soon be available would revolutionize hepatitis C treatment, particularly in low- and middle-income countries, as long as they were affordable. Similarly, treatment of hepatitis B could change significantly through increased screening and access to quality-assured, affordable sources of existing medicines. The draft resolution could be strengthened if it: urged Member States to implement hepatitis B birth-dose vaccination; encouraged protecting and making full use of public health flexibilities to reduce prices; and requested the Director-General to include hepatitis C medicines in WHO's prequalification programme. In addition, funders such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNITAID and the United States President's Emergency Plan for AIDS Relief should include hepatitis B and C treatment and care among their funding priorities. As with HIV/AIDS, civil society pressure was valuable, but above all it was the political will of governments that would lead to affordable treatments.

Dr NAKATANI (Assistant Director-General) welcomed members' comments, which would further guide the Secretariat's work. The discussion had been initiated as a result of the recent awareness of hepatitis as a major global public health concern. He had noted the emphasis on: inadequate surveillance, unsafe injections and the insufficient use of cost-effective interventions, such as vaccination and infection control, as well as poor access to medicines and diagnosis. In view of the large number of affected communities, such interventions needed to be integrated in primary health care within the context of universal health coverage. The member for Myanmar had mentioned the possibility of using WHO collaborating centres for developing teaching materials. In that regard, WHO was already working with a network of relevant institutions and nongovernmental organizations. Replying to the member for Maldives, he said that the prequalification group intended to update the list of prequalified serological tests for hepatitis B and C by the end of 2014. He recognized the need to fully integrate viral hepatitis care and treatment within primary health care, as mentioned by the member for Japan and the representative of Colombia. In reply to the representative of the United States of America, who had highlighted the fragmented approach, he explained that, in an attempt to overcome the problem, the Secretariat had adopted a "matrix" or horizontal working method to tackle the different aspects of hepatitis management that involved different headquarters programmes, for example, Humanitarian Response and the Global Outbreak Alert and Response Network in the case of outbreaks of hepatitis A and E, and the vaccination group in the case of

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vaccination. Headquarters would also work closely with regional and country offices. Several members had mentioned the four strategic axes of the framework for global action to prevent and control viral hepatitis infection, but issues of access to medicines and new technologies also posed a significant challenge. As a result, the Secretariat planned to convene a meeting of a Scientific and Technical Advisory Group on viral hepatitis, to be held back-to-back with discussions involving as many stakeholders as possible, including nongovernmental organizations and industry.

The CHAIRMAN took it that the Executive Board wished to take note of the report.

The Board noted the report.

The CHAIRMAN proposed that, as the draft resolution was work in progress, discussion of the agenda item should be suspended and resumed later in the session.

It was so agreed.

(For continuation of the discussion, see the summary record of the thirteenth meeting, section 2.)

4. PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 8 of the Agenda

Monitoring the achievement of the health-related Millennium Development Goals: Item 8.1 of the Agenda (Documents EB134/17, EB134/17 Add.1 and EB134/18)

The CHAIRMAN proposed that the agenda item should be discussed in two parts: “Monitoring the achievement of the health-related Millennium Development Goals” and “Health in the post-2015 United Nations development agenda”.

It was so agreed.

Dr EZZAT (Egypt), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that, despite some achievements, full attainment of the Goals by 2015 could prove difficult for many countries in the Region. Common challenges included: inadequate political commitment, weak health systems, complex emergencies, political unrest, illiteracy (particularly among women) and insufficient resources, coupled with uneven distribution. He commended the support provided by WHO, UNICEF and UNFPA to countries in the Region for developing plans to accelerate work to achieve Goals 4 and 5; the plans had been launched in the nine countries that were unlikely to reach the Goals on schedule, including his own. He called on donors, development agencies and the international community to further support the initiative.

Mr COTTERELL (Australia) said that Australia’s aid programme continued to reduce poverty and lift the living standards of vulnerable people, particularly in the Indo-Pacific region. It was deeply concerning, however, that even though maternal deaths were preventable, the rate of decline in their number would have to almost double if the targets for Goal 5 were to be achieved. Progress had been made against communicable diseases, but drug resistance threatened the gains made and half the world’s population was still at risk of contracting malaria. Many child deaths occurred in the newborn period; to significantly improve progress towards the targets for Goal 4, more attention must be paid to newborn survival.

He commended the report on newborn health (document EB134/17 Add.1) and expressed support for the process for developing the draft action plan for ending preventable deaths. His country would participate in the planned consultations.

He endorsed the outcome document of the United Nations General Assembly's Special Event on progress towards achievement of the Millennium Development Goals. The impact of HIV infection in the Western Pacific Region, particularly among populations at higher risk, remained a matter of concern. He looked forward to welcoming Board members to the 20th International AIDS Conference, scheduled to be held in Melbourne on 20–25 July 2014.

Dr MATCHOCK-MAHOURI (Chad), speaking on behalf of the Member States of the African Region, commended the report on achievement of the Goals. In the African Region, about 32% of countries were likely to reach the target of reducing under-five mortality by two-thirds by 2015. Although the number of maternal deaths had declined, only 4% of countries were on course to meet Target 5.A. Member States were committed to accelerating progress towards achieving Millennium Development Goals 4 and 5 by focusing on sexual, reproductive, maternal, newborn and child health while respecting national legislation and culture. In their efforts to attain Goals 4 and 5, countries in the Region faced three main challenges: a lack of resources, weak health systems and unequal access to effective interventions.

(For continuation of the discussion, see the summary record of the seventh meeting, section 1.)

The meeting rose at 17:30.

FIFTH MEETING

Wednesday, 22 January 2014, at 09:10

Chairman: Professor J. HALTON (Australia)

WHO REFORM: Item 5 of the Agenda

Reform implementation plan and report: Item 5.1 of the Agenda (Documents EB134/5 and EB134/39)

Dr CUYPERS (Belgium), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, drew attention to the Committee's discussion on WHO reform (document EB134/3, paragraphs 2–6). The Committee had considered the reform implementation plan and report prepared by the Secretariat (document EB134/5) and the second-stage evaluation on WHO reform, prepared by an external consultant (document EB134/39). It had noted delays in the delivery of documentation and the continued increase in the number of agenda items submitted to governing body meetings, which might limit the time available for in-depth strategic discussion and thus weaken their capacity for oversight. The Committee had called upon the Secretariat to focus on “people issues” and on achieving key improvements, enhancing the quality of the information it provided and communicating more effectively, especially with key agents of change. The Secretariat had also been asked to improve the monitoring framework, focusing on key priorities, and to tailor the reform to the varying needs of the WHO regions.

Dr OMI (Japan), while endorsing recommendation 2 of the evaluation report, which called for a stronger theory of change for WHO reform, pointed out that change was merely a means to an end, not an end in itself. It was important to analyse why and in which areas change was needed and to consider the cost implications of changes.

Dr AMMAR (Lebanon), speaking on behalf of the Member States of the Eastern Mediterranean Region, observed that the approval of the Programme budget 2014–2015 in its entirety had given Member States oversight over all WHO resources and had guided the financing dialogue aimed at improving the predictability, alignment, flexibility and transparency of WHO financing. The programme budget should be used as an accountability tool, strengthening programmatic evaluation and performance assessment by measuring the results which the Organization was committed to achieving at global, regional and country levels.

Although the importance of strengthening country offices had been emphasized, it was not clear how far they had benefited from the reform so far. For example, there was still no explicit, transparent, performance-based accountability mechanism for WHO country representatives. Country offices were essential to the effectiveness and reputation of WHO, but they were still not given the resources they deserved, nor were they being made sufficiently accountable.

The bottom-up planning exercise scheduled for the biennium 2016–2017 should be launched without delay, taking into account countries' health strategies and priorities. The Secretariat should review the distribution of the workforce and strengthen the Organization's presence in countries. It should also consider compulsory geographical rotation for international staff members, as was the case in other international organizations. Change management activities directly aimed at Member States should be introduced, with specific reference to the crucial relationship with the WHO country offices.

Professor LOUME (Senegal), speaking on behalf of the Member States of the African Region, observed that there had been a number of notable achievements in the Region. The Regional Office had been reorganized to match the new structure of the programme budget, the terms of reference of the Programme Subcommittee of the Regional Committee for Africa had been revised, a management framework for internal oversight and improved risk management had been created, and a reform support team had been set up in the Office of the Regional Director. Turning to the four recommendations of the second-stage evaluation (document EB134/39), he emphasized that staff must be involved in the process, and that the governance procedures of the regional committees must be harmonized. He was confident that the reforms would produce better health outcomes and a more effective and transparent Organization.

Dr CAPAK (Croatia), speaking on behalf of the European Union and its Member States, said that the former Yugoslav Republic of Macedonia, Montenegro, Iceland, Serbia, Albania and the Republic of Moldova aligned themselves with his statement. The European Union supported the institutionalization of the changes initiated under the WHO reform agenda. It particularly supported the Secretariat's aim of further refining and strengthening the programme budget as the primary tool for institutional accountability and transparency. It also supported the clear definition and strengthening of the role of the category networks to align managerial and technical structures across the three levels of the Organization. In that regard, he drew attention to the recommendation of the Joint Inspection Unit of the United Nations System that the Global Policy Group should be institutionalized and that corporate alignment should be extended to the level of Assistant Directors-General.

With regard to governance reforms, the number of agenda items and resolutions submitted to the governing bodies should be reduced, as their excessive number obstructed decision-making. The timely dispatch of documentation and the early submission of draft resolutions were crucial to the efficiency of the governing bodies' work. He welcomed the Secretariat's proposal for a revised process for developing agendas for the Executive Board and the Health Assembly. The financial and administrative implications of resolutions and decisions must be fully taken into account.

The European Union recognized the agreed principles of engagement between WHO and non-State actors and welcomed the proposed adjustments to the policy on the involvement of nongovernmental organizations. It favoured a light process of consultation with Member States between January and May 2014 and called on the Secretariat to prepare a specific proposal for consideration at the Sixty-seventh World Health Assembly.

The European Union strongly supported the steps taken to strengthen WHO's internal management controls and to enhance institutional transparency, accountability and stewardship of resources at all levels, particularly the establishment of the Compliance, Risk Management and Ethics Office, which would strengthen risk management throughout the Organization. Successful reform would require strengthening of WHO's overall performance. In that regard, he asked for more details of the revision of the country cooperation strategy framework. The revised human resources strategy was also a key tool in the reform process, and the European Union expected to see clear deliverables in that area in 2014–2015.

Mr COTTERELL (Australia) welcomed the Secretariat's acceptance of the recommendations of the second-stage evaluation. The evaluation included recommendations both for the Secretariat and for Member States, and he hoped that the debate at the current session would yield clear decisions that would ensure that Member States bore their fair share of responsibility in implementing the reforms.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) affirmed that the reform process, as indicated in the second-stage evaluation (document EB134/39), was ambitious and results-oriented and adopted a cross-cutting and risk management approach. The introduction of new methods of work was bound to entail risk, but it was less of a risk than not engaging in reform. Changes must be made in order to improve global health. Member States and the Secretariat should work together to reduce the number of agenda items considered at governing body meetings.

Dr PE THET KHIN (Myanmar) observed that several areas of reform appeared to be progressing very well. It was essential, however, to monitor the reform process carefully and take corrective action immediately if necessary. Referring to document EB134/5, paragraph 6, he asked what approaches the Secretariat, especially regional and country offices, had found to be most appropriate for meeting the challenges of introducing bottom-up planning and what roles had been played by health ministries and other agents. Genuine bottom-up planning would facilitate achievement of the Organization's aims and be useful to individual Member States. The Secretariat should prepare or update guidelines for such planning for country programme managers.

More robust budgeting procedures were required. He was confident that budgeting could be made less cumbersome, easier to manage and more transparent. The views of WHO country office staff should be taken into account in the process. It might also be useful to study the budgeting procedures of other United Nations agencies. All new staff and longer-term temporary international professionals should be properly briefed about the reform process, which would enable them to be actively involved in it and give them a sense of ownership of the endeavour.

Mr REINA (Mexico) commended the focus on tangible results and a strategic approach in WHO's reform efforts. Institutionalization of the agreed changes would improve the Organization's performance and provide greater benefits for Member States in their pursuit of their health priorities. The programme budget web portal should be regularly updated to reflect programme performance and resource allocation, so that any shortfalls in performance and regional programme implementation could be identified promptly. The reform process should include frameworks for managing and evaluating the work of the regional committees and their relationship with the country offices in order to gauge WHO's performance at country level – the main measure of the success of reform.

Turning to the four recommendations of the second-stage evaluation, he emphasized that, while Member States were the main drivers of change, the regional committees must also move the reform process forward using their own working procedures. The theory of change should provide options and opportunities in respect of the risks and consequences of any action undertaken. The Secretariat should strengthen its communication activities on the basis of an evaluation and prepare an information document on the planning and budgeting of the reform, in line with the five stages of reform output and the resources approved for the biennium 2014–2015, in order to monitor its effectiveness in budgetary terms.

Dr CARBONE (Argentina) said that Member States' approval of the Twelfth General Programme of Work 2014–2019 and of the Programme budget 2014–2015 in its entirety had been a key step towards greater accountability and transparency. Countries should be more engaged in bottom-up planning of the Organization's activities at all three levels and in aligning the priorities they established with available resources. It was important to measure the results produced by WHO and the way in which those results contributed to health outcomes. While progress had been made in internal WHO governance reform, especially with regard to standards for WHO engagement with non-State actors, it was also essential to prioritize external governance; WHO should promote health issues in external processes and spearhead the debate on the post-2015 development agenda, with a view to achieving universal health coverage with a focus on equity and social determinants.

Her delegation supported the managerial and human resources reforms introduced thus far and welcomed the development of a communication strategy. It encouraged the Secretariat to continue improving the results chain and to identify indicators that would facilitate monitoring and oversight change by Member States. She looked forward to receiving the revised reform implementation plan, with key performance indicators.

Dr VALVERDE (Panama), noting that the reform process afforded an opportunity for WHO to improve predictability, transparency and accountability at all levels, welcomed the proposals to streamline the agendas of the governing bodies. The informal consultation on WHO's engagement with non-State actors, held in Geneva in October 2013, had been a landmark event; efforts to enhance relations between the Organization and such actors should continue. Strategic resource allocation was

an important reform issue at the regional level, and she looked forward to discussing the matter during the current session.

Mr TSECHKOVSKI (Russian Federation)¹ said that progress had been made, albeit not to the same extent, in all areas of WHO reform. The changes now needed to be institutionalized through a strategic approach. In order to enhance the efficiency of its work, the Secretariat was seeking fuller and more predictable financing for the programme budget. The Member States also expected higher-quality and more complete and timely information. The Secretariat's view, expressed in document EB134/5, that the greatest progress had been made in financing reforms was not borne out by the statistical and qualitative data on the various categories and programmes. He was particularly concerned about the level of financing for the area of noncommunicable disease control, which had the lowest proportion of funding from voluntary contributions among the five technical categories of activity, and there was no information about the possibility of allocating regular budget funding to make up the shortfall. He would like information about any negotiations the Secretariat had held with donors in recent weeks. The issue must be discussed openly if adverse consequences for noncommunicable disease control activities in the post-2015 period were to be avoided.

Dr LIU Yue (China)¹ welcomed the bottom-up approach to planning and the increased engagement of countries in WHO's budgeting process. The change process must be accompanied by full and timely communication; it was important not to wait for the 2014 sessions of the regional committees if changes were to be well aligned with national health development priorities. Cost accounting based on expected outputs and deliverables would help to make the most of WHO's limited resources.

Turning to managerial reform, she welcomed the reduction in administrative costs and the human resources reforms, noting that the latter were necessary in order to retain the outstanding talent required to improve performance. She agreed that the success of reform would be judged by WHO's performance at country level and looked forward to seeing a revised version of the reform implementation plan at the next session of the Board in May 2014. With regard to governance reform, joint efforts by Member States would be required to improve the strategic nature and efficiency of governing body meetings. Thus far, however, there had been little consultation with or evaluation of the actions taken by Member States on the issue.

Dame Sally DAVIES (United Kingdom of Great Britain and Northern Ireland)¹ said that the approach to WHO reform was similar to that taken in the establishment of her country's National Institute for Health Research: the first step had been to listen to stakeholders' views and understand the issues involved. The aim had been to create an institute that operated transparently and with proper accountability, providing value for money and focused on delivery of services – also the aim of WHO reform. Now that the initial stage of gathering stakeholders' views was complete, it was important to introduce needed reforms swiftly, particularly in respect of governance and human resources. She supported the approach suggested by the Secretariat for the implementation of the four recommendations in the second-stage evaluation, which was a very useful document. Both Member States and the Secretariat must play their part in ensuring the success of the reform process and enabling WHO to fulfil its global health leadership role. In particular, Member States must show restraint and limit the number of agenda items and resolutions tabled at governing body sessions.

Dr BARBOSA DA SILVA (Brazil), acknowledging the progress made in the reform process, particularly on the financial dialogue, said that it was now time to proceed with governance and managerial reforms, which were still in their early stages. Brazil would continue to support the process.

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Mr SEN (Turkey)¹ said that the comprehensiveness and the complexity of the reform process required long-term, dedicated efforts at all stages by all stakeholders. However, the process could not go on indefinitely. The lengthy discussions and the recommendations made to date showed what action needed to be taken. In the area of programmatic reform, WHO must develop a mechanism and criteria for bottom-up planning, realistic costing and alignment of activities for the next biennium. In governance reform, the number of agenda items and draft resolutions must be managed in the interests of strategic decision-making, while promoting more efficient and responsive work on a wide range of needs and priorities. Managerial reform was another area requiring wise and bold action to ensure better performance, efficiency, accountability and transparency. The reform process as a whole would require strong commitment, continuous support, an adequate change management and communication strategy, monitoring and adequate financing.

Mr KUEMMEL (Germany),¹ affirming that WHO reform was moving in the right direction, said that further progress was needed during the current biennium in four areas. The first and most important was strengthening the work of the governing bodies. Attempts thus far seemed to have resulted in unmanageable agendas and made it less likely that the governing bodies could exercise effective oversight of the Organization's activities. There had been much less input than usual from members at the previous week's meeting of the Programme, Budget and Administration Committee, which he attributed to the difficulty of studying an exceptional volume of documentation on an unprecedented number of agenda items in preparation for the meeting. He hoped that an effective way could be found to reduce governing body agendas to a manageable length.

A truly coordinated approach to resource mobilization across all levels of the Organization was the key to aligning available funding with the programme budget, and rapid progress in that regard was needed. Strengthening of WHO's role vis-à-vis other global health actors was a central aim of the reform. It was essential to acknowledge the new actors that had emerged and enable the Organization to engage with them while safeguarding its integrity. Lastly, there must be a more strategic focus on the reform of human resources which, as the second-stage evaluation pointed out, had suffered from a piecemeal approach in the past.

Ms MATSOSO (South Africa) asked what activities were planned for introducing the reform implementation plan at regional and country levels. She also enquired about the cost implications of the recommended quality assurance and evaluation mechanisms, pointing out that, as noted in the second-stage evaluation, reporting needed to change from an event-driven activity to a regular monthly process that would help to assess progress.

Mr KASE (Papua New Guinea), observed that development partners often provided considerable resources for activities at country level and that sometimes the priorities of those partners were not fully aligned with national priorities. That was an issue that WHO reform must address.

Mr BUTLER (Bahamas)¹ said that in the effort to transform WHO from a policy organization to an implementation-oriented organization, it was important for Member States to consider the budget implications of measures that they asked the Secretariat to implement. It was also important to be clear about the goals of every policy direction given to the Secretariat. Draft resolutions should be implementation-oriented and, ideally, fully negotiated before meetings, so that their specific goals were clear.

Dr MIŠE (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, welcomed the Secretariat's efforts to align governance processes across the regional committees and encouraged it to do more to align the processes by which non-State

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actors engaged with the regional committees, particularly during their annual sessions. Ensuring clear procedures for the participation of non-State actors and allowing them sufficient time to make their statements would enable the Organization to make better use of nongovernmental resources. He supported the proposal to improve electronic access to the proceedings of the governing bodies and hoped that the forthcoming session of the Health Assembly would be webcast. Regular webcasting of governing body sessions would increase Member States' ability to engage with WHO, make WHO proceedings more accessible to the public and reinforce the Organization's role as a public health organization.

Dr SMITH (Adviser to the Director-General) said that it had been encouraging to hear the strong expressions of support for the evaluation recommendations. Thanking participants for their comments and guidance, he observed that they had acknowledged the complexity of the reform process and highlighted the need to focus on the desired end result. That meant, first, identifying the ultimate goal of reform and, second, defining a clear process for managing change, risks and results. It had emerged from the second-stage evaluation that, while the Secretariat had provided clear plans for the development of policies, procedures and documentation, it had not explained clearly enough exactly how the reform would be implemented, especially at regional and country levels. The first step in implementing a theory of change would be to describe the various steps of the reform in detail. A revised implementation plan covering those steps would be presented to the Health Assembly in May 2014. Participants had also called for more precise targets and indicators, which would be included in the new results framework to be submitted to the Independent Expert Oversight Advisory Committee in April and then incorporated into the revised implementation plan.

It was clearly necessary to determine more precisely the impact of the reform on staff in terms of structures, roles and behaviours. An impact assessment would be conducted so that staff at all levels would understand the implications of changes for them. A new project management tool was being developed, which would enable both the Secretariat and Member States to monitor the status of delivery of specific outputs. The new tool would be demonstrated at the Health Assembly in May 2014. The first stage of evaluation had looked mainly at whether the problems to be addressed by reform had been correctly diagnosed, while the second stage had analysed whether the correct mechanisms and systems were in place to deal with them. At a later date, however, it would be necessary to evaluate whether the reform had achieved the desired results. A process for that would be agreed in due course.

Replying to the point raised by the representative of the Russian Federation, he said that, at present, approximately 50% of the budgeted funding for noncommunicable disease activities (Category 2 in the Twelfth General Programme of Work) was available, amounting to approximately US\$ 160 million, including around US\$ 77 million in voluntary contributions. Additional information about financing for the Programme budget 2014–2015 could be provided when the Board discussed the financing dialogue.

The Board took note of the reports.

Options for improved decision-making by the governing bodies: Item 5.2 of the Agenda (Documents EB134/6 and EB134/6 Add.1)

Streamlining national reporting and communication with Member States: Item 5.3 of the Agenda (Document EB134/7)

The CHAIRMAN, noting that the Board was asked to provide guidance on a number of specific questions listed in the relevant documents, invited members to focus on two main issues in relation to agenda items 5.2 and 5.3. The first was how to improve access to governing body meetings and documentation by electronic means, which would enhance transparency, reduce WHO's environmental impact and provide some cost savings. The second was how the governing bodies were to manage their volume of work. Member States would doubtless continue to add new items to the

agenda, and while their right to do so must not be constrained, a way had to be found to focus on the most important strategic priorities.

Dr OMI (Japan), noting that document EB134/6 proposed that a maximum number of agenda items should be set for sessions of the Executive Board, enquired whether the same would be done for the Health Assembly. In his view, a limit should also be established for the latter.

The DIRECTOR-GENERAL said that, eventually, it would be desirable to set a maximum number of agenda items for the Health Assembly. However, it seemed advisable to address the Board's agenda as a first step. In any case, items were rarely included on the agenda of the Health Assembly without prior discussion by the Board.

Dr MEMISH (Saudi Arabia) said that the number of agenda items discussed by the Board should be limited, in order to improve the effectiveness of its work. As to agenda item 5.3, the Secretariat's work on a minimum set of health indicators and the three related technical projects (described in document EB134/7, paragraphs 4 and 5) was commendable. It should, however, strengthen countries' capacity to generate their own indicators, rather than relying on mathematical models for the creation of data sets. National figures should be used whenever available, regardless of constraints imposed by the study methods, since they were more reliable than statistical models. Modelling allowed better comparability between countries, but the resulting data did not accurately represent the real situation for certain countries and could result in a change in their baseline figures, thereby preventing comparisons within the country over time and affecting programme evaluation and policy-making.

He welcomed the proposal to convene a meeting of Member States on needs and approaches to reporting national health policy and laws. It would be useful, as well, to develop an international platform for comparing health policy regulations and best practices. He also agreed that there was a need for a new Organization-wide information management strategy, as proposed by the Secretariat.

Mr COTTERELL (Australia), speaking on item 5.2, expressed support for the actions proposed by the Secretariat to build the capacity of new Board members and officers, provide electronic access to governing body meetings and minimize the use of paper documents. He also supported the implementation, on a trial basis, of the Secretariat's proposal for limiting the number of agenda items. The new process should then be evaluated before it was used more widely. He agreed with the proposal for minimizing the late submission of draft resolutions. In addition, he would suggest that, when the Secretariat sought a decision from the Board Officers about the inclusion of additional items on the agenda, it should also provide an update on the expected timing of meeting documents. The Officers could then decide whether items for which documentation was likely to be late should be deferred. Progress reports should be discussed only if a decision on further action was required. Otherwise, Member States could submit their comments in writing and they could be posted on the WHO website before the opening of the session. He supported the principle of electronic voting for the appointment of the Director-General and agreed with the proposal to rent an appropriate voting system (document EB134/6 Add.1, paragraphs 6–9).

Turning to item 5.3, he commended the Secretariat's efforts to streamline reporting by Member States and urged it to consider adapting an existing data collection tool, if feasible. As part of an overall reporting system, reporting requirements should be expressed more clearly in resolutions; he asked the Secretariat when such a system might be developed. He supported the continuing work on national health policies and laws and would welcome an inter-regional meeting on the issue.

Dr AZODOH (Nigeria), speaking on behalf of the Member States of the African Region, expressed the hope that the decisions and recommendations already adopted by the Board would be implemented, especially those relating to governance and managerial reforms. Regarding the process for establishing the governing body agendas, she was concerned that the procedure proposed in document EB134/6 would tend to reduce the time available for placing items on the agenda, making it

difficult to evaluate proposed items thoroughly before including them. The proposal should be discussed further. The countries of the African Region favoured option 2 as set out in paragraph 22 of the document: a potential agenda item should meet all three of the criteria established by the Board in resolution EB121.R1. In addition, a maximum number of items should be set for the agenda of each meeting.

Despite the creation of regional health observatories, there had been no reduction in the number of questionnaires and reporting requests from regional offices and headquarters. The Secretariat should continue its efforts to minimize such requests. The African countries supported the proposal for a mechanism for reporting on Member States' implementation of governing body resolutions (document EB134/7, paragraphs 7–10), which should further reduce multiple reporting requests. Reporting on national health policies and laws should include reporting on key interventions.

Dr KAMALIAH MOHAMAD NOH (Malaysia) said that capacity-building opportunities should be made available to representatives of all Member States, not merely new Board members. She agreed with the proposal to improve electronic access to governing body meetings and supported the use of an electronic voting system for the appointment of the Director-General. A criteria-based approach to limiting the number of agenda items was preferable to the imposition of a maximum number of items, which might not be feasible. Many public health challenges required attention, and it might not be advisable to defer them for six months or more. She could not agree to a mechanism to sanction late documentation (document EB134/6, paragraphs 39–42). With the increasing number of items, it was inevitable that documents would sometimes be submitted late.

She supported the overall framework for national reporting and communication with Member States proposed by the Secretariat in document EB134/7 and looked forward to a more detailed report at the 136th session of the Board.

Dr REYNDERS (Belgium) said that the enormous number of agenda items and draft resolutions on the agenda for the current session put the effectiveness of the Board and the smooth implementation of WHO reform at risk. The proposal for a revised process for preparing the agenda would allow for the inclusion of items of an urgent or exceptional nature at a late stage, but it was not clear what items would be considered urgent or exceptional. The practice of the regional committees could provide useful guidance. For example, the European Region had adopted a rolling multiannual agenda that was regularly updated by the Standing Committee, allowing Member States to focus on priorities while maintaining a long-term vision. Regional resolutions were submitted only after consultation with the Regional Director and Standing Committee. The late submission of documentation was another concern. The issue of timely availability of documents should be included in the performance management evaluations of the Secretariat services concerned.

Mr REINA (Mexico) supported the proposal to introduce an electronic voting system for the appointment of the Director-General, provided that it was secure and reliable. A framework for implementation of the voting system should be designed, covering electronic security, access codes to prevent multiple voting, procedures to be followed in case of technical failure, and oversight of the system.

With regard to national reporting, he welcomed the preparation of a set of agreed indicators for monitoring and evaluation of the health situation at global and regional levels. The standardization of criteria and data collection methods would facilitate the analysis of trends in global health. Transparency was a priority for Mexico, and he therefore welcomed the proposal to set up a web-based platform to improve communication between the Secretariat and Member States. He agreed that such a platform would need to be based on an overall information management strategy.

Governance reform was crucial if the process of change was to achieve the desired results. It was essential to intensify debate on the topic and solicit the opinions and suggestions of Member States. He called on the Board and the Secretariat to ensure that all aspects of governance reform were thoroughly discussed with a view to reaching solid and well-thought-out agreements that could be adopted at the forthcoming Health Assembly.

Dr AMMAR (Lebanon) welcomed the progress made in the areas of capacity-building for new Board members, electronic access to governing body meetings and the reduced use of paper documents. Many delegations had expressed their concern about the Board's overcrowded agenda, which was becoming incompatible with thorough and serious discussion. If the trend continued, the Board would soon find it impossible to complete its work in the allotted time, even with night meetings. Moreover, if governing body meetings were webcast as proposed, more participants were likely to speak on each item. He therefore proposed that a maximum number of agenda items for each session should be established. If that number was exceeded, then items that fulfilled all of the three criteria set by the Board in resolution EB121.R1 would be placed on the agenda first, followed by those fulfilling two of the criteria, and so on until the maximum number was reached. The remaining items could be deferred to a later session.

It would always be difficult for Board members to refuse the request of another member to add an item to the agenda. For that reason, he proposed that the Director-General should appoint a technical committee, not involving Member States, to assess whether proposed items met the three criteria before they were submitted to the Officers of the Board for a final decision. That procedure would increase objectivity and avoid embarrassment.

Responding to a request for clarification from the CHAIRMAN, he suggested that the Director-General could select the members of the committee from among qualified staff; she might also appoint experts from outside, if appropriate.

Ms DUSSEY-CAVASSINI (Switzerland), expressing support for the suggestions made by the members for Australia and Belgium, said that there were too many items on the Board's agenda. If WHO was to remain efficient, effective and flexible, it must be selective and focus on areas in which it could make a difference. Switzerland would therefore support the introduction of clear and transparent criteria for inclusion of items on the agenda. It would then be incumbent on Member States to respect those criteria. The experience of the European Region, which had developed a set of tools to improve governance, demonstrated that progress was possible.

Dr PE THET KHIN (Myanmar) welcomed the actions taken by the Secretariat with regard to capacity-building and training. In order to promote greater understanding of the regional perspective and increased linkages between the global and regional levels, Executive Board members should attend their respective regional committee sessions. Selected Board members might also attend high-level policy meetings at the regional level, which could help to streamline WHO's policy direction. During country visits, WHO representatives and senior officials from regional offices could brief Board members on issues of policy importance or contentious matters.

Myanmar supported minimal use of paper documents. However, in view of poor internet access in many developing countries, it favoured limited printing of verbatim records and of the provisional summary records of the January session of the Executive Board and of Committees A and B of the Health Assembly, in order to ensure access to their rich content for WHO staff at country and regional levels and for national health professionals.

Mr PIPPO BRIANT (Argentina), endorsing the statement made by the member for Mexico, welcomed the actions proposed to improve the effectiveness and efficiency of the governing bodies, including the identification of innovative measures to improve access, strengthen capacity and training and optimize the use of technology. Argentina was concerned that that the proposal for a revised process for the agendas of the governing bodies set out in part I(a) of document EB134/6 could adversely affect the active participation of countries with relatively low levels of institutional development. A mechanism should be found that would foster the participation of all States and ensure timely treatment of priority issues. The proposal to establish a maximum number of agenda items was interesting and, provided there were safeguards for exceptional cases, should be considered as a complement to the evaluation of proposed agenda items on the basis of objective criteria. He would like clarification, however, as to whether the requirements for submission of new items would be applicable to Member States only or to all actors identified in Rule 9 of the Rules of Procedure of the

Executive Board, including the Director-General and specialized agencies with which the Organization had entered into effective relations.

Regarding the late dispatch of documents, the approach set out in paragraph 42 of document EB134/6 could provide a good basis for the Secretariat to develop a specific proposal. As to reform of reporting requirements, the suggestion in paragraph 45 that Member States should note all the progress reports at once seemed feasible and was preferable to limiting their number.

Mr SVERSUT (Brazil) said that the options put forward for improved decision-making in the governing bodies would enhance the transparency and efficiency of WHO. He welcomed the proposals to minimize the use of paper documents, which would help to streamline communication between the Secretariat and Member States and reduce costs. The proposed live webcasts of meetings should be available to all registered participants in sessions of the governing bodies, regardless of their geographical location. With regard to the agendas of the governing bodies, Brazil agreed in principle to the proposal to modify the existing requirement so that a proposal for inclusion of an agenda item would have to meet any two of the three criteria set out in resolution EB121.R1. It also supported a limit on the number of agenda items. In order to increase Member State participation and enhance transparency in the preparation of the provisional agenda, he suggested the establishment of a screening body composed of two representatives of each region to assist the Officers of the Board and the Secretariat, which, coupled with broader electronic consultations with all Board members, would help to create a provisional agenda that better reflected the priorities of all Member States.

The CHAIRMAN pointed out that the Officers already included a representative of each region and asked whether the proposed screening body would be an additional entity.

Mr SVERSUT (Brazil) said that he was flexible as to the modalities. What was important was that two representatives from each region were involved in the preparation of the provisional agenda, the aim being to increase Member State participation in the process.

Ms MATSOSO (South Africa) said that South Africa would support the use of an electronic voting system on an ad hoc basis in view of the cost implications. She congratulated the Secretariat on the reduction in the use of paper, which by her calculations had saved approximately 300 trees. Stressing the need to have a clear idea of the cost implications of reform proposals, she noted that the savings from reduced printing costs were sufficient to pay a team of interpreters for six days. Regarding the proposal by the member for Lebanon, she would support a limit on the number of agenda items, but had difficulty with the idea of establishing a technical committee outside the governing bodies to evaluate proposed agenda items, which might mean amending the WHO Constitution. Noting that considerable time would be gained by removing progress reports from the Board's agenda, she suggested that whatever platform was developed for reporting progress on WHO reform might also be used for progress reports.

Mr ROMERO PUENTES (Cuba) said that his delegation could support an electronic voting system, which should be as easy as possible to use. While he understood the problems associated with heavy agendas, he believed that they were also a positive sign of the Organization's growing capacity to deal effectively with global public health problems. Member States should retain the sovereign right to propose agenda items on the basis already identified within the framework of the reform. Noting that the duration of governing body sessions of other United Nations organizations was considerably longer than those of WHO, he suggested that consideration might be given to extending the duration of Board sessions.

He supported, in principle, the suggestion made by the member for Brazil concerning the agendas of the governing bodies but considered that the approach proposed by the member for Lebanon did not differ significantly from the current procedure. While every effort should be made to meet the deadlines for proposal of agenda items, the option should exist to examine late proposals on a case-by-case basis.

The DIRECTOR-GENERAL recalled that the Executive Board had previously met for one month. Very few Executive Board participants would now be able to be away from their capitals for that length of time. She would therefore not recommend increasing the duration of Board sessions. Indeed, in her view the Board was to be congratulated for reducing the duration of its sessions so significantly.

The CHAIRMAN affirmed that extending the duration of Board sessions would effectively exclude some key decision-makers who could not be away from their capitals for long periods of time. Longer sessions would also entail significant additional costs.

Dr EZZAT (Egypt) supported the position taken by the member for Saudi Arabia and the proposal put forward by the member for Lebanon. He also supported the establishment of a set of criteria to form the basis for inclusion or exclusion of agenda items, and endorsed the view that capacity-building and training should be provided for all Executive Board members, not only new members.

Dr VALVERDE (Panama) welcomed the efficient use of paper, the use of new information and communications technologies and training for Board members, all of which her country had proposed in the past. All the issues raised in the reports by the Secretariat should receive due attention in order to improve WHO governance. The discussions on the matter should be as inclusive as possible and driven by Member States, with the close collaboration of the Secretariat, and should lead, as suggested by the member for Mexico, to an agreement that could be adopted at the next Health Assembly.

Dr ASADI-LARI (Islamic Republic of Iran) expressed support for the proposal made by the member for Lebanon. He called for the provision of documents well in advance of governing body meetings and for increased direct electronic communication with Board members, and supported the introduction of all electronic facilities to that end. The number of resolutions produced was a concern, since the actions mandated therein had to be implemented at national level, which imposed a heavy burden on health workers, especially in rural areas. Resolutions should be formulated so as to respond to global health issues in the most efficient way.

Dr CUYPERS (Belgium), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, said that the timely provision of documents was important not only to enable all members to participate actively in discussions, but also to allow chairmen to prepare for meetings. The large number of documents and their complexity should not be an excuse for late dispatch, and he therefore supported the suggestion made by the member for Belgium that staff responsible for the timely delivery of documents should be made more accountable through performance evaluation. The Secretariat might also undertake a more detailed and critical review of the document clearing process.

Dr SHAKEELA (Maldives), welcoming the efforts to modernize the functioning of WHO, suggested that consideration might be given to identifying specific reform indicators and targets, building greater flexibility to provide for eventualities in the programming and handling of the work of the governing bodies and programme implementation, establishing clear channels of communication between offices and organizational units, developing a mechanism to ensure that structure was determined by issues, building mechanisms for transparency in monitoring and reporting, restricting the number of agenda items and grouping items under a limited number of themes, and avoiding the overlapping of meetings.

The CHAIRMAN said that she had heard no opposition from Board members to modernization, minimal use of paper documents or the introduction of an electronic voting system. She therefore invited non-Board members to comment on those matters only if their views differed and to focus their

comments on the number of criteria for inclusion of agenda items and their assessment. She noted that the Board could implement arrangements on a trial basis.

Dr DAULAIRE (United States of America),¹ pointing out that a reduced agenda could facilitate the timely delivery of documents, said that his delegation did not support any sanction with regard to late documents. Nevertheless, the Secretariat should make every effort to make documents available by the deadline of six weeks before the opening of a Board session.

He appreciated the Secretariat's focus on streamlining national reporting and communication with Member States and welcomed the work on data collection and definition of a minimum set of indicators for use by all Member States. For countries that had reporting systems on which their programmes relied, alignment would be important.

Noting the large number of operative paragraphs in the resolutions adopted by the Health Assembly since 2004, he emphasized that it was important to develop new resolutions only when absolutely necessary in order to avoid duplication of work. To that end, he requested the Secretariat to consider establishing an online library of resolutions arranged by topic area.

Ms LANTERI (Monaco),¹ endorsing the comments made by the member for Switzerland, welcomed the option to implement an arrangement based on the Secretariat's proposals for a trial period. Member States had been saying for years that governing body agendas were too long, yet they continued to propose new topics for discussion; they must take responsibility for limiting the number of agenda items, possibly using the criteria proposed. As suggested by the member for Australia, consideration should be given to placing on the agenda for discussion only substantive items requiring some action. In her view, it would be useful for the governing bodies to discuss WHO's action as the health cluster lead in humanitarian emergencies, and she would therefore like to see that the matter added to a future agenda.

In relation to reporting, the specificities of small countries should be taken into account. Lastly, she would welcome a WHO application for tablet computers.

Dr GULDVOG (Norway),¹ referring to the criteria for establishing the agenda, said that he was in favour of requiring that a proposal met two of the three criteria set out in resolution EB121.R1. With regard to the process for developing the agenda of the governing bodies, he could support the step-by-step proposal, but considered that a period of three months should be maintained for submission of additional agenda items. Although he supported the idea of a maximum number of agenda items, he was concerned that Member States might attempt to circumvent the limit by increasing the number of subitems.

Norway supported the 48-hour rule for presentation of draft resolutions to the Board. The proposals for minimizing the late submission of documents might be counterproductive, with valuable time lost in determining whether or not to discuss the relevant agenda items. It remained the responsibility of the Secretariat to ensure the timely dispatch of documents; if increased administrative capacities were required for that purpose, the Director-General should take the necessary action and submit proposals to the governing bodies as required. Finally, he proposed that progress reports should be taken up for substantive discussion only once a year, at the Health Assembly.

Ms GIROD (United Kingdom of Great Britain and Northern Ireland)¹ said that all stakeholders had to play a part in making the governing bodies work more efficiently: the Secretariat should publish documents in a more timely manner, and Member States should exercise discipline in proposing additional agenda items and draft resolutions. The induction briefings provided by the Secretariat for new Board members were useful. Her delegation welcomed the concept of a maximum number of agenda items. With regard to the criteria for establishing the agenda, it had initially supported a

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

requirement that proposals met two of the three criteria. However, in the light of suggestions made during the discussion, it would support the implementation on a trial basis of a model along the lines proposed by the member for Lebanon. If a screening committee was established to consider proposals for agenda items, however, Member States must accept its recommendations. Lastly, she asked to what extent examples of good practice in the regions were being taken into account, and noted that the European Region had introduced several governance reforms.

Ms ST LAWRENCE (Canada)¹ said that efforts to improve the functioning of the governing bodies should be accelerated. While she recognized that there was no quick solution to the challenges facing WHO, and that a culture shift was required on the part of both Member States and the Secretariat, incremental changes could be made. Meeting agendas should be more focused and strategic, and agendas at the global and regional levels should be designed so as to minimize duplication of discussion. To that end, the Chairman of the Executive Board should act as a focal point to facilitate communication and distribute agenda items among the bodies concerned. The Officers of the Board, under the leadership of the Chairman, should be more active between meetings. In the interests of increased transparency, the minutes of meetings of Officers should be distributed electronically.

She supported a requirement that proposed agenda items must meet two of the three criteria of resolution EB121.R1, but considered that the establishment of a maximum number of items was likely to result in a proliferation of subitems. Moreover, such a rigid approach failed to give sufficient consideration to the variation in complexity of agenda items. Reports by the Secretariat should place less emphasis on background and more on analysis and guidance for Member States regarding options and desired outcomes. New resolutions should be adopted only when absolutely necessary and should be accompanied by a full analysis by the Secretariat of impact, including available resources.

Dr LIU Yue (China)¹ said that the report on options for improved decision-making by the governing bodies (document EB134/6) contained a number of useful suggestions. With regard to reform of reporting requirements, China agreed that Member States should note all progress reports at once, rather than taking up each one individually. Turning to streamlining of national reporting, she noted the large number of resolutions adopted and actions mandated between 2004 and 2013 and suggested that the integrated reporting system used by the Secretariat could facilitate implementation of resolutions at the national level. However, the implications of implementation for national health data also had to be considered.

Mr KUEMMEL (Germany)¹ said that there was an urgent need to establish clear rules in order to ensure that governing body agendas were manageable. As evidenced by the agenda for the current session, the existing procedure for deciding on additional agenda items and late submissions of draft resolutions was clearly flawed. It would be preferable to provide guidance and oversight on a limited number of items, rather than allowing an unlimited number of items, without being able to provide adequate guidance on all. Germany therefore supported the Secretariat's proposal to establish a maximum number of agenda items, as well as the proposal made by the member for Australia regarding the consideration of progress reports. In order to ensure that additional agenda items and late draft resolutions were truly of an urgent nature, he suggested that Member States should be allowed to propose such items only with the cosponsorship of 12 Member States from three WHO regions. With a view to promoting strategic decision-making by the Executive Board, focusing the discussions and strengthening transparency, the Secretariat should outline more clearly in the documents prepared for the Board the specific decisions to be taken and present clear options that it considered feasible.

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

Mr HOLM (Sweden),¹ speaking also on behalf of Estonia, Lithuania, Latvia, Denmark and Finland, said that if WHO was to deliver results and remain relevant, Member States and the Secretariat needed to become more effective and focused and take true ownership of the reform. To that end, they must work together to ensure a manageable number of agenda items and an adequate degree of preparation for governing body meetings, including the timely publication of documents. Proposals for agenda items and draft resolutions should be assessed with an eye to whether they were in line with the General Programme of Work and the programme budget, which set the Organization's strategic direction. To enhance Member State ownership of the programme budget, clear links between it and any proposed agenda item or draft resolution should be identified. Lessons could be learnt from regional efforts to improve governance – for example, the European Region was using a rolling agenda with a view to improving long-term planning and had begun the process of sunseting resolutions in order to reduce the reporting workload.

Ms DUSSEY-CAVASSINI (Switzerland) expressed support for the proposals made by the representatives of Norway and Germany concerning, respectively, progress reports and criteria for the inclusion of urgent items and late resolutions.

Dr SAMMAK (Syrian Arab Republic),¹ expressing support for the proposal by the member for Lebanon, suggested that agendas might be divided into groups of items dealing with such topics as disease and health management policies, technical issues, WHO reform, development policy, and financial and legal affairs, each to be considered by a subcommittee, which would then report to the plenary for a decision.

On another note, he expressed gratitude to the Secretariat for its swift response to the escalating needs of the Syrian people and for its effective participation in the delivery of medicines and medical supplies to insecure areas. He urged the Secretariat and Member States to speak out against the illegal entry of medicines and vaccines and to call for the lifting of economic sanctions in the case of medical supplies for the Syrian people.

Mr CORRALES (Panama) said that progress reports should be submitted only to the Health Assembly, as suggested by the representative of Norway, and that consideration might also be given to making such reports available on the WHO website well before the Health Assembly.

Mr SEN (Turkey)¹ said that application of criteria to ensure consistency between agenda items and the General Programme of Work was crucial. A key issue was how the criteria to manage and limit the number of agenda items were to be applied. While it was reasonable to set a maximum number of agenda items, further clarification was required as to how such a limit would work in practice and what action was to be taken if the number of items that met the agreed criteria exceeded it. Turkey could agree to the 48-hour rule for the submission of resolutions (as recommended in paragraph 32 of document EB134/6). It agreed that an explanatory memorandum should be required for all additional submissions; the Secretariat should support Member States in preparing such documentation, if needed. All proposed changes should be piloted in the Executive Board before being introduced in the Health Assembly.

Turning to national reporting and communication with Member States, he said that Turkey welcomed the idea of a web-based communication platform and looked forward to receiving further information on an overall information management strategy and new systems and methods. It would welcome a searchable database allowing easy access to resolutions and decisions adopted by the governing bodies.

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

Ms BOTERO HERNÁNDEZ (Colombia),¹ noting that a degree of proportionality should exist between the benefits, level of use and costs associated with the governing bodies, said that Colombia would support any initiative aimed at making more efficient use of resources. Endorsing the view expressed by the member for Mexico regarding governance reform, she called for a broader and more specialized discussion of the matter at State level prior to the next Health Assembly.

Mr GALINDO (Bolivarian Republic of Venezuela)¹ expressed support for the proposal by the member for Brazil and the comments by the member for Cuba regarding the need for a balanced approach to agenda items.

Mr ROMERO PUENTES (Cuba) said that, in the light of the Director-General's comments, he would not pursue the idea of extending the duration of Board sessions. Nevertheless, it was worth considering an extension of one or two days, which in the case of the current session would have obviated the need for night meetings.

The suggestion that resolutions should be introduced only if they were deemed absolutely necessary raised a number of questions. For example, who would decide whether a resolution was absolutely necessary? It would be unacceptable to his delegation that an agenda item proposed by a Member State should be refused if it met the agreed criteria. Noting that further consideration of the issue was required, he said that, among all the suggestions made, his delegation would be inclined to support the proposal by the member for Brazil.

The CHAIRMAN, noting that there appeared to be consensus on a number of matters, asked the Secretariat to formulate a draft decision setting out possible options based on the discussions.

Mr SOLOMON (Office of the Legal Counsel) said that the Secretariat would be pleased to produce a draft decision setting out possible options for implementation during a trial period of two years. In response to the question raised by the member for Argentina, he said that under Rule 9 of the Board's Rules of Procedure, an explanatory memorandum was required not only of Member States, but also of the United Nations and the specialized agencies; it was also required of the Director-General and the Secretariat if they proposed items that were not standing items. That requirement would continue under the proposed new procedure for establishing the agenda. A maximum optimal number of items should not be understood to imply a ceiling but rather a target that could be waived should the Executive Board so decide.

The DIRECTOR-GENERAL observed that the discussion had been very rich and many good suggestions had been made. She had noted that Member States wished to preserve their authority to raise agenda items, which was appropriate. She would, however, encourage them to ensure that agenda items were clearly linked to the General Programme of Work and the programme budget, thus minimizing the need to mobilize additional financial resources, and to use the programme budget as an accountability mechanism. The Secretariat had already introduced a change in its reports on financial and administrative implications of proposed resolutions, providing information on the linkages to different categories of work and programme areas, thereby promoting the horizontal integration of work. It was doing its utmost to implement the wishes of Member States and looked forward to their continued support.

The large number of agenda items was only one reason for the late dispatch of documents. Another reason was the large number of intersessional meetings requested by Member States, which often finished shortly before governing body meetings, leaving insufficient time for the preparation of reports in all six languages. She agreed that improvements could be made to streamline the internal document clearance process. However, she would be reluctant to provide for additional capacities to

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

expedite the production of documents, as suggested by the representative of Norway, because doing so would raise administrative costs, which she was certain Member States would not want. She appealed to Member States always to be mindful of the cost implications of their well-meaning suggestions and of the need to strike the correct balance between the resources allocated for programmes and for administration.

The Secretariat would be pleased to implement agreed options on a trial basis, including best practices of the regions such as rolling agendas and sunseting of resolutions. The suggestions by the members for Lebanon and Brazil, although welcome, would create additional mechanisms and additional work for the Board and its Officers. Furthermore, she was sure that no technical staff appointed by her from inside or outside the Organization would dare to tell a Member State not to propose an agenda item. She therefore urged Member States to use existing governing body mechanisms. Lastly, she agreed that criteria would be useful only if they were respected by all.

The CHAIRMAN said that, if the agenda was too long, the simple reality was that not all items could be considered in the amount of time allotted for governing body sessions. She proposed that further discussion of the item should be deferred pending circulation of the draft decision to be produced by the Secretariat.

It was so agreed.

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

The meeting rose at 12:40.

SIXTH MEETING

Wednesday, 22 January 2014, at 14:35

Chairman: Professor J. HALTON (Australia)

WHO REFORM: Item 5 of the Agenda (continued)

Framework of engagement with non-State actors: Item 5.4 of the Agenda (Document EB134/8)

The CHAIRMAN, introducing the item, said that the views of Member States and non-State actors had been taken into account in preparing the Secretariat report. Owing to the complexity of the modern landscape of nongovernmental organizations, it would be difficult to find a perfect solution; it would perhaps be better to agree on a basic framework that could be amended in future.

Mr REINA (Mexico) recommended that the regulatory framework that currently governed WHO's interaction with non-State actors should be strengthened, particularly with regard to transparency, due diligence, risk assessment and risk management. He supported the development of a web-based register of basic information that would include the non-State actor's name, sources of finance, structure, governance and legal status. He was concerned that progress needed to be made in the discussions on governance reform and requested that a suitable setting should be provided for that purpose, like that afforded by the Programme, Budget and Administration Committee for programmatic and financial reform. An inclusive approach would result in a solid and well structured agreement for submission to the Sixty-seventh World Health Assembly.

Mr ROMERO PUENTES (Cuba) said that the use of the broad term "non-State actors" was problematic since it did not distinguish between the various actors, such as nongovernmental organizations and private sector entities. As previously stated, his delegation wished to clarify the policies applicable to non-State actors: there were documents concerning WHO's relations with private commercial entities, which had been reviewed by the Executive Board; policies on the Organization's engagement with global health corporations, which had been recorded in Health Assembly resolution WHA63.10, and the principles governing relations between the Organization and nongovernmental organizations. In general, the principles being applied were appropriate, although some improvements could be made. He noted that the definitions contained in the report were different from those previously adopted and requested that they should be further discussed in the informal consultations that would be held before the next Health Assembly.

Dr SHAKEELA (Maldives) recognized the work of WHO in developing a more detailed framework of engagement with non-State actors that highlighted transparency and the management of risks and conflicts of interest. The Organization's integrity should not be compromised by such interaction, and any guidelines, policies and procedures adopted within the framework should clearly state the international obligations and responsibilities of each party. She welcomed the proposed overarching principles for engagement with non-State actors and agreed that close collaboration with them would add value to the work of WHO in areas such as evidence generation, knowledge management, information gathering and research. An analysis of previous experiences of WHO in that field would be useful. She looked forward to the development of separate policies and operational procedures for engagement with the different types of non-State actors described in the report.

Ms PENEVEYRE (Switzerland) stressed that WHO needed to adapt to the changing cast of actors in the global health sphere and that it should continue to play its unique normative role. She welcomed the overarching principles outlined in the report, that any engagement should respect the intergovernmental nature of WHO, demonstrate a clear benefit for public health, be conducted on the basis of transparency and prevent conflicts of interest. In order to put those principles into practice, it would be necessary to regulate the Organization's engagement with non-State actors using clear and precise procedures. That was an essential condition for maintaining the reputation of WHO and respect for its mandate.

Dr NCHABI KAMWI (Namibia), speaking on behalf of the Member States of the African Region, expressed appreciation for the work accomplished by non-State actors in his Region but emphasized that WHO should remain an organization composed only of Member States. A clearer definition was needed of the overarching principles that would govern engagement with non-State actors and how they would be applied, particularly in respect of due diligence, risk sharing and management, conflicts of interest and transparency. The definition of non-State actors should be simplified to mean any institution that did not belong to a State. He welcomed the proposal that further consultations should be held before the next session of the Executive Board.

Dr AL-THANI (Qatar) recommended that regional specificities and different country contexts should be taken into account when setting policy in respect of non-State actors. An inventory of the health-related nongovernmental organizations, associations and civil society organizations operating in WHO regions should be established, using unified criteria and models. Technical support should be provided to ministries of health and public health institutions in Member States regarding the establishment of relationships with non-profit organizations. Such support was particularly important in fragile countries where international actors sometimes operated outside national health plans and strategies.

Mr COTTERELL (Australia) welcomed the five overarching principles and four clear boundaries for WHO engagement with non-State actors described in the report and the intention of the Secretariat to enhance transparency, due diligence, risk assessment and risk management. In particular, he welcomed the proposal to establish an online transparency register and the intention that all future due diligence and risk management procedures would be applied at all levels of the Organization and to all types of engagement with non-State actors. He supported the immediate implementation of the actions proposed in paragraph 28 of the report. It would be useful for the Secretariat to provide Member States with the results of any research that it had done on the principles and procedures used by other national and multilateral public organizations in their relationships with non-State actors. WHO's current interactions with non-State actors should be mapped and information provided on how existing rules and procedures could be adapted or revised as part of the new framework. Such work should be undertaken as soon as possible, and drafts of the proposed separate policies and operational procedures should be prepared in time for consideration by the Sixty-seventh World Health Assembly in May 2014 or by the Executive Board at its next session.

Dr VALVERDE (Panama) supported the proposal to continue consultations on WHO's future engagement with non-State actors and noted with satisfaction that transparency, openness and inclusiveness, as well as risk reduction, had been included in the five overarching principles that would guide the Organization in that regard. As a member of the Executive Board's Standing Committee on Nongovernmental Organizations, she supported the suggestion that the documentation presented to it should be published on the WHO website. It would be useful if the Secretariat could develop some creative ideas on how to improve the transparency of the Committee's interactions with the Executive Board, the Secretariat and intergovernmental organizations.

Dr BARBOSA DA SILVA (Brazil) said that definition of clear rules of engagement with non-State actors was a crucial dimension of the reform process. A one-size-fits-all approach to

engagement would not work, as it was important to take into account the differences between non-State actors and to consider those differences in each dialogue with them. Further work was needed on the definitions of different types of non-State actors, but the overall objective of the Organization's engagement was achievable if a well defined process and policy were put in place. He stressed the importance of avoiding conflicts of interest and expressed support for continued discussions on the issue prior to the Sixty-seventh World Health Assembly, particularly with regard to strengthening the definitions of engagement and the different types of actors.

Mr PIPPO BRIANT (Argentina) supported the five principles for engagement outlined in the report and stressed that decision-making should remain the sole purview of Member States. In addition, it was essential for interactions with non-State actors to be transparent and protected from undue influence, risks and conflicts of interest. Recalling the discussions held by the Executive Board at its 133rd session, he reiterated his suggestion that an ethics committee should be established, with the participation of Member States, in order to analyse conflict of interest statements and manage the possible risks that could arise. It was essential for the different types of non-State actors to be divided into subgroups based on their aims, composition, source of financing and other criteria, as stated in paragraph 8 of the report. The participation by non-State actors in official meetings and consultations should be considered by Member States on a case-by-case basis. He welcomed the principles on due diligence and risk management, as set out in paragraphs 23 and 24 of the report, and proposed, in the interests of transparency, that nongovernmental organizations should always have to present their statements for analysis by Member States. He requested that consultations, both for elaboration of the general framework of engagement and for development of the operational procedures applicable to the different types of non-State actors, should be open to all Member States.

Dr BEJTJA (Albania) said that risk assessment procedures should be applied systematically to all types of non-State actors. Transparency in the risk assessment and risk management approach was essential and he would welcome further elaboration of risk management procedures. His country supported the proposals concerning the next steps to reform WHO's engagement with non-State actors contained in paragraph 28 of the report.

Dr MYINT HTWE (Myanmar) said that a clear framework of engagement with non-State actors was crucial as an increasing number of organizations wished to work with WHO. It was vital that any such engagement did not compromise the integrity of the Organization. The five overarching principles were positive, but another that should be considered was whether the aims and approach of any potential partner were in conflict with WHO's policies and general programme of work. Some actors currently worked in competition with the activities of WHO. In order to avoid such occurrences, a detailed checklist was needed to help to analyse risks and potential conflicts of interest. Programme managers in health ministries around the world should also be aware of the list of non-State actors engaged with WHO. He agreed that further consultations on the item should be held before the Sixty-seventh World Health Assembly.

Ms ALGOE (Suriname) supported the statement made by the member for Namibia and agreed that decisions within WHO should be made by Member States alone. Nevertheless, she recognized that it was important to work with non-State actors on global health issues and that it was necessary to develop a mechanism to govern such collaboration.

Dr REYNDERS (Belgium) said that interaction with non-State actors would strengthen the role of WHO in the global health sphere and enable the Organization to address current and future public health challenges using a multisectoral approach. However, it was of the utmost importance to maintain the integrity and objectivity of WHO by protecting it from undue influence by bodies with any real, perceived or potential conflict of interest. He supported the next steps described in paragraph 28 of the report but considered that a proposal for procedures and a risk assessment and risk management

policy that would be applied at all levels of the Organization should be prepared with due diligence and submitted to the next Health Assembly for its consideration.

Dr LIU Yue (China),¹ welcoming the clear definitions contained in the report, said that when undertaking the next steps outlined in paragraph 28 of the report, the Secretariat should take time to analyse the current situation and proceed with caution. For example, she wondered about the amount of work required to clear statements by nongovernmental organizations and how the Secretariat could ensure that the conditions mentioned in the footnote on page 6 of the report would be met if the statements were not cleared in advance.

Ms LANTERI (Monaco)¹ said that the collaboration with non-State actors had been essential for elaboration of the Pandemic Influenza Preparedness Framework and demonstrated that it was necessary to engage with entities other than Member States. The participation of non-State actors did not detract from the intergovernmental nature of WHO. The Secretariat had prepared a very useful report that would help the Organization to improve transparency and manage any risks to its reputation. She supported the proposals contained in the report and was keen to participate in the consultations to be held before the next Health Assembly.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland)¹ said that it would be impossible for WHO to fulfil its convening role if it was unable to engage with all of the actors that were able to contribute to the global health agenda. Member States should continue to have the exclusive right to make decisions within WHO, while other actors could contribute expertise, resources and new ideas, as had been seen in the development of the Pandemic Influenza Preparedness Framework. Transparency was the key safeguard, offering reassurance of the global and public health benefit of all interactions and the preservation of WHO's integrity. The development of a code of conduct, rules of engagement or a general policy that was applicable to all non-State actors would ensure a shared understanding and hence avoid extensive discussions on conflicts of interest during each negotiation. Such a document could be used to identify the purpose and scope of any engagement and whether there were any real or perceived conflicts of interest.

Mr LUTNÆS (Norway)¹ expressed support for the objectives, overarching principles and boundaries described in the report and for the proposed next steps set out in paragraph 28. He welcomed the proposal to hold further informal consultations during which the various elements to be included in policies and operational procedures for different types of non-State actors could be examined.

Dr DAULAIRE (United States of America)¹ strongly endorsed the statement made by the representative of the United Kingdom of Great Britain and Northern Ireland. He fully agreed with the outcome of the informal consultation held in October the previous year, that strengthening the management of engagement with non-State actors must be based on WHO's existing policies, with enhanced systems for increasing transparency and conducting due diligence, risk assessment and risk management. If possible, the framework of engagement with non-State actors should be finalized at the Sixty-seventh World Health Assembly, so that it could be used within the Twelfth General Programme of Work. He encouraged the Executive Board to endorse key elements of the framework, such as the objectives, principles and working definitions, at the present session in order to build momentum and confidence in the process. In addition, the immediate establishment of a transparency registry would provide a solid footing for the next round of consultations. WHO would benefit from a more systematic and transparent identification of risks and conflicts of interest in its interaction with non-State actors; a principled approach with a clear framework of ethics and due diligence was

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

needed. Since non-State actors could provide information and expertise that was beneficial to the work of WHO, individuals from private sector entities should be allowed to participate in advisory groups where they could provide and share relevant information, as long as there were clear and universally applied rules on ethics, transparency and conflicts of interest. For consistency, policies on non-State actors should be applied at all levels of WHO, including in regional offices and hosted partnerships.

Mr BLAIS (Canada),¹ emphasizing the importance of a whole-of-society approach to address public health challenges, said that although increased engagement with all types of non-State actors was needed, it was important to maintain the integrity of WHO and its normative standards and guidelines and to ensure that decision-making remained with Member States alone. He welcomed the progress made and encouraged WHO to accelerate the development of the framework. He considered that a single comprehensive policy and set of procedures should be developed; however, the documents should distinguish between the different types of non-State actors, in order to facilitate due diligence and risk assessment activities. Differentiation was an important tool to ensure transparency and to protect WHO from any real, perceived or potential conflict of interest; a clear methodology would be required in order to avoid subjectivity and ensure consistency in the criteria used.

Ms KUIVASNIEMI (Finland)¹ emphasized the importance of developing new principles for engagement with non-State actors and requested that they be discussed at the Sixty-seventh World Health Assembly, following further consultations with Member States. Maintaining and strengthening the credibility, integrity and objectivity of WHO was of the utmost importance, and she looked forward to further debate on the subject.

Mr BOISNEL (France)¹ said that the overall strategy governing engagement with non-State actors should be approved at the Sixty-seventh World Health Assembly. He welcomed the consultations that had been held and the progress made in the areas of transparency, due diligence and risk management; however, progress in other areas was still lacking. While the report differentiated between different types of non-State actors, he believed it was important to include distinctions based on different types of risk and different types of possible interaction.

Mr SEN (Turkey),¹ welcoming the approach and principles outlined in the report, particularly with regard to due diligence and risk assessment, said that clear benchmarks should be established in order to assess the contribution of non-State actors to global health. The boundaries described in the report were adequate, and clear criteria and operational procedures were needed in order to preserve them. He was in favour of distinguishing between non-profit and private sector organizations; it would be useful if the Secretariat could provide options on that issue for further discussion at the next Health Assembly. He looked forward to receiving a detailed analysis of WHO's current engagement with non-State actors, including a breakdown of the numbers and types of non-State actors, working areas and programmes, information on the financial contributions of both parties and a description of the criteria currently used for the selection of non-State actors to which WHO provided funding. The role of the Executive Board's Standing Committee on Nongovernmental Organizations should be clearly articulated in the new strategy and its documentation posted on the WHO website as outlined in paragraph 28(d) of the report.

Mr KUEMMEL (Germany)¹ said that, by focusing first on the risks and obstacles linked to engagement with non-State actors, the discussion had been started in reverse order. The starting point should be a discussion of why and in what way WHO needed to engage with health-related non-State actors. If WHO was unable to engage with non-State actors, it would be unable to fulfil its leadership role in global health; engaging with non-State actors did not change the Member State-led nature of

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

the Organization. Germany therefore welcomed the proposed framework, including the overarching principles and boundaries, as they would help to protect WHO from undue influence; however, there was a need for further consultations before the next Health Assembly.

Ms GROVES (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, welcomed activities aimed at strengthening WHO's engagement with non-State actors and improving transparency and accountability insofar as those receiving health care services had the right to be involved in all policy decision-making that affected them. The fact that details of that engagement were now available on the WHO website was an important step forward, as was the proposal that non-State actors would no longer be required to submit statements for advance clearance. Dedicated webpages on WHO governing bodies' sessions would promote such engagement, and effective participation could be further facilitated by ensuring access to all documents and allowing adequate time for contributing to consultations. Matters still requiring additional clarification included the definition of a conflict of interest and of different non-State actors and their interactions with WHO. Additional input from non-State actors should also be permitted in the interest of ensuring that the values of transparency and inclusion were reflected in the final framework.

Mr STEWART (Corporate Accountability International), speaking at the invitation of the CHAIRMAN, urged that lessons be learnt from the WHO Framework Convention on Tobacco Control. A main concern was that the framework of engagement detailed in the report de-emphasized the fundamental difference between public-interest nongovernmental organizations and business-interest nongovernmental organizations and set no distinct rules for commercial interests. It therefore failed to meet the objective of improving the quality of engagement while protecting the Organization's independence, integrity and trustworthiness. He recommended that WHO should assert its leadership by clarifying that objective, analysing current policies and internal procedures, as requested by Member States in the consultation the previous year, compiling all available information into one summary document for ease of reference, recognizing and establishing clear safeguards against inherent conflicts of interest of private commercial entities, and reinforcing the primary authority of Member States in setting health policy.

Dr LEGGE (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN and also on behalf of the People's Health Movement, said that the proposed framework was highly flawed: it defined conflict of interest as comparable to a commercial interest in policy-making outcomes; it took into account neither the power nor the modalities of influence exercised by different non-State actors; its consideration of the different faces of private enterprise was inadequate; and it confused risk management with conflict of interest. Bearing in mind that the core issue was the possible perversion of WHO's mandate, all those considerations must be reflected in any risk management strategy. WHO's involvement in the International Medical Products Anti-Counterfeiting Taskforce (IMPACT) also provided a useful case study in terms of protocols that should have been in place to ensure the Secretariat's full awareness of the implications of its relationship with IMPACT. In short, the proposed framework should be reformulated with all those considerations in mind, in the interest of containing the real risks to WHO's mandate.

Dr LHOTSKA (Consumers International), speaking at the invitation of the CHAIRMAN, agreed that it was critical from the public health perspective, as well as politically indispensable, to draw a distinction between public-interest actors and private, commercial and other actors who were guided by the logic of the market and profit-making. The problem was illustrated by the working definitions set out in the report. Public-private partnerships and multistakeholder engagements were also missing, as was the analysis requested by Member States. Another concern related to the inappropriate and irrelevant references to "intellectual bias" and "a fixed policy position" in the context of conflicts of interest, as conflicts relating to interaction with commercial and for-profit interests invariably posed the greatest risks to WHO's integrity, independence and trustworthiness.

Member States might therefore wish to call for an expert meeting on conflicts of interest, with public participation, as part of the series of consultations due to take place in advance of the forthcoming Health Assembly.

Ms CREEDON (International Special Dietary Food Industries), speaking at the invitation of the CHAIRMAN, expressed support for the five overarching principles and the four boundaries for WHO's engagement with non-State actors, as set out in the report. Given the potential of all actors for conflicts of interest, clear definitions and principles were essential in order to reinforce trust in the process of that engagement. Looking forward to the outcome of the discussion, she endorsed the need for due diligence, risk assessment and risk management in order to strengthen WHO's engagement with non-State actors.

Ms KUSYNOVÁ (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN and also on behalf of the FDI World Dental Federation, the International Council of Nurses, the World Confederation for Physical Therapy and the World Medical Association, which, together with her organization, formed the World Health Professions Alliance, welcomed the Secretariat's continuing efforts to advance the critical issue of engagement with non-State actors. The working definitions of those actors, however, excluded such entities as WHO collaborating centres and public-private partnerships. Furthermore, no correlation had been made between the nature and purpose of an organization, and distinctions were irrelevant in view of the intention to apply due diligence procedures and risk assessment to all types of non-State actors. As to participation, it was unacceptable that invitations for nongovernmental organizations to attend meetings in which they were eager to engage should be received only a few days in advance, thereby reducing their ability to provide relevant input. The opportunities for engagement through remote access were to be commended and should be increased. It was regrettable that a decision on the proposed next steps would be taken only at the next Board session, entailing a delay in their operationalization until 2015. She suggested that the Board should designate one of its members to serve as the main liaison for nongovernmental organizations in official relations with WHO.

Dr SILBERSCHMIDT (Senior Adviser to the Director-General), welcoming Member States' support for the next steps proposed in paragraph 28 of the report, said that the Secretariat would start work on them immediately. In response to requests for analysis of current engagement with non-State actors, he explained that the Secretariat had recently published a report describing the current engagement with four types of non-State actors. Acknowledging the request for detailed analysis of relationships with non-State actors, particularly with regard to financing, he said that the Secretariat was proposing to carry out such research as part of the preparations for the web-based register. The Secretariat was also in contact with networks of nongovernmental organizations and private sector focal points and continued to contact other international organizations regarding their interactions with non-State actors. However, if Member States learnt of any best practices in other organizations, they should inform the Secretariat. With regard to revision of current rules, guidance was needed. Lastly, he acknowledged the proposal by the member for Panama regarding the Standing Committee on Nongovernmental Organizations and said that the matter would be included in the forthcoming informal consultations.

The DIRECTOR-GENERAL said that any policy agreed by Member States on engagement with non-State actors would be applied at all levels of the Organization. In the twenty-first century WHO needed to engage with non-State actors in order to exercise the leading and coordinating role in global health and fulfil its constitutional mandate. She welcomed the references to the important role that non-State actors, including civil society organizations and private sector entities, had played in the development of the Pandemic Influenza Preparedness Framework. She reiterated, however, that the policy decisions must be made by the Member States. She welcomed the support for the five principles for engagement. She highlighted the two key areas of activity where Member States had stressed that industry should under no circumstances be allowed to exercise influence: the policy space

that was the prerogative of Member States and technical standard setting. Beyond those two areas, where engagement with non-State actors was possible, the Secretariat would, as requested, further strengthen the conflict of interest and risk assessment procedures and would continue its work on differentiation of actors. With regard to the proposed register of non-State actors, any description would be based on information provided; if any civil society organization saw information that was inaccurate, it should let WHO know. It was relatively easy to identify private sector entities, but the nature of nongovernmental organizations was liable to change. The delivery of statements by nongovernmental organizations would not be pre-screened any more but was subject to rules, and an organization would be subject to sanctions if it broke them. Lastly, she acknowledged that there continued to be conflicting views on whether one comprehensive policy was needed or whether several separate policies were required for different groups. It was important to note that if there were separate policies, the basic principles would be the same. The Secretariat would take its work forward based on an analysis of the views expressed.

The CHAIRMAN took it that the Executive Board wished to take note of the report.

The Board noted the report.

Financing dialogue: Item 5.5 of the Agenda (Document EB134/9)

Strategic resource allocation: Item 5.6 of the Agenda (Document EB134/10)

Financing of administrative and management costs: Item 5.7 of the Agenda (Document EB134/11)

The CHAIRMAN said that, under the three remaining items under Item 5 of the Agenda, the Board was invited to note the report on the financing dialogue (document EB134/9); to review the proposed approach and the principles outlined and provide further guidance, including suggestions for engaging Member States in developing strategic resource allocation (document EB134/10); and to consider the report and provide guidance on the proposed approaches for administration and management budgeting and financing, with a view to their being incorporated into the proposed programme budget for 2016–2017 (document EB134/11). All three items had been discussed by the Programme, Budget and Administration Committee, and the Committee's report on that discussion was to be found in document EB134/3.

Dr CUYPERS (Belgium), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, said that the Committee had noted that the process of the financing dialogue was new and that its design would evolve further, but had nevertheless commended the model and had asked the Board to continue the dialogue, which would ensure the Organization's financial viability and optimize the orientation of available funds towards agreed priorities. It had stressed the need for an effective policy on engagement with non-State actors and for continued expansion of the donor base. The Committee had also asked the Secretariat to continue providing support for the financing dialogue, in particular to furnish comprehensive information on funding gaps through the programme budget web portal and to ensure coordinated resource mobilization for agreed priorities.

Regarding strategic resource allocation, the Committee had expressed strong and broad support for the approach outlined and the proposal to apply the three pillars (robust bottom-up planning, realistic costing of outputs, and clear roles and functions across the three levels of the Organization). The Committee had agreed that further consultations were required before the World Health Assembly in May 2014 and proposed that pragmatic means and the Committee itself be used to facilitate the engagement of Member States. It had considered the possibility of holding an extraordinary meeting and requested the Director-General, in consultation with the Chairmen of the Executive Board and the Committee, to present feasible options for consideration by the Executive Board.

Regarding the financing of administration and management costs, the Committee had noted the current shortfall in the Real Estate Fund. It had endorsed the new definition and categorization of costs in the report and the proposed approach to the allocation as programme-specific (categories 1 to 5) or for the provision of stewardship and governance (category 6). It had stressed the need to ensure accurate budgeting across the Organization for the purposes of developing and maintaining infrastructure. It had asked the Secretariat to pursue its cost-reduction efforts, to apply economies of scale as appropriate and to ensure that those measures had clear benchmarks.

Mr REINA (Mexico), speaking on behalf of the Member States of the Region of the Americas and referring to the issue of resource allocation, said that the reform process presented a historic opportunity for making progress in terms of transparency and accountability. He acknowledged the importance of the recommendation made by the Joint Inspection Unit and the external consultant to strengthen the transparency and accountability mechanisms facilitating Member State oversight. WHO should concentrate on country needs, from the moment it started to formulate a programme to the time it allocated resources for implementation, and should seek an appropriate budget allocation process that was more transparent and that encompassed regional and global levels. The aim was to have clear and transparent criteria for resource allocation, with priority given to technical work in countries. The Region of the Americas proposed the establishment of a working group of regional representatives that would hold at least one physical meeting before the Sixty-seventh World Health Assembly; it should advise on the development of a new strategic resource allocation methodology based on the principles of transparency and accountability and on greater resource predictability at the three levels of the Organization, taking account of the 2006 mechanism for strategic resource allocation and the lessons learnt from its implementation. The group could work on the basis of a Secretariat review of how the 2006 mechanism had functioned. To that end, he awaited the Secretariat's proposal, in consultation with Member States, for how to determine the new strategic resource allocation methodology to be used to establish the programme budget for 2016–2017, in accordance with World Health Assembly decision WHA66(9).

Dr MATCHOCK-MAHOURI (Chad), speaking on behalf of the Member States of the African Region, welcomed the report on the financing dialogue, which provided a comprehensive update on the progress achieved and the challenges that remained with respect to financing the programme budget. He commended the web portal, which was an excellent working tool. It would be important to strengthen the financing dialogue in order to obtain adequate and predictable budgetary resources for the Programme budget 2014–2015. He wished to highlight that disparities between programmes and within categories led to imbalances that affected underfunded programmes for which it was difficult to mobilize donors; poor coordination of resource mobilization efforts could be remedied through stronger advocacy for a broader donor base and confirmation of financial contributions. The Programme budget 2014–2015 was not yet fully funded, a source of major concern; and alignment of programme funding remained a challenge. He appreciated the Director-General's efforts to minimize the impact.

Dr AMMAR (Lebanon), speaking on behalf of the Member States of the Eastern Mediterranean Region, commended the results of the financing dialogue to date: the budget was expected to be fully funded and the new web portal was proving to be an effective means of enhancing accountability and transparency; new ideas had been generated, as had promising mechanisms for achieving better alignment and greater flexibility of financing and a broader donor base. All Member States should be encouraged to adhere to the mechanism of supplements to assessed contributions, but more formal mechanisms of solidarity should be encouraged at the regional level.

Turning to the fair allocation of resources, which had always been a WHO guiding principle and had been translated into two new concepts, bottom-up planning and results-based budgeting, he said that it was important not to place countries with the greatest needs at a disadvantage in terms of budget allocation, effective disbursement and results achievement. Workforce distribution should therefore be reviewed in order to strengthen the capacity of country offices. All those elements were interlinked; they should be given priority and their implementation started in 2014–2015 so that they could be fully

operationalized in 2016–2017. To that end, the Secretariat should establish a working group of internal, and possibly external, experts as soon as possible, in order to review the current mechanism of resource allocation and propose a methodology that was consistent with the reforms. The outcome would be submitted to the Programme, Budget and Administration Committee in May 2014.

The Member States of the Eastern Mediterranean Region had expressed concern several times about the fact that administration and management costs were financed essentially by assessed contributions, even when incurred by programmes financed by voluntary contributions. Such cross-subsidization had worsened over the years, even as the share of voluntary contributions in the total budget had risen, a process that ran counter to the good governance principles of effectiveness, transparency and accountability. They considered that their concern was best addressed by the third option in the external review of WHO's administration and management costs, namely the use of "cost drivers" to allocate a fair proportion of administration and management costs to each programme.¹ For all that, the high cumulated administration costs, which would remain a concern for years to come, should not be hidden. The approach suggested for 2016–2017 of financing stewardship and governance from assessed contributions, while allocating infrastructure and administrative charges to programmes, might be an acceptable compromise. He asked whether the costs of operating the Global Service Centre in Kuala Lumpur had been compared to costs at headquarters and in the regional offices.

Ms VUKOVIĆ (Croatia), speaking on behalf of the European Union and its Member States, was pleased that the financing dialogue had clearly established the fundamental principles of WHO financing: predictability, transparency, alignment, sustainability and accountability. The budget was the central tool for financing, planning, monitoring and accountability; the Member States therefore had to reinforce their ownership of the Programme budget 2014–2015, pursuant to their decision to approve it in its entirety in May 2013. The proposed programme budget for 2016–2017 would require more work and, in that regard, internalizing more robust budgeting processes in order to align organizational results across the three levels was the right approach. The web portal and WHO's commitment to develop it further were welcome developments that would enhance transparency and improve donor understanding of the funding situation and resource allocation at the three levels of the Organization. The Secretariat's proposal to formulate a coordinated resource mobilization strategy was also welcome, as it would strengthen the "One WHO" approach and, like the web portal, help donors to identify funding needs and inform their funding decisions. She urged WHO to broaden its donor base.

Turning to the report on strategic resource allocation, she particularly welcomed the fact that the new methodology would be based on robust bottom-up planning and realistic costing of deliverables, which would help to identify accurately the resources needed at all levels of the Organization. The process of developing the methodology should be driven by the Secretariat, which should draw up concrete proposals and hold "light" consultations with Member States before the World Health Assembly in May 2014. Regarding the financing of administration and management costs, she welcomed the recommendations from the external review, expressed support for the Director-General's proposals to carry them out, and thanked the Secretariat for its commitment to clarify the definitions, effects and consequences of the different rates and detailed costs of hosted partnerships.

Dr SHAKEELA (Maldives) said that the Programme budget 2014–2015 represented a significant but transitional step forward in the reform process; further improvements would be needed for the coming budget cycles. She looked forward to receiving the proposed key principles and steps for strategic resource allocation from the Secretariat working group, and emphasized the need to pay closer attention to technical prioritization and alignment of the Secretariat's work with the needs of Member States. Resources were unevenly distributed between countries and between technical areas

¹ See document EB134/11, paragraph 22(3).

within the South-East Asia Region. The real health needs of countries in the Region had to be critically examined and the level of flexibility with regard to voluntary contributions increased. Maldives, for example, had a low disease burden but faced health service delivery challenges and human resource constraints. In that regard, the Region needed more focused and more effective resource mobilization so as to finance underfunded programmes. Referring to the 2013 discussions of the criteria used to allocate resources within regions, and in view of the evolving health situation and growing country needs, she said that the resource allocation process had to be more effective and the allocation of resources more transparent, especially regarding the criteria and method used to calculate the base allocation; consideration had to be given to strengthening the involvement of Member States in that process.

Dr BARBOSA DA SILVA (Brazil) believed that WHO reform demanded constant work and steadfast commitment from Member States, who were responsible for deciding on and, together with the Secretariat, implementing any changes needed. The report on the second stage of evaluation of WHO reform¹ referred to the positive steps that had already been taken, such as programmatic priority-setting, changes in the terms of reference of the Programme, Budget and Administration Committee, the outcome of the financing dialogue and the change management actions led by the reform support team. The web portal on the Organization's finances contained clear, well presented and objective information and was a model for other managerial tools aimed at improving transparency and accountability. Coordinated resource mobilization across the three levels of the Organization was crucial for effective synergy of efforts aligned with the Organization's priorities. The human resource dimension of the reform process would require Member States to give careful consideration to how they could improve their support for, *inter alia*, WHO staffing policies and assignment of personnel. He endorsed the recommendation of the member for Mexico that a working group be formed on strategic resource allocation.

Dr KARGBO (Sierra Leone) said that, although considerable progress had been made in terms of focus and division of labour, shortcomings remained with regard to resource allocation. Resource predictability and transparency were limited, and resource mobilization was poorly coordinated and inefficient, leading to fragmentation and misaligned financing across the Organization. Strategic resource allocation should be firmly rooted in the principle of equity, support countries with the greatest needs and be directed where WHO could have the greatest impact. Country-level resources should be allocated more strategically by focusing on a smaller and realistic set of programmatic priorities.

Dr OMI (Japan) noted that the Secretariat's report on strategic resource allocation identified clarity of roles and responsibilities as one of the three key pillars of the new methodology, a move that he commended. The division of labour across the three levels of the Organization had been discussed time and time again, and it was clear that it must be linked to resource allocation. Had the Secretariat already started, or was it ready to start, developing a costing mechanism that promoted a more transparent and rational method for allocating resources across the three levels of the Organization?

Mr COTTERELL (Australia) expressed support for the recommendations and observations of the Programme, Budget and Administration Committee on all three items under consideration and, like the previous speaker, wondered what progress had been made with regard to the division of responsibilities. How did the Director-General plan to consult Member States on the issue of strategic resource allocation before a decision was taken? He considered it important that future work be based on a technically sound proposal developed by the Secretariat in line with the principles set out in the report, and urged that further consultations with Member States be conducted as efficiently as

¹ Document EB134/39.

possible, using web-based methods and during scheduled meetings of the Programme, Budget and Administration Committee and of other governing bodies. Regarding the financing of administration and management costs, he asked whether a more detailed report, including information on the proposed differential programme support cost rates, would be submitted to the governing bodies in May 2014.

Ms PENEVEYRE (Switzerland), referring to the issue of strategic resource allocation, noted that forthcoming programme budgets would be stable, making it even more important that resources were used to the greatest effect in order to improve results. She agreed with the three pillars of the new strategic resource allocation methodology and proposed to add a fourth criterion, the value added by WHO. The challenge would be to operationalize those concepts in the limited time available so that the programme budget for 2016–2017 did not become another transitional budget. She favoured an efficient process whereby the Secretariat would develop the new methodology on which Member States would decide. It was also the Member States' responsibility to be aware of what was at stake and to ensure that work progressed rapidly, transparently and constructively. Referring to the financing of administration and management costs, she supported the approach set out in the report and trusted that it would be implemented without delay.

Mr PIPPO BRIANT (Argentina), referring to the financing dialogue, believed that it was crucial to improve the alignment, predictability, flexibility and transparency of financing and to broaden the donor base in order to achieve the priorities set by the World Health Assembly.¹ The web portal provided information on the Organization's results, programmes, budget and financial situation, and it would enhance coordination on resource mobilization and risk planning. The vulnerability inherent in WHO's current financial situation, whereby most contributions came from a small pool of Member States and other donors, was a source of concern. It was therefore important to agree on a framework of engagement with non-State actors, in order to promote funding diversification without putting Member States' priorities at risk.

Turning to the Secretariat's report on the financing of administration and management costs, he said that direct financing from assessed contributions was not the best option. A way had to be found to stabilize funding by diversifying the donor base and strengthening the commitment being built through the financing dialogue. The case had not been made for the proposal to finance stewardship and governance only from assessed contributions. As concerned the Secretariat's report on strategic resource allocation, he endorsed the proposal to base the new methodology on the three pillars proposed. He also endorsed the proposal made by the member for Mexico for a geographically representative physical meeting of Member States before the World Health Assembly in May 2014.

The CHAIRMAN observed that most speakers had welcomed the financing dialogue and the web portal, but had made various suggestions about the process for developing the new strategic resource allocation methodology. Some had suggested that the Secretariat should propose the process; others had requested the establishment of a working group or had sought the Director-General's advice on how to proceed. It had also been suggested that the process should be entrusted to the Programme, Budget and Administration Committee. Regarding the financing of administration and management costs, one Board member had expressed clear support for the third option proposed in the Secretariat report. She asked the Secretariat and the Director-General to give their views on the process in the light of the existing options, constraints and opportunities.

The DIRECTOR-GENERAL said that the three pillars of the new strategic resource allocation methodology were issues that the Organization must address if it wished to be the leader in global health. The division of labour went to the heart of the issues of responsibility, financial allocations and lack of

¹ See decision WHA66(8).

accountability. Unless it was addressed, WHO would not be able to engage in results-based planning and budgeting or foster accountability. She paid tribute to the regional directors for the Eastern Mediterranean and the Western Pacific, who, with the assistant directors-general and others, had led the taskforce on the roles and functions of the three levels of WHO. The taskforce's report, which was available on the WHO reform webpage, had paved the way for the Programme budget 2014–2015. Subsequently, the Regional Director for Europe and the Deputy Director-General had chaired a taskforce on resource mobilization, which had also issued a report, and had prioritized its most important recommendations. At the second financing dialogue, the Regional Director for Europe had presented the concept of Organization-wide coordinated resource mobilization, which now had to be operationalized. Regarding another pillar – robust bottom-up planning – the Regional Director for the Eastern Mediterranean and an assistant director-general had led a taskforce to consider the role of the assistant directors-general and how the bottom-up process could deliver on priorities. When it came to realistic costing, she explained the logic underlying administration and management costs, whereby she should allocate more funds to the 47 country offices in the African Region than to the 11 country offices in the South-East Asia Region. The 2006 mechanism for allocating resources was no longer valid; she was therefore prevented from making strategic allocation decisions once the programme budget had been approved. The formula used to calculate allocations was inadequate for the humanitarian response segment of the programme budget.

Based on her assessment of the current status of work on the three pillars, she suggested that, immediately after the current session of the Executive Board, the Secretariat should work with the regional offices on robust bottom-up planning for the programme budget for 2016–2017. It should pursue the costing exercise so as to establish realistic costs and work towards greater clarity on the roles and responsibilities of the three levels of the Organization. In the immediate future, she considered that the process should be taken forward by the Programme, Budget and Administration Committee, and she would therefore ask one Member State on the Committee from each of the six regions including the Committee Chairman to engage in a light process that she intended to oversee. Most of the work would be done by the Secretariat, which, where required, would call on external advice in certain areas. The working group would report to the Programme, Budget and Administration Committee at its next meeting before moving on to the next stage. She reminded Member States that they did not have to decide on the methodology in May 2014, because the programme budget would continue to evolve.

In response to a query from Mr PIPPO BRIANT (Argentina) about the terms of reference and membership of the proposed working group, the DIRECTOR-GENERAL said that, although she had initially considered involving all members of the Programme, Budget and Administration Committee, cost considerations had compelled her to suggest that the working group should consist of one member from each region. The group would do the technical work, with the help of external experts; the full Committee would then discuss the results and present its conclusions to the Executive Board.

Dr AMMAR (Lebanon), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that, although any decisions on resource allocation per se would be made by Member States, development of a methodology would require expert advice, which he encouraged the Secretariat to seek.

Dr CUYPERS (Belgium), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, said that, if the Committee's next meeting was to be successful, then Member States' concerns would need to be heard; the Director-General's proposal met that condition. Furthermore, objective advice should be sought from independent experts and a model developed comprising various scenarios that took into account the views of Member States and the Director-General, for discussion at the Committee meeting. If those two conditions were met, the Committee's next meeting had every chance of success.

Mr KILANI (Tunisia)¹ commended the report on strategic resource allocation, which aimed to obtain optimal results for all activities. In that respect, he recalled that in 1996, at WHO's request, Tunisia had invested in the establishment of the WHO Mediterranean Centre for Vulnerability Reduction.² The centre was now fully operational but underutilized. In order to stop the waste and mismanagement of resources that implied, Tunisia had long suggested that international training and professional development functions be delocalized to the centre, as had been recommended by the group of experts dispatched to Tunisia by the Director-General and agreed at a meeting between Tunisia's Prime Minister and Minister of Health and the Director-General in Tunis in July 2012. A decision to that effect would be in line with WHO reform, as it involved delocalization, cost efficiency, staff mobility and, above all, staff technical development.

Dr LIU Yue (China)¹ appreciated the transparency and outcome of the financing dialogue, and agreed that alignment between available funds and programmatic priorities required further analysis in order to ensure adequate funding for all priority areas. Regarding resource mobilization, the donor base should be gradually expanded on the basis of a more complete framework of engagement with non-State actors so as to avoid potential conflicts of interest and risks. Referring to the Secretariat's report on strategic resource allocation, she expressed support for the three pillars of the new methodology, which would help to strengthen transparency and accountability. The Secretariat should ensure full cost recovery, especially in respect of hosted entities, which should not add to the Organization's administrative and management burden. She welcomed the efforts made to lower administration and management costs. With regard to the funding of infrastructure and administration support, she asked whether the precise differential programme support cost rates for each donor would be known only after donors had submitted the plan of earmarked funds and whether that would lead to negotiations with donors in exceptional cases.

Ms KOROTKOVA (Russian Federation)¹ said that the financing dialogue was an important tool that should be used for funding budgets for 2014–2015 and in the future. The web portal was intended to provide access to up-to-date results, but it could become a powerful accountability tool if detailed information on the Organization's use of funds was included. The Secretariat's comprehensive report on strategic resource allocation would serve as the starting point for drafting the proposed programme budget for 2016–2017. In line with the principle of fairness in resource allocation, the Organization must include all countries when assessing country needs. Even countries with good health indicators and high income levels wanted to improve the health of their population and expected to benefit from their participation in the Organization, first and foremost in the form of global and regional public goods. Those countries could make financial contributions or participate in the development of best practices, cutting-edge technologies and effective strategies. The report stated that regional offices would include the "adaptation of global policies, norms, standards and guidelines to the specificities of the region"³ but did not clearly set out the contributions to be made by the regions. There were no provisions for regional offices to contribute to the development and creation of intellectual and public goods. Her country and other countries in the European Region wished to expand evidence-based knowledge in priority areas such as the prevention and control of noncommunicable diseases, improvement of primary health care, strengthening of health systems, public health and healthy ageing. Her delegation proposed that resource allocation should also cover the contribution by regional offices to the development of global policies and standards, and that wording to that effect should be added to the paragraph in the report. Specific criteria should be used to allocate resources among the

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

² Now known as the Mediterranean Centre for Health Risks Reduction.

³ Document EB134/10, paragraph 18 (2).

seven main offices for the development of public goods, in order that each office could make use of the resources for the benefit of all. Such efforts would be easy to evaluate based on results.

Ms STIRØ (Norway)¹ said that the financing dialogue had achieved a growing sense of collective responsibility for aligning available funding with priorities. Nevertheless, challenges remained when it came to distributing funds across categories and programmes, underscoring the need for robustness and flexibility in each category. Although she understood the need to ensure continuity at the beginning of the biennium and noted that 80% of assessed contributions had been allocated to that end, she wondered whether those allocations could be changed later in the budget cycle if the category concerned became fully financed through voluntary contributions. Coordinated resource mobilization to fill the remaining gaps would place new demands on all concerned. To achieve strong coordination of fundraising activities, the Secretariat had to play a leading role; the new approach would require significant changes in behaviour on the part of the Secretariat, Member States and other contributors. A critical factor of success would be the development of a budget with a complete results chain, including costing of outputs and division of labour throughout the Organization, that would also serve as the basis for the allocation of resources across WHO. The three pillars of the method proposed were likely to further that end. Regarding the way forward, she preferred an effective and smooth process. It was important not to have another transitional programme budget, which could undermine the progress made thus far. The Director-General's proposal for a light process appeared to be a good middle ground in that respect.

Ms BLACKWOOD (United States of America)¹ expressed appreciation for the web portal, endorsed the recommendations made by the Programme, Budget and Administration Committee, and expressed support for the process proposed by the Director-General in respect of strategic resource allocation and the principles outlined.

Mr BLAIS (Canada)¹ asked the Secretariat for more information on how, and at what point during the biennium, it intended to inform Member States about ongoing financing gaps. Could the web portal provide not just figures but also strategic analyses of gaps?

Mr KUEMMEL (Germany)¹ recalled that resolution WHA66.2, adopted by the World Health Assembly in May 2013, had requested the Director-General to submit regular reports on the strategic allocation of flexible funding through the Executive Board, and asked how flexible resources had been strategically allocated to date. In his view, the success of WHO reform depended to a large extent on whether the Organization could move from the current transitional programme budget to a robust programme budget with costed outputs for the next biennium. That would require clear progress on the three pillars of the new strategic resource allocation methodology. He endorsed the proposal made by the member for Mexico for a light consultative process, namely an extended meeting of the Programme, Budget and Administration Committee before the World Health Assembly in May 2014.

Mr SEN (Turkey)¹ acknowledged the Secretariat's efforts to increase funding alignment, predictability, flexibility and transparency through the financing dialogue, and was very pleased with the web portal. The Organization's success in securing funds for the current biennium could be attributed to the positive effect of the financing dialogue. The dialogue did not, however, mitigate the risks associated with the narrow donor base and might even mask future threats.

Strategic resource allocation was an important factor in risk mitigation, and the three pillars of the new methodology outlined in the Secretariat's report were promising in that regard. The initial principles of resource allocation referred to in the report appeared to be reasonable and offered a sound basis but required further development. Additional work was also needed in order to establish a

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

mechanism for adjustment between country needs and global and regional priorities and commitments. Given the time left, it did not appear possible to have fruitful discussions at the next World Health Assembly and subsequent regional committee sessions, which would require details of the budget and allocation mechanism for the next biennium. One option would be to schedule an extra day at the Programme, Budget and Administration Committee meeting, open to Member States wishing to join; web-based consultations and mission briefings in the coming months could feed into the discussions in May. It was the Member States that had requested better strategic resource allocation, and it was therefore for them to decide, drawing on the expertise of the Secretariat and external experts where needed.

Turning to the issue of administration and management costs, which had been budgeted in a separate category in the current programme budget, he noted that the external review had found shortcomings in that approach. He therefore welcomed the proposal to budget administration and management costs under each technical category. Separating stewardship and governance costs under category 6 would be one option; another would be to give further consideration to partial cost recovery from programmatic areas. At present, almost all administration and management costs were financed from assessed contributions. That might change, however, with the application of charges to voluntary contributions. It seemed reasonable to have different types of cost recovery formula for the sake of equity, but those formulae should be adjusted carefully in order to preserve funds and restrict leakages.

Dr FABBRI (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN and on behalf of the People's Health Movement, said that, although the financing dialogue had brought some benefits in terms of a more coordinated mobilization of funds that was more closely linked to the programme budget, it was at best a stop-gap measure. The transaction costs associated with holding the dialogue and managing the mix of revenue sources were huge in terms of senior staff time and cash expenditure; major donors, including large Member States, private philanthropists and corporations, continued to exercise undue influence over WHO's programme, significantly reducing its autonomy as a Member-State driven Organization; and important initiatives decided by the World Health Assembly were being held up for lack of funding. The financing dialogue was predicated on a continued freeze on assessed contributions, which was one of the fundamental causes of dysfunction at WHO. The second-stage evaluation had clearly warned Member States to take their duty of care to the Organization more seriously. It had encouraged them to increase assessed contributions substantially and to augment the flow of voluntary contributions to the core account. With no commitment to a real increase in assessed contributions, any reform proposal would remain ineffective in the long run. She urged Member States to insist on sustainable financial mechanisms through adequate untied funding of WHO.

The CHAIRMAN, summing up the debate, noted agreement on the importance of the financing dialogue. With regard to strategic resource allocation, a group representing the regions would work together with the Chairman of the Programme, Budget and Administration Committee and the Secretariat, calling on technical financing experts as appropriate and necessary. Mission briefings and an extended Committee meeting in May 2014 had also been requested in order to ensure that Member States were kept abreast of all developments in that regard. She took it that the Executive Board agreed with her understanding.

It was so agreed.

The Board noted the reports.

(For adoption of a decision, see the summary record of the twelfth meeting, section 4.)

The meeting rose at 17:30.

SEVENTH MEETING

Wednesday, 22 January 2014, at 18:40

Chairman: Professor J. HALTON (Australia)

PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 8 of the Agenda (continued)

Monitoring the achievement of the health-related Millennium Development Goals: Item 8.1 of the Agenda (Documents EB134/17 and EB134/17 Add.1) (continued from the fourth meeting, section 4)

Dr NCHABI KAMWI (Namibia) said that the number of maternal and newborn deaths could be greatly reduced by: increasing the number of available skilled health workers; making the necessary equipment available; and, in his country, providing waiting facilities for expecting mothers near health facilities. He noted with concern that in some African communities herbal medicines were used to induce labour, potentially causing hypertonic contractions and resulting in intrauterine fetal deaths and excessive bleeding. The Secretariat was requested to review the matter and assist with research into the herbs being used.

Dr BAYE LUKONG (Cameroon), noting that deaths in the neonatal period constituted a high proportion of the mortality of children under five years of age, welcomed the report on the development of the draft action plan to end preventable deaths. Although child mortality had been reduced, progress in reducing neonatal mortality rates was slow, as was the case in her country. Insufficient emphasis was being placed on specific interventions to improve newborn health. She strongly supported the development of the draft action plan, as it would complement the Global Strategy for Women's and Children's Health by focusing on maternal and newborn health around the time of birth. Given the importance of the topic, she proposed that it be considered as a separate item by the Sixty-seventh World Health Assembly.

Dr KAMALIAH MOHAMAD NOH (Malaysia) noted the substantial but uneven progress towards reducing child and maternal mortality and improving nutrition. Intensified collective action and expansion of successful approaches would overcome the challenges posed by existing inequities and inequalities. The draft action plan on newborn health clearly articulated a vision and objectives, proposed actions and research priorities, and provided a monitoring framework. She agreed with the proposed approach to finalizing the document for submission to the Sixty-seventh World Health Assembly.

Dr AMMAR (Lebanon) said that it was clear from the reports that, although substantial progress had been made globally towards attaining the health-related Millennium Development Goals, large gaps persisted among and within countries. He commended the work of the independent Expert Review Group, in line with the recommendations of the Commission on Information and Accountability for Women's and Children's Health; proper follow-up of those recommendations was required. A better understanding of the contextual factors hindering progress was needed, with work on cross-cutting issues such as the social determinants of health and health system strengthening. Particular attention should be paid to countries experiencing long-lasting conflicts and political unrest, with better coordination among United Nations bodies and development partners, and sustained support adapted to the complex emergency situations in the Eastern Mediterranean Region.

Dr OKABAYASHI (Japan) said that health workers and community volunteers in resource-limited settings contributed significantly to the remarkable progress that had been made towards achievement of the health-related Millennium Development Goals. His country's support had included technical cooperation for improving maternal and child health. Although mortality rates for children under five years of age had been falling, the improvement in newborn mortality rates was relatively slow. The development of the draft action plan on newborn health would help to accelerate the reduction of those rates, but such a plan would not be effective without allocation of sufficient financial and human resources.

Mr ROMERO PUENTES (Cuba) said that Cuba's infant mortality rate of 4.2 per 1000 live births in 2013 placed it in first rank in the Region of the Americas. The country had also reached Millennium Development Goals 5 and 6 with respect to improving maternal health and combating HIV/AIDS. Although the development of a global partnership for development in line with Goal 8 was not directly connected to health, his country had sent more than 40 000 health workers to 64 countries and was working on training 100 000 doctors over 10 years to support neighbouring countries, which was equivalent to a contribution of several million United States dollars.

Dr SHAKEELA (Maldives) said that Maldives was the only country in South-East Asia to achieve five out of the eight Millennium Development Goals. The targets were set for 2015 with 1990 values as benchmarks, but she cautioned against the use of global indices, aggregates and benchmarks for measuring progress in tackling regional and local challenges. Some countries in the South-East Asia Region could be categorized as having achieved Target 7.C on sustainable access to safe drinking water and basic sanitation despite the fact that their water was contaminated. Disregard for individual country vulnerabilities and characteristics could allow countries to regress on achievements made towards other health-related Goals, and data dissociated from geography yielded only a partial picture. A holistic and systematic approach was important for ensuring that countries that had made impressive gains did not backslide. The Government of Maldives wanted the sustainable development goals to be a continuation of the Millennium Development Goals. Setbacks to attaining the Millennium Development Goals should be reflected in the formulation of sustainable development goals and the post-2015 development agenda.

Dr CAPAK (Croatia), speaking on behalf of the European Union and its Member States, said that the rate of progress towards the achievement of health-related Goals had to be accelerated. The number of women and children dying from preventable causes continued to be unacceptably high. Substantial progress was required on maternal health; faster achievement of Target 5.B on universal access to reproductive health would contribute significantly in that respect.

Newborn mortality was becoming the leading cause of death in children under five years of age, and further action was needed in the context of a continuum of care encompassing reproductive, maternal and child health, and on interventions to reduce maternal mortality. He welcomed the accelerated response to neonatal health envisaged in the draft action plan on newborn health, but sought further information on the process of its further elaboration and the synergies with related initiatives. Implementation and reporting on the action plan should be country-led and follow the aid-effectiveness principles of the International Health Partnership; parallel structures at global and national levels should be avoided whenever possible.

Great progress had been made towards Goal 6, yet the burden of HIV infection, tuberculosis and malaria remained high. As more people living with HIV were eligible for treatment under WHO's consolidated guidelines on the use of antiretroviral medicines for treating and preventing HIV infection, issued in 2013, the European Union remained committed to universal and equitable access.

Strong country ownership, inclusive leadership, gender equality, a human rights-based approach and democratic governance were crucial for achieving the Goals. To accelerate progress, more attention should be paid to other cross-cutting challenges, including social and environmental determinants of health, discrimination, economic barriers to health services, strengthening integrated and quality health systems, and universal health coverage.

Dr MYINT HTWE (Myanmar) said that progress towards the achievement of the health-related Goals was appreciable, but perception of the current situation depended on the reliability of the available data and the existence of good health information systems. The Secretariat should accord appropriate importance to streamlining and strengthening country health information systems, especially with respect to improving data analysis capacity and using the information to take appropriate action at all levels.

Document EB134/18 noted that it was unclear how or whether agreement on targets would be reached at the current stage. There was no universally accepted methodology for setting future targets and the task was all the more difficult at the global level. The most important was to implement programmes in a systematic, cost-effective manner with simple and feasible monitoring mechanisms to steer the course of action.

Mr PALOPOLI (Argentina) welcomed the proposed consultation process on the draft action plan on newborn health. He outlined his Government's policies on maternal and child health and their results. Comprehensive policies to ensure access to health care for children had led to a sustained reduction in the mortality rate for children under five years of age. Policies ensured that births took place in health facilities that could provide essential obstetric care as defined by WHO. Its immunization strategy, with 16 vaccines, was cost-effective and had substantially reduced infant mortality rates. Some 95% of newborns received adequate nutrition through breastfeeding, and active income-transfer policies ensured universal access to food for children. Other policies included the provision of counselling by public health services nationwide to uphold the individual's right to take reproductive health decisions, and all patients infected with HIV had guaranteed free access to antiretroviral treatment. Mortality and incidence rates were in line with the targets for 2015. Timely diagnosis for pregnant women and their sexual partners was important, as were timely interventions for preventing mother-to-child transmission of HIV and early diagnosis and treatment of infected children. His Government supported WHO's recommendation on the adoption of triple antiretroviral treatment for life post-partum. His country had also made progress against tuberculosis, malaria and Chagas disease and had taken the initiative to produce medicines for the latter.

Mr KASE (Papua New Guinea) said that, although many small Pacific island countries were well on their way to achieving the health-related Goals, his country's progress was not encouraging. His Government had responded to the Director-General's call for the Commission on Information and Accountability for Women's and Children's Health to improve reporting and accountability in a way that fit his country's specific situation. It had developed roadmaps and monitoring frameworks to ensure that appropriate programmes were implemented to improve child health and lower the maternal mortality ratio. The Organization's excellent support had ensured that the process corresponded to the country's needs, but the support could not be maintained for lack of resources. Maternal and child health remained a priority for the Government, but resources were being allocated to other important areas and it was unlikely that his country would meet the targets of the Millennium Development Goals. He called on the Secretariat to increase its technical support in order to help the country come closer to meeting the targets by 2015.

Dr BEJTJA (Albania) said that the Millennium Development Goals had proved to be a powerful driver in improving the health of populations. He supported the draft action plan on newborn health as outlined in the report (document EB134/17 Add.1). The experience and input of other United Nations bodies and non-State actors could be useful to the process.

Ms PENEVEYRE (Switzerland) said that, in order to consolidate and accelerate the progress made towards achievement of the Goals, all determinants of health should be taken into account to a greater extent with renewed commitment to combat health inequalities, such as malnutrition, which underlay nearly half the deaths of children under five years of age, and gender-specific inequalities with regard to sexual and reproductive rights. She supported the inclusion of health in the post-2015 development agenda, with the aim of maximizing health for all at all stages of life. Priorities included

universal health coverage, continued efforts towards the achievement of the Goals, sexual and reproductive health for all, controlling noncommunicable and neglected tropical diseases, and improving mental health.

Ms STIRØ (Norway)¹ said that, despite substantially lower mortality rates for women and children globally, efforts to reach Goals 4, 5 and 6 needed urgent expansion, leadership, collaboration and monitoring. More investment was also needed to capitalize on the opportunities for extending high-impact interventions to reach the most vulnerable people. Her Government had answered the United Nations Secretary-General's call to act since the launch of the Every Woman Every Child initiative by contributing to the newly established Reproductive, Maternal, Newborn and Child Health Fund, hosted by UNFPA, with the aim of supporting partner countries' priorities in delivery of health services to women and children. The Fund would provide catalytic resources to fill gaps identified by countries.

Results-based financing in health offered a promising approach to improving health service delivery, and her Government was committed to the multi-donor Health Results Innovation Trust Fund hosted by the World Bank. The results of pilot projects showed better health service delivery to women and children. The goal was to scale up such projects to country level.

She urged the adoption of innovative approaches with non-State partners, underpinning WHO's vital role, in the common effort to achieve the Goals. That should be given the highest priority. Any unfinished business should be carried forward to the post-2015 agenda.

Mrs EL BERRAK (Morocco)¹ said that her country had reduced maternal and child mortality by two thirds in the 20 years from 1992 to 2011, with significant progress achieved especially in the previous five years. The national action plan for 2012–2016 aimed to accelerate the reduction of maternal and newborn mortality rates, containing measures that focused on rural and underserved areas, and sought to ensure continuity of care for women and children. Her country was on track to attain the health-related Goals and was grateful for the support of the Regional Office for the Eastern Mediterranean and the regional initiative for accelerating progress towards Goals 4 and 5. The initiative had targeted nine countries with the highest mortality rates and would reach its objectives with the generous assistance of the donors.

Mrs PEAN MEVS (Haiti)¹ acknowledging with gratitude WHO's continuing support to her country, applauded the draft action plan on newborn health, whose adoption by the Health Assembly she recommended. She noted that her Government had decided to open two midwifery schools in order to build capacities in the field of preventive care for women and newborns.

Mr TSOY (Russian Federation)¹ said that his Government was accelerating efforts to reach the Goals by 2015. It would add pneumococcal vaccination for young children to the national vaccination schedule in 2014 and varicella vaccination in 2016. Malaria continued to affect public health and national economies on a global scale. It was supporting the programme to eliminate malaria in the European Region by 2015, had a comprehensive programme against HIV infection and was fulfilling its obligations accepted in the United Nations Declaration of Commitment on HIV/AIDS in 2001. New guidelines on HIV treatment and care had been developed in line with WHO's recommendations and access to antiretroviral treatment had been significantly increased. The Government supported international initiatives to strengthen health care systems, infectious disease monitoring, research, measures against outbreaks of avian influenza, and control of HIV/AIDS, tuberculosis and malaria, to improve access to prevention and treatment of communicable diseases and to prevent epidemics associated with natural and man-made disasters.

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

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland)¹ said that substantial progress was still needed for the Goals to be met. Newborn mortality would soon account for half all deaths in children under five years of age, and the international community had to take more action. She strongly welcomed the accelerated response to neonatal health set out in the draft action plan on newborn health and welcomed the proposed consultative process. She expressed the hope that the Health Assembly would adopt the final draft plan in May 2014.

Dr DE BERNIS (United Nations Population Fund) said that the Beyond 2014 Review of the International Conference on Population and Development had shown that, despite improvements in access to sexual and reproductive health in the previous 20 years, gross inequalities persisted, especially for the most disadvantaged women and girls. Their health and well-being must be given priority in the post-2015 development agenda, and in proposals related to universal health coverage. The new ambitious target of eliminating preventable maternal mortality proposed for the post-2015 development framework would entail intense country consultations. A second State of the World's Midwifery report would be issued at the International Confederation of Midwives' triennial Congress (Prague, 2–5 June 2014). Both initiatives, in conjunction with the Countdown to 2015 report, would contribute to the post-2015 dialogue on universal health coverage. Achieving gender equality and promoting sexual and reproductive rights of women and young people was the surest route to the fulfilment of human rights, dignity and well-being for all people.

Ms HOLLY (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, said that the Health Assembly should take a close interest in the draft action plan on newborn health and ensure not only its endorsement but also its translation into political action. Newborn mortality was an excellent indicator of the strength of a health system and of progress towards universal health coverage. Reducing newborn mortality rates required a comprehensive primary health care system that could provide high-quality round-the-clock care before, during and after labour. Because newborn mortality rates were highest in the poorest communities, services needed to cover the poorest people and not rely on out-of-pocket payments. The draft action plan sought to ensure that no baby was born without the presence of a skilled health worker. Newborn, maternal and child health should be an integral part of work towards universal health coverage and the post-2015 development agenda, with goals and targets established. She urged Member States to support the draft action plan, participate in the consultations, and ensure that the final product led to concrete results.

Dr LUCHESI (World Vision International), speaking at the invitation of the CHAIRMAN, said that the draft action plan should advance the goals of the Every Woman Every Child movement and global initiatives such as the United Nations Commission on Life-Saving Commodities for Women and Children, the WHO Commission on Information and Accountability for Women's and Children's Health, and UNICEF's progress report on Committing to Child Survival: A Promise Renewed. Coordination was also needed with the global targets set in the comprehensive implementation plan on maternal, infant and young child nutrition endorsed by the Health Assembly in resolution WHA65.6. The draft action plan's goal to end preventable newborn deaths by 2035 was in line with his organization's call for Member States to set a high-level goal in the post-2015 development agenda to end all preventable maternal, newborn and child deaths. The newborn mortality rate should be included as an indicator in any agreed monitoring framework for universal health coverage, and newborns should be a high priority in efforts to enumerate every newborn and every child. He urged Member States to support the further elaboration of the draft action plan, and asked that they submit a draft resolution, endorsing the final text, for consideration by the Sixty-seventh World Health Assembly.

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

Mr CANINI (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN and on behalf of the People's Health Movement, said that the draft action plan was comprehensive and underlined the need for a publicly funded, integrated health system based on the principles of primary health care. It thus ran counter to the ambiguous constructions of universal health coverage, which treated mixed public–private health systems with competitive, stratified health insurance as one of several valid ways of delivering health care. He took issue with the statement in document EB134/18 (paragraph 27) that the “position of health is so far well established” as reflecting an attitude of intersectoral competition rather than collaboration, an approach that did not promote collaboration on structural determinants of health. Improving the health of the world's population would depend on achieving important goals in other sectors, and intersectoral competition did not facilitate cooperation to that end.

Dr KIENY (Assistant Director-General) acknowledged the dramatic progress being made in many countries but said that many would not achieve the Millennium Development Goals' targets by 2015. Speakers had highlighted common challenges, including a lack of resources, the social determinants of health, and weak health systems. Such challenges loomed particularly large in countries affected by conflict, which hampered progress towards the health-related Goals. It was essential to sustain the major gains made by many countries. Maintaining the momentum in eliminating poverty-related diseases and preventable deaths should remain a core element of the post-2015 development agenda. Online consultations on the draft action plan on newborn health would begin immediately after the session of the Board, and she urged all interested parties to submit their comments so that the Secretariat could submit a revised draft to the Health Assembly in May.

She concurred with the expressed need to strengthen national health information systems in order to be able to monitor progress towards targets accurately at global, national and subnational levels. Those systems should include well functioning civil registration and vital statistics systems, which were currently in place only in a minority of countries.

WHO was committed to supporting the implementation of the recommendations of the Commission on Information and Accountability for Women's and Children's Health in spite of limited resources. It would also continue to provide a supportive Secretariat to the important oversight work of the independent Expert Review Group.

The Board noted the reports.

Health in the post-2015 United Nations development agenda: Item 8.1 of the Agenda (Document EB134/18)

Dr AMMAR (Lebanon), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the report provided a good synthesis of discussions on the post-2015 development agenda, in which health would be considered a pillar of sustainable social and economic development.

With regard to the 12 goals and 54 targets formulated by the High-level Panel of Eminent Persons on the Post-2015 Development Agenda, he noted that goal 4 was to “Ensure healthy lives”, and six other goals related to health. The targets associated with goal 4 involved a mixture of outcome, output and process indicators; they would have to be reformulated in order to expedite implementation.

WHO needed to align health-related goals and targets with the outcome of the WHO and UNICEF thematic consultation on health and to accommodate the recommendations of regional committees as much as possible. Sustaining the achievements made towards the Millennium Development Goals was a starting point, but tackling noncommunicable diseases had to be introduced and universal health coverage emphasized as both an end and a means to an end, just as health was considered an outcome by itself and a means to economic and social development. He asked the Secretariat to keep health ministers informed and to follow up with foreign affairs ministers and the permanent missions to the United Nations in New York.

Mr COTTERELL (Australia) said that, in line with new geopolitical realities, discussions on the post-2015 development agenda covered a wider range of views than had been the case for the Millennium Development Goals. In order to build on those, the new framework should respond to the highest priority development challenges yet be concise and compelling. In line with the outcome document from the Special Event on progress towards achievement of the Millennium Development Goals held in 2013, his Government supported a single unified development framework with a limited set of goals aimed at eradicating poverty in the context of sustainable development. The new framework should deal with barriers to development, such as poor governance, insecurity and instability; promote women's economic empowerment; and meet the needs of people with disabilities. Investing in health enabled economic growth and reduced poverty. Equitable access to health care would help to ensure that all people enjoyed the benefits of the post-2015 agenda. The debate on the design of new post-2015 goals was still in its early stages, and his Government was carefully considering those discussions.

Dr KAMALIAH MOHAMAD NOH (Malaysia) said that the processes undertaken to outline a global framework for health in the post-2015 development agenda had shown WHO's commitment to securing the place of health as a vital part of the next generation of global goals.

She fully supported the need for a single framework and a set of goals based on the tenets of sustainable development that were universal and applicable to all countries. Discussions of universal health coverage, maximizing health across all stages of life, sexual and reproductive health and rights, and noncommunicable diseases were essential to shaping that framework. It should also include measures to accelerate and complete work to achieve the health-related Millennium Development Goals.

Ms DÁVILA CHÁVEZ (Mexico), speaking also on behalf of Argentina, Denmark, Netherlands, Norway and Sweden, said that consideration of the post-2015 development agenda should not displace the need to fulfil obligations to achieving the current Goals, particularly those towards which less progress had been made. The post-2015 agenda needed to protect the right to health for people of all ages. Health was important as an end in itself, but also for development. Future development goals should be designed so that their achievement would require consistency, shared solutions and accountability across multiple sectors. Her Government was committed to increasing life expectancy and good health for all, using a multisectoral approach to the social determinants of health. Universal health coverage was crucial for ensuring accessibility of services and medicines. Accelerating progress towards the achievement of the Goals was not enough. Reducing the burden of major noncommunicable diseases and ensuring sexual and reproductive health and rights were central to the post-2015 development agenda, and WHO should promote the inclusion of health-related priorities in that agenda. She urged the Secretariat to play, in coordination with other health organizations and the Member States, an active role in the upcoming intergovernmental negotiations on the future development agenda.

Ms ALGOE (Suriname), speaking on behalf of the Union of South American Nations (UNASUR), said that a healthy population was a precondition for equitable and inclusive development, and therefore health needed to play a central role in the future development agenda. The economy and the environment had a direct impact on health. The post-2015 development agenda needed to promote multisectoral policies that dealt with the social determinants of health. Universal health coverage should not be limited to medical assistance to the sick but should cover prevention, health promotion and access to treatment.

The post-2015 agenda should also include unachieved Millennium Development Goals. It was the duty of all Member States to fulfil the commitments that were important to their populations by ensuring access to universal, inclusive and equitable health systems, promoting preventive health measures and increasing life expectancy. The health sector was capable of articulating the related agendas from the perspective of the social determinants of health and universal health coverage while stressing the need for equitable quality services.

Dr OKABAYASHI (Japan) said that successful development without health was impossible, although health was usually taken for granted. His Government had launched the Strategy on Global Health Diplomacy in May 2013, recognizing that health was indispensable to human security. It prioritized global health in its foreign policy and thus contributed to building a world where every person could receive basic health care services thanks to universal health coverage. It urged leaders of Member States to take the “health in all policies” approach and incorporate health into the post-2015 development agenda.

Mr ROMERO PUENTES (Cuba) said that inclusion of health in the post-2015 development agenda should not prevent the achievement of the Millennium Development Goals. Health was at the core of discussions of sustainable development. The way that sustainable development differed from other development models currently in use needed to be clarified. The new development goals needed to include goals for noncommunicable diseases, equity and health rights, and universal access to safe water and sanitation. Universal health coverage was a central objective and should be an operational goal. The post-2015 development agenda should view health and well-being for all and the achievement of maximum health at all stages of life as a global goal.

Dr MATCHOCK-MAHOURI (Chad), speaking on behalf of the Member States of the African Region, said that the post-2015 development agenda must maximize the position of health in order to promote universal health coverage at all levels in United Nations development programmes, and it must maintain and incorporate a health-related goal along with health indicators into the goals for other aspects of development. A health information system should be developed to ensure better health indicator monitoring.

Dr BARBOSA DA SILVA (Brazil) said that consultation process relating to the post-2015 development agenda needed to take place at national, regional and global levels. He was optimistic about the placement of health at the centre of the new agenda, in the form of universal coverage, and believed that competition between different health issues was essential for defining health objectives and indicators. Millennium Development Goals that had not been attained by all countries should be retained and new challenges, such as noncommunicable diseases, should be incorporated. It was important to know with certainty that the best outcomes for all were being sought. In view of the inconsistencies among health systems, reliable and comparable data were needed for assessing achievement of health goals under the post-2015 development agenda. Synergy between global agendas, the importance of health as an indicator and the results of sustainable development needed to be taken into consideration.

Dr ASADI-LARI (Islamic Republic of Iran) supported WHO’s leading role in arguing for the inclusion of health in the post-2015 development agenda. While most Millennium Development Goals had been reached in many countries, the progress made would have to be followed up vigilantly in some countries in the post-2015 era. Furthermore, achieving universal health coverage and tackling noncommunicable diseases, social determinants of health and health equity should become the new goals on the way to attaining comprehensive and sustainable health at national and global levels.

Mr PALOPOLI (Argentina) said that the new agenda should take into account the way health contributed to development, address the social determinants of health and aim to eliminate inequities. Intersectoral and intergovernmental action was needed in order to generate synergies between public policies and the health sector must play a dynamic role in the process. The links between health and social determinants must be clearly defined. The concept of universal access to health should appear as a goal in the post-2015 development agenda. The right to health meant universal access to health, improved services and care, disease prevention and financial protection for catastrophic events.

Although the definition of overall goals had led to successful alignment of efforts at the international level, it would be important in the next stage to adjust to subnational realities and visualize the inequities between and within countries. Intermediate goals were desirable to help to

determine progress and to adjust public policies. The new agenda should deal with outstanding commitments under the existing Goals, before adding the monitoring of new indicators.

Dr SHAKEELA (Maldives) said that health was a gauge of what people-centred and equitable development sought to achieve and was important as an end in itself. The post-2015 development agenda should clearly articulate the inextricable links between health and development. Synergies between health and other sectors could be augmented through the “health in all policies” approach. The notion of good health was evolving towards maintaining good health rather than solely preventing and treating disease. Health systems needed to adapt to higher expectations and new demographic and environmental challenges, address a broad range of determinants of health, improve the health of disadvantaged and marginalized groups, and meet the specific health needs of people at different stages of life. Young people living in a digitally interconnected world with unprecedented access to information would be driving transformative change. A variety of factors would affect progress on health. Any future health goal must be universally relevant, but targets and indicators must be adaptable to an individual country’s circumstances.

Mr BOISNEL (France)¹ said that, in seeking a more sustainable approach to health development, lessons must be drawn from the efforts thus far made in pursuit of the Millennium Development Goals. Three imperatives needed responses: guaranteeing to all, without discrimination, the right to the best attainable standard of health; strengthening health systems in order to provide access to good-quality and affordable essential services; and taking into account the social, economic and environmental determinants of health. Together those elements formed the goal of universal health coverage that should feature on the post-2015 sustainable development agenda, particularly as it would additionally promote poverty reduction and enhance health globally. Moreover, it was clearly defined and measurable, thanks to the excellent work on indicators done by WHO in conjunction with the World Bank. It was also a broadly unifying goal, which was a vital consideration in the period leading up to the next session of the United Nations General Assembly in 2014. All countries were therefore urged to join in a detailed examination of the subject with a view to achieving a consensus at the Health Assembly in May.

Ms NIU Hongli (China)¹ said that consultations must be further pursued in the interest of ensuring that health was adequately reflected in the post-2015 development agenda, including a greater allocation of resources. New health-related targets should remain consistent with the Millennium Development Goals and take into account the public health impact of socioeconomic change, demographic structure and noncommunicable diseases. With regard to such diseases, more attention should be paid to screening, prevention and control, and the development of indicators. Sufficient attention should be paid to differing political, socioeconomic and health systems in the context of universal health coverage, which should be more clearly defined and for which a measurable and comparable evaluation framework should be developed. Social determinants of health must also be considered.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland)¹ underlined the importance of universal health coverage; it must feature in the post-2015 development agenda as a target under an outcomes-focused health goal. Indeed, expressing goals in terms of outcomes was the only means of assessing the quality of care for all population groups, guaranteeing services to the poorest and most vulnerable, and recognizing health benefits gained through improvements in the social determinants of health.

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

Ms GIBB (United States of America)¹ said that the inclusion of global health in the post-2015 agenda remained a high priority for her Government. The health component of that agenda should build on successes and the work of ongoing programmes with the aim of ending preventable child and maternal deaths and creating an AIDS-free generation. Current efforts to include health as central to development within a coherent, data-driven and measurable framework should be further pursued. Although universal health coverage was an important unifier in the discussion, it was not an outcome in itself; it should be discussed as a goal accompanied by clear health targets and supported by evidence-based interventions.

Mr BLAIS (Canada)¹ stated that unfinished business, including improving women's and children's health, should be prioritized in any new framework in order to preserve the gains of the past decade and ensure that outstanding issues were resolved. Accountability must also be incorporated with a view to the fulfilment of commitments and the achievement of long-term sustainable results. The post-2015 development agenda should preferably comprise a final and single set of goals. Health information systems should be strengthened as a means and prerequisite for achieving all health-related goals.

Mrs TAKAENZANA (Zimbabwe)¹ said that all goals and targets that might be elaborated for the post-2015 agenda must be applicable to all countries and consistent with national laws and development priorities. They must likewise fully respect differing religious and ethical values and cultural backgrounds, in addition to remaining in conformity with universally recognized international human rights.

Mr MWANGI (World Heart Federation), speaking at the invitation of the CHAIRMAN and also on behalf of The NCD Alliance, urged the Secretariat and Member States to champion health goals and a health-in-all-policies approach to the post-2015 development process. The agenda should include the outcome-focused goal of maximizing healthy life expectancy, which would cover mortality, morbidity and disability at all ages in a non-competitive manner. By contrast, universal health coverage was insufficient as the overarching health goal. The framework could usefully contain the agreed target of a 25% reduction in relative mortality from noncommunicable diseases by 2025 and related targets in such areas as obesity, air pollution and transport. The forthcoming comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases would surely provide further guidance on the integration of those diseases into the post-2015 agenda.

Dr MIŠE (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, fully supported the inclusion of universal health coverage in the post-2015 development agenda. Health equity and access to health care must constitute the underlying principles of universal health coverage as a social protection component. Additional work was needed, however, in order to: include, in the disaggregation of the proposed equity measures, such critical dimensions as gender, geography, ethnicity, age and disability; ensure that universal health coverage responded to the needs of everyone, especially vulnerable and marginalized populations; determine clearly the essential package of services falling under universal health coverage; and develop global and national mechanisms for monitoring targets. On those and other issues, health ministries must keep their country's representatives and foreign ministries informed of developments for input into the negotiations on the post-2015 development agenda, with an emphasis on the crucial health-in-all-policies approach.

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

Dr CASSELS (Office of the Director-General), commenting on the discussion, agreed that the context had changed and that it was vital to convey the substance of the current debates to those involved in the final negotiations on the post-2015 development agenda. All goals must be universally applicable and also take into account the lessons learnt from the Millennium Development Goal experience, specifically the benefit of setting a small number of concise goals and the need to measure progress towards their attainment. Work on achieving the health-related Goals must be carried through to fruition by devoting more attention to: the health of women, children, newborns and adolescents; noncommunicable diseases; sexual and reproductive health and rights; maintaining the gains accomplished in fighting AIDS, tuberculosis and malaria; and framing health as a right in the post-2015 agenda, in which equity, gender and the social, economic and environmental determinants of health should also feature prominently. It was vital, moreover, to strike the right balance between maximizing health across the life course through universal health coverage and ensuring that such coverage was a central part of the overall agenda.

Concerning the relationship between health and sustainable development, he rejected accusations levelled against the Organization of prioritizing health over all other considerations; notwithstanding the place of health on its agenda, WHO comprehensively considered all determinants of health and engaged in work linked with other areas, such as safe drinking water, basic sanitation and food security, for which goals were likely to be set with health as an important measure of progress. Member States would be regularly updated on those matters.

Another point emphasized during the discussion was the importance of a manageable mixture of specific goals and targets that would influence and drive work forward. The first step would be agreement on a framework, from which setting goals and targets would flow. As to the centrality of measurement, in the event of controversy over the inclusion of legal identity under the governance-related goal proposed in the report of the High-level Panel of Eminent Persons on the Post-2015 Development Agenda, health might serve as the alternative for keeping vital registration squarely on that agenda.

The DIRECTOR-GENERAL, recalling that the Organization had produced briefing documents and updates, reiterated the crucial role of foreign affairs ministries and other partners in the new negotiating context of the debate. Nothing must be taken for granted, and the importance of health must be continually driven home throughout the final negotiating process. The number of goals currently on the table – she had counted some 140 – was overwhelming, but the Millennium Development Goals experience taught that limiting the number of goals had brought governments together and could lead to the creation of goal-related synergies.

Concerning the important issue of legal identity, civil registration was the indispensable access route to a multitude of services, including health and education. Failings in registration created gaps in data that made it impossible to measure progress, such as vaccination coverage, or plan to meet health needs with the necessary degree of accuracy. She urged Member States to advocate for those matters vigorously during the negotiating exercise.

The Board noted the report.

Multisectoral action for a life course approach to healthy ageing: Item 8.2 of the Agenda (Document EB134/19)

Dr NCHABI KAMWI (Namibia), speaking on behalf of the Member States of the African Region, confirmed the ageing of populations in the Region, which placed additional pressure on already overstretched health systems. A multisectoral approach was essential to the development of strategies for meeting the additional needs of elderly populations, such as access to food, housing and transport. He urged the Secretariat to promulgate and re-emphasize the interventions proposed by the Regional Committee for Africa at its sixty-third session for guiding the implementation of programmes on healthy ageing and care of the elderly, among them the integration of palliative care into primary health care and the prioritization of issues related to population ageing in national

development frameworks. Support from decision-makers must likewise be emphasized as a means of achieving the intended objectives.

Dr KAMALIAH MOHAMAD NOH (Malaysia) confirmed the potential medical and social burden of ageing on health systems that were inadequately designed to meet the needs of elderly people for chronic, long-term and palliative care. WHO's work on developing a robust information system containing age- and sex-disaggregated data across the whole life course, with standard indicators for monitoring the health of the elderly, would undoubtedly assist service development and planning. The new social models with a life course approach would be another welcome tool for strengthening intergenerational links and promoting multisectoral action. The Malaysian development agenda would continue to be ageing-sensitive, with a focus on: employment and employability; the culture of elderly care within the family; empowerment of elderly-friendly communities; and incentives for continued home care.

Mr COTTERELL (Australia), welcoming WHO's work on healthy ageing and the particular focus on long-term care, expressed support for the development of a global strategy and global action plan on ageing and health, provided that it was within the agreed programme budget. He similarly supported the establishment of a formal advisory group comprising a balance of experts in elder care and health systems.

Dr OKABAYASHI (Japan) said that initiatives taken in his country to cope with the steadily increasing number of people aged over 65 years (projected to exceed 30% of the population by 2025) included the creation of an appropriate medical, nursing and social support system, and confirmed that social security funding would be greatly affected by the decline in workforce numbers caused by the progression of ageing. Japan intended to share with other countries the findings of a review of its contributions to international active ageing. The achievement of universal health coverage was also closely related to health systems strengthening with a view to the delivery of essential health services to older persons. The issue of ageing should feature more prominently in discussions of universal health coverage. He looked to WHO for the development of evidence-based policy options.

Dr MYINT HTWE (Myanmar) said that WHO should be well prepared, within its mandate, to address healthy ageing and problems of old age from all aspects, including prevention, cure and rehabilitation, through a life course approach. It could most effectively do so by establishing regional units responsible for coordinating elderly health care issues and cooperating with other stakeholders. Member States could also pursue similarly dedicated initiatives. Mindful of the burden of the elderly on health systems, he requested information on a road map for initiating in other countries projects similar to the "Knowledge translation on ageing and health" project to be applied in China in 2014. The health and care of older persons was a wide-ranging sphere and WHO's close collaboration with the International Association of Gerontology and Geriatrics and the International Federation on Ageing was therefore a welcome step. Healthy ageing-related activities must, however, be constantly reviewed and findings reported to Member States through WHO regional offices. Such activities should also be promoted in national programmes and strategies as a matter of policy. With the first global report on ageing and health due to be issued in 2015, Member States could benefit from workshops devoted to detailed discussion of the report's conclusions.

Mr LUTZOW STEINER (Mexico), noting that population ageing was a global phenomenon but more evident in the presence of poverty, disease and social vulnerability, called for strategies to change the social determinants of the health and well-being of older people. Many conditions began at early stages in life, making it important to establish a culture of healthy ageing. The lack of knowledge and financial resources were crucial factors and needed to be considered in the formulation of integrated public policies for enabling older adults to remain active, professionally and socially, while contributing to the fight against poverty and the accompanying phenomena and in full respect of their

rights. Healthy ageing was one of his Government's national health priorities, and he supported the development of a global strategy on ageing and health.

Mr ROMERO PUENTES (Cuba) said that the process of ageing in Cuba was one of the fastest in the Latin American region; 25% percent of the population were expected to be older than 60 years within 10 years. The increase in life expectancy was a positive outcome of social development in his country. More research was needed, in particular to identify ways of preventing the onset of disability in older adults. Similarly, there was a need for a global strategy on ageing and health and a corresponding action plan with measurable indicators that would determine future global priorities in that area.

Dr CARBONE (Argentina) said that health in old age was determined by risk factors that emerged throughout life and had a cumulative effect. Alleviating the burden of disease associated with ageing required systems that worked throughout the entire life course. In addition, work was needed on the social determinants of health and the promotion of healthy lifestyles. Her Government had established a national programme that promoted the health, welfare and rights of older people, with primary focus being on care, through the provision of services for dependent adults, and the education and training of health professionals. The programme also promoted health and disease prevention for all ages, collaborated with other programmes and the Ministry of Health, and had formed a national intersectoral advisory commission. It was important to establish a "taxonomy" of measurable, comparable and objective indicators for monitoring the health of older adults and identifying the most cost-effective interventions. A guideline for self-care and a report on the health of the elderly in Argentina would be issued later in the year.

Dr VALVERDE (Panama) concurred that an ageing population would have a great impact on demand for health services in relation to many diseases. She supported the elaboration of a global strategy on ageing and health, including palliative care. She sought more information on the topic, such as the study referred to by the member for Japan. It was notable that two of her country's provinces had an ageing rate equal to that of developed countries.

Ms CAI Fei (China)¹ recalled resolution WHA65.3 regarding multisectoral actions to promote healthy ageing with its guidance to Member States. In 2012, her Government had amended the law on the protection of the rights of the elderly and taken steps to define its responsibilities for the provision of care for the elderly. She supported the establishment of a system that ensured that health care services covered the elderly and improved health care networks serving the elderly. The provision of care at home and the introduction of elder care in community health care facilities were also being developed. More research was needed in the field of healthy ageing and health care services for the elderly.

Dr BLUMENTHAL (Finland)¹ said that an ageing population posed challenges for Europe and his country was no exception. An ageing population was also a significant resource for society, if it put an emphasis on disease prevention and the promotion of health and functional capacity. Member States needed more guidance and support from the Secretariat, however. He welcomed the initiative to prepare a global strategy and action plan on ageing and health, but raised five issues. Existing strategies and action plans, including those for noncommunicable diseases, should be taken into account as a basis for activities. The drafting process should be transparent and participatory, in order to strengthen commitment and implementation. The strategy and action plan should follow a comprehensive, health-in-all-policies approach that considered all relevant sectors and stakeholders.

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

Health promotion and functional capacity should be strongly emphasized. Indicators must be defined for demonstrating the progress in implementing the action plan and strategy.

Mr MAMACOS (United States of America)¹ offered some suggestions to strengthen the report. The concept of the continuum of care should include disease self-management and a reference to care for both physical and mental conditions. His country's experience showed that, with the right education and tools, older adults were better able to manage chronic conditions and maintain wellness. New systems of long-term care should include the element of choice for the individual. He supported the recommendation to improve health data on older persons, for instance through disaggregation by sex, gender and age. Maltreatment of elderly people and end-of-life issues were examples of areas where evidence and data were limited. Given its cross-cutting relationship to ageing populations, disability should be examined as well. Direct references to maltreatment should be included in the Organization's first global report on ageing and health.

Mr SIMPSON (FDI World Dental Federation), speaking at the invitation of the CHAIRMAN and also on behalf of the other members of the World Health Professions Alliance, concurred with the approach set out in the report. He encouraged the Secretariat to place more emphasis on prevention at all ages by including a specific recommendation to that effect; to make more explicit references to interprofessional collaborative practice and education; to reinforce the importance of ensuring that health workers themselves were healthy and supported; and to broaden the focus from mortality to encompass morbidity and quality of life in the context of data gathering and the Organization's role in that regard.

Dr BEARD (Ageing and Life Course) said that population ageing posed many challenges as the proportion of the population of working age shrank and demand for health services and other resources increased. Conversely, older populations were a social resource for their families, communities and society, although health was crucial to their ability to contribute. Population ageing thus demanded a public health response. Speakers' interventions reflected the diversity of the challenges. Some countries were dealing with population ageing while still contending with issues of food security, safe drinking water and basic sanitation. He acknowledged the expressions of support for the development of a global strategy and action plan, and the comments that such an action plan should take into account existing strategies and action plans and advocate a health-in-all-policies approach were well taken. Other central elements would be an emphasis on health promotion and functional capacity, research and the development of relevant indicators, a life course perspective, social determinants of health, care at home and self-management of illness. Consultation and the sharing of experiences would be crucial. He looked forward to further contributions from the Member States as the Organization developed a comprehensive response to population ageing.

The Board noted the report.

International Code of Conduct on Pesticide Management: Item 8.5 of the Agenda (Document EB134/22)

The CHAIRMAN invited comments on the report and the International Code of Conduct therein. Hearing no comments, she took it that the Board wished to take note of the report and the International Code of Conduct.

The Board noted the report and the International Code of Conduct on Pesticide Management.

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

Contributing to social and economic development: sustainable action across sectors to improve health and health equity: Item 8.7 of the Agenda (Document EB134/54)

The CHAIRMAN drew attention to a draft resolution, which was sponsored by Argentina, Croatia, Czech Republic, Finland, Latvia and Lithuania, and which read:

The Executive Board,

Having considered the report on contributing to social and economic development: sustainable action across sectors to improve health and health equity (follow-up of the 8th Global Conference on Health Promotion),¹

RECOMMENDS to the Sixty-seventh World Health Assembly, the adoption of the following resolution:

The Sixty-seventh World Health Assembly,

PP1 Reaffirming the principles of the Constitution of the World Health Organization stating that the achievement of any State in the promotion and protection of health is of value to all; and that governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures;

PP2 Reaffirming the right of every human being without distinction of any kind to the enjoyment of the highest attainable standard of physical and mental health, and to a standard of living adequate for the health and well-being of oneself and one's family, including adequate food, clothing, housing and to the continuous improvement of living conditions; (UNGA res 68/98, PP4);

PP3 Recalling the Alma Ata Declaration, the Primary Health Care Strategy and the Global Strategy of Health for All by the year 2000, and their calls for coordination, cooperation and intersectoral action for health among relevant sectors and aspects of national and community development;

PP4 Acknowledging the United Nations General Assembly document "The Future we want", and in particular its recognition that health is a precondition for and an outcome and indicator of all three dimensions of sustainable development and the call for the involvement of all relevant sectors for coordinated multisectoral action to address urgently the health needs of the world's population [66/288];

PP5 Recalling resolutions on health promotion, public information and education for health,² on health promotion,³ on health promotion and healthy lifestyles,⁴ on health promotion in a globalized world,⁵ and taking note of the outcome documents of the seven Global WHO Conferences on health promotion,⁶ and their calls for strengthened health promotion;

PP6 Recalling the call of the Ottawa Charter for healthy public policies and supportive environments, the Adelaide Statement on Healthy Public Policies, and the Nairobi call to action for closing the implementation gap in health promotion;

¹ Document EB134/54.

² Resolution WHA42.44.

³ Resolution WHA51.12.

⁴ Resolution WHA57.16.

⁵ Resolution WHA60.24.

⁶ Ottawa, 1986; Adelaide, Australia, 1988; Sundsvall, Sweden, 1991; Jakarta, 1997; Mexico City, 2000; Bangkok, 2005; Nairobi 2009.

PP7 Recognizing the Programme Budget of the World Health Organization for the biennium 2014–2015 and its category 3 “Promoting health through the life course”;

PP8 Reaffirming commitments made with respect to considering global health in the context of foreign policy [A/RES/63/33] and reiterating recommendations to consider universal health coverage in the discussions on the post-2015 development agenda, including broad public health measures, health protection and addressing determinants of health through policies across sectors; [A/RES/67/81]

PP9 Recalling the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, which recognizes the primary role of Governments in responding to the challenge of noncommunicable diseases and the essential need for the efforts and engagement of all sectors of the society to generate responses for the prevention and control of noncommunicable diseases, as well as the important role of international community and international cooperation in assisting the Member States in these efforts; [A/RES/66/2]

PP10 Noting further the WHO global strategy for the prevention and control of noncommunicable diseases, which stresses that health gains can be achieved much more readily by influencing public policies in sectors like trade, taxation, education, agriculture, urban development, food and pharmaceutical production than by making changes in health policy alone [A61/8, P14] as well as endorsement of the global action plan for the prevention and control of noncommunicable diseases 2013–2020; [WHA66.1.];

PP11 Noting that the health sector has a key role in working with other sectors in ensuring drinking water quality, sanitation, air quality and limiting exposure to health-damaging chemicals and radiation levels, as recognized in World Health Assembly resolutions;¹

PP12 Recognizing that a number of mental disorders can be prevented and that mental health can be promoted in the health sector and in sectors outside health; [WHA65.4] and that global support is necessary for national and local work on mental health and development, including through the Mental Health Action Plan and the WHO MINDbank;

PP13 Noting further the relevance of the WHO Framework Convention on Tobacco Control for many sectors, and related WHO strategies and action plans, underscoring the importance of addressing common risk factors for noncommunicable diseases across sectors; [WHA65.3]

PP14 Noting the cooperation needs under International Health Regulations, including among the United Nations agencies, and between and within Member States;

PP15 Acknowledging the Rio Political Declaration on Social Determinants of Health and its determination and its call for the development and implementation of robust, evidence-based, reliable measures of societal well-being, building where possible on existing indicators, standards and programmes and across the social gradient, that go beyond economic growth [Rio political declaration], and recognizing the important advocacy role of health ministries in this regard;

PP15*bis* Acknowledging the final report of the Commission on Social Determinants of Health “Closing the gap in a generation: health equity through action on the social determinants of health” as a resource of evidence for action on social determinants of health and health inequities;

PP16 Recognizing that Health in All Policies refers to taking the health implications of decisions systemically into account in public policies across sectors, seeking synergies, and avoiding harmful health impacts, in order to improve population

¹ Resolutions WHA59.15, WHA61.19, WHA63.25, WHA63.26, WHA64.15, WHA64.24.

health and health equity through assessing consequences of public policies on determinants of health and well-being and on health systems;

PP17 Concerned of gaps in taking into account across government, at various levels of governance, impacts of policies on health, health equity and functioning of the health system,

(OP) 1. NOTES with appreciation the Statement of the 8th Global Conference on Health Promotion: Health in All Policies, held in Helsinki, and notes the ongoing work on the Framework for Country Action;

(OP) 2. URGES Member States:¹

(a) to champion health and the promotion of health equity as a priority and take efficient action on the social determinants of health and NCD prevention;

(b) to take measures, including, where appropriate, effective legislation, structures, processes and resources that enable societal policies which take into account and address their impacts on health determinants, health protection, health equity and health systems functioning, and to measure and track social determinants and disparities in health;

(c) to develop, as appropriate, and maintain adequate and sustainable institutional capacity and skills, including within the health authorities and relevant research and development institutes such as National Public Health Institutes, to achieve, through actions across sectors, improved outcomes from the perspective of health, health equity and health systems functioning;

(d) to take action to enhance health and safeguard public health interests from undue influence by any form of real, perceived or potential conflict of interest, through management of risk, strengthening of due diligence and accountability and increasing the transparency of decision-making and engagement; [A/RES/68/98]

(e) to include, as appropriate, local communities and civil society actors in the development, implementation and monitoring of policies across sectors, including by mechanisms for community engagement and public participation;

(f) to contribute to the development of the post-2015 development agenda by emphasizing that policies in sectors other than health have a significant impact on health outcomes, and by identifying synergies between health and other sector policy objectives; [based on A61/8, P14]

(OP) 3 REQUESTS the Director General:

(a) to prepare, for the consideration, by the Sixty-eighth World Health Assembly, in consultation with Member States¹ and United Nations organizations, and within existing resources, a Framework for Country Action, for adaptation to different contexts, taking into account the Statement of the 8th Global Conference on Health Promotion (Helsinki, 2013), aimed at supporting national efforts to improve health, ensure health protection, health equity and health systems functioning, including through action across sectors on determinants of health and risk factors for noncommunicable diseases, based on best available knowledge and evidence;

(b) to provide guidance and technical assistance, upon request, to Member States in their efforts towards implementation of Health in All Policies, including through building necessary capacities, structures, mechanisms and processes for measuring and tracking social determinants and disparities in health;

¹ And, where applicable, to regional economic integration organizations.

- (c) to strengthen WHO's role, capacities and knowledge-resources to give guidance and technical assistance for implementation of policies across sectors at the various levels of governance, and ensure coherence and collaboration with WHO's own initiatives requiring actions across sectors, including in the global response to the challenges posed by NCDs;
- (d) to continue to work and provide leadership with the United Nations agencies, development banks, other international organizations and foundations, with the view of taking health considerations into account in major strategic initiatives and their monitoring, including the post-2015 development agenda, promoting the incorporation of the approach of social determinants of health, and urge these organizations to achieve coherence and synergy with commitments and obligations related to health in their work with member States;
- (e) to report back to the World Health Assembly on the progress made at the Sixty-ninth World Health Assembly (2016) through the Executive Board.

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

1. Resolution: Contributing to social and economic development: sustainable action across sectors to improve health and health equity (follow-up of the 8th Global Conference on Health Promotion)	
2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)	
Category: 2. Noncommunicable diseases	
Programme area: Noncommunicable diseases	Outcome: 2.1 Output: 2.1.1
Programme area: Mental health and substance abuse	Outcome: 2.2 Output: 2.2.1
Programme area: Nutrition	Outcome: 2.5 Output: 2.5.1
Category: 3. Promoting health through the life-course	
Programme area: Social determinants of health	Outcome: 3.4 Output: 3.4.1
Programme area: Health and the environment	Outcome: 3.5 Output: 3.5.2
Programme area: Gender, equity and human rights mainstreaming	Outcome: 3.3 Output: 3.3.1
How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?	
This resolution would contribute to improved health and health equity and social and economic development through sustained action across sectors. It would further strengthen the health sector's role in working with other sectors to tackle health issues particularly prevention and control of noncommunicable diseases. It will strengthen collaboration both within WHO and between WHO and its partners.	
Does the programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)	
Yes.	

3. Estimated cost and staffing implications in relation to the Programme budget**(a) Total cost**

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) Three years (covering the period 2014–2016)

(ii) Total: US\$ 1.45 million (staff: US\$ 790 000; activities: US\$ 660 000)

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 980 000 (staff: US\$ 530 000; activities: US\$ 450 000)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

Staffing costs would be incurred at headquarters only; activity costs would be incurred at all levels of the Organization.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

If "no", indicate how much is not included.

Not applicable.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

Yes.

If "no" indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

No.

If "no", indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ 980 000; source(s) of funds: assessed contributions and core voluntary contributions, with resource mobilization efforts undertaken, especially through the financing dialogue.

Dr ASADI-LARI (Islamic Republic of Iran) acknowledged the Secretariat's work in the area. He proposed that the draft resolution should reflect equity measures, such as the widely-used Urban Health Equity Assessment and Response Tool (Urban HEART), which provided data on health inequality and involved local communities in responding to the inequalities. That instrument could be valuable for measuring and monitoring progress towards achieving health equity.

In response to a request by Dr CARBONE (Argentina), the CHAIRMAN invited the representative of Finland to take the floor and outline the proposed amendments that had been received.

Dr LAHTINEN (Finland)¹ recalled that health was maintained by society and the health sector was not solely responsible. Including health in policy-making across sectors was not an easy task and needed rigorous development. WHO's call to include health in major global health initiatives, including in the post-2015 development agenda, was timely. Extensive discussion was needed on the current global health agenda that went beyond sectoral boundaries and required the social, economic and environmental determinants of health to be tackled. At the country level, each Member State had its own context, traditions and policy-making across sectors. His Government wanted the Organization to continue to play a strong role for health in global policies and serve as a source of guidance and technical support at the request of Member States on the implementation of health policies.

The reason for submitting the draft resolution had been to underline the need for increased emphasis on developing and implementing policies across sectors for health and health equity. Several amendments had been proposed, namely: in preambular paragraph 8, "including" should be deleted and replaced with "also considering"; in preambular paragraph 11, "food and nutritional safety," should be added after "sanitation,,"; in paragraph 2(a), "economic and environmental" should be added after "social," and "including in noncommunicable disease prevention" should replace "and noncommunicable disease prevention"; in paragraph 2(b), "cross-sectoral" should be added before "structures"; in paragraph 2(c), "such as to assess health implications of policy initiatives of all sectors, explore cross-sectoral solutions and to negotiate policies across sectors," should be added after "capacity and skills", and "through actions across sectors" should be deleted; in paragraph 2(e), "relevant stakeholders, such as" should be added after "as appropriate," and the subparagraph should end at the words "... across sectors"; in paragraph 3(a), a comma should be added in place of "and" after "Member States" and the words "and other relevant stakeholders as appropriate," should be added; and in paragraph 3(c), a comma and the words "including by compiling and analysing good practices by Member States," should be added after "knowledge-resources".

Dr ASADI-LARI (Islamic Republic of Iran) proposed that in paragraph 2(b) the words "including Urban HEART" should be added in brackets after the words "health equity".

Dr KAMALIAH MOHAMAD NOH (Malaysia) recalled that the Health Assembly had adopted resolution WHA65.8 on the outcome of the World Conference on Social Determinants of Health. How did that text, which she considered to have been rather vague, differ from the draft resolution before the Board?

Dr OLLILA (Finland)¹ said that, although many actions relating to social determinants of health had been planned and there was much evidence on cross-sectoral matters, implementation was lagging. The current draft resolution focused on the ways in which the Secretariat could provide Member States with technical support and guidance in order to implement cross-sectoral initiatives and plans. The Organization would also become stronger with respect to global intersectoral policies.

Dr KAMALIAH MOHAMAD NOH (Malaysia) said that she would need more time to compare the two texts.

Mr COTTERELL (Australia) agreed with the member for Malaysia that there had been prior work in that area. Noting the length of the draft resolution, he reminded the Board of its role in helping the Health Assembly to manage its business and encouraged the sponsors to shorten the text.

Dr VALVERDE (Panama) said that, in order to respond to social and economic development challenges and make universal health coverage a reality, the Organization needed to strengthen its work at the regional, national and world levels. Intersectoral measures and public health policies were

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

key elements for the promotion of health and achievement of health equity. She therefore requested that her country be added to the list of sponsors of the draft resolution.

Ms MATSOSO (South Africa) asked for a revised text to be provided the following morning.

Mr KESKİNKILIÇ (Turkey)¹ supported the draft resolution and wanted his country to be added to the list of sponsors.

Ms NIU Hongli (China)¹ supported the draft resolution. It would provide an important element in the implementation of the outcome of the 8th Global Conference on Health Promotion and be important for the mainstreaming of health in all policies and improvement of health and health equity.

Dr OLLILA (Finland)¹ noted that, in addition to the social determinants of health, the text dealt with multisectoral actions on environmental and economic determinants.

The CHAIRMAN said that a document with the revised draft resolution would be circulated later in the session.

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

The meeting rose at 21:25.

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

EIGHTH MEETING

Thursday, 23 January 2014, at 09:10

Chairman: Professor J. HALTON (Australia)

1. **PROMOTING HEALTH THROUGH THE LIFE COURSE:** Item 8 of the Agenda (continued)

Public health impacts of exposure to mercury and mercury compounds: the role of WHO and ministries of public health in the implementation of the Minamata Convention: Item 8.6 of the Agenda (Document EB134/23)

The CHAIRMAN, introducing the item, drew attention to a draft resolution proposed by Argentina, Colombia, Costa Rica, Ecuador, Libya, Panama, Switzerland, United States of America and Uruguay, and which read:

The Executive Board,

Having considered the report on Public health impacts of exposure to mercury and mercury compounds: the role of WHO and ministries of public health in the implementation of the Minamata Convention,¹

RECOMMENDS to the Sixty-seventh World Health Assembly the adoption of the following resolution:

The Sixty-seventh World Health Assembly,

PP1 Recalling World Health Assembly resolutions WHA60.17 on oral health: action plan for promotion and integrated disease prevention, WHA63.25 on the improvement of health through safe and environmentally sound waste management, and WHA59.15 on the Strategic Approach to International Chemicals Management, as well as the strategy for strengthening the engagement of the health sector in the implementation of the strategic approach adopted by the International Conference on Chemicals Management at its third session;

PP2 Recognizing the importance of dealing effectively with the health aspects of the challenges that chemicals and wastes, including mercury, may pose, particularly to vulnerable populations, especially women, children, and, through them, future generations;

PP3 Recalling the renewed commitments on sustainable development set out in the United Nations Conference on Sustainable Development Rio+20 outcome document “The future we want”, of June 2012, as well as the Adelaide Statement on Health in All Policies of 2010, and the 8th Global Conference on Health Promotion, held in Helsinki in 2013, which promoted intersectoral collaboration across all sectors to achieve healthy populations;

PP4 Taking note that negotiations on the text of a new multilateral environmental agreement on mercury were concluded in October 2013 with the adoption of the Minamata Convention on Mercury, being the first time a specific article on health aspects

¹ Document EB134/23.

has been included, as well as other relevant provisions, and that the Convention places certain obligations on State Parties that will require action, as applicable, by the health sector, together with other competent sectors, including the phase-out of mercury thermometers and sphygmomanometers, the phase-out of mercury-containing cosmetics, including skin-lightening soaps and creams, the phase-out of mercury-containing topical antiseptics, measures to be taken to phase down mercury-added dental amalgam, and the development of public health strategies on the exposure to mercury of artisanal and small-scale gold miners and their communities;

PP5 Recalling that the objective of the Minamata Convention on Mercury is to protect human health and the environment from anthropogenic emissions and releases of mercury and mercury compounds;

PP6 Bearing in mind that the Minamata Convention on Mercury encourages Parties to: (a) promote the development and implementation of strategies and programmes to identify and protect populations at risk, particularly vulnerable populations, and which may include adopting science-based health guidelines relating to the exposure to mercury and mercury compounds, setting targets for mercury exposure reduction, where appropriate, and public education, with the participation of public health and other involved sectors; (b) promote the development and implementation of science-based educational and preventive programmes on occupational exposure to mercury and mercury compounds; (c) promote appropriate health care services for prevention, treatment and care for populations affected by the exposure to mercury or mercury compounds; and (d) establish and strengthen, as appropriate, the institutional and health professional capacities for the prevention, diagnosis, treatment and monitoring of health risks related to the exposure to mercury and mercury compounds;

PP7 Noting that the Minamata Convention on Mercury states that the Conference of the Parties, in considering health-related activities, should consult, collaborate and promote cooperation and exchange of information with the WHO, ILO and other relevant intergovernmental organizations, as appropriate;

PP8 Thanking the preparatory work of WHO, during the negotiations, analyzing different risks and available substitutes, as well as analysis and identification of areas requiring additional or new effort, under the Minamata Convention, and encouraging further and continuous analysis and other efforts as may be needed;

OP1 WELCOMES the formal adoption by States of the Minamata Convention on Mercury in October 2013;

OP2 ENCOURAGES Member States:¹

- (1) to take the necessary domestic measures to promptly sign, ratify and implement the Minamata Convention on Mercury, which sets out internationally legally binding measures to address the risks of mercury and mercury compounds on human health and the environment;
- (2) to actively participate in national, regional and international efforts to implement the Minamata Convention on Mercury;
- (3) to address the health aspects of exposure to mercury and mercury compounds in the context of the health sector uses, and also on the other negative health impacts that should be prevented or treated, by ensuring the sound management of mercury and mercury compounds throughout their life cycle;

¹ And, where applicable, regional economic integration organizations.

- (4) to recognize the interrelation between the environment and public health in the context of the Minamata Convention implementation and sustainable development;
- (5) to promote appropriate health care services for prevention, treatment and care for populations affected by the exposure to mercury or mercury compounds, including national fish consumption advisories and effective risk communication strategies;
- (6) to ensure close cooperation between health ministries and ministries of environment, as well as labour, industry, economy, agriculture and other ministries responsible for the implementation of aspects of the Minamata Convention on Mercury;
- (7) to facilitate the exchange of epidemiological information concerning health impacts associated with exposure to mercury and mercury compounds, in close cooperation with WHO and other relevant organizations, as appropriate;

OP3 REQUESTS the Director-General:

- (1) to facilitate WHO's efforts to provide advice and support to Member States to assist them towards the implementation of the Minamata Convention on Mercury in all health aspects related to mercury consistent with WHO's programme of work, in order to promote and protect human health;
- (2) to support Member States to develop and implement strategies and programmes to identify and protect populations at risk, particularly vulnerable populations, and which may include adopting science-based health guidelines relating to the exposure of mercury and mercury compounds, setting targets for mercury exposure reduction, where appropriate, and public education, with the participation of health and other involved sectors;
- (3) to cooperate closely with the Minamata Convention Intergovernmental Negotiating Committee, the Conference of the Parties and other international organizations and bodies, mainly UNEP, to fully support the implementation of the health-related aspects of the Minamata Convention on Mercury and to provide information to the Committee and Conference of the Parties on the progress made in this regard.

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

1. Resolution: Public health impacts of exposure to mercury and mercury compounds: the role of WHO and ministries of public health in the implementation of the Minamata Convention	
2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)	
Category: 3. Promoting health through the life-course	
Programme area: Health and the environment	Outcome: 3.5 Output: 3.5.1, 3.5.2 and 3.5.3
Category: 2. Noncommunicable diseases	
Programme area: Noncommunicable diseases	Outcome: 2.1 Output: 2.1.1
Category: 5. Preparedness, surveillance and response	
Programme area: Food safety	Outcome: 5.4 Output: 5.4.3

How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?

By facilitating the prevention of human exposure to mercury and mercury compounds the resolution would directly contribute to the outcomes for the programme areas listed, namely: reduced environmental threats to health; increased access to interventions to prevent and manage noncommunicable diseases and their risk factors; and all countries adequately prepared to prevent and mitigate risks to food safety.

Does the programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) A significant level of activities would be required from 2014 to 2020; activities would continue at a reduced level beyond that period (the Minamata Convention does not have an end-date).

(ii) Total (2014–2020): US\$ 9.03 million (staff: US\$ 2.68 million; activities: US\$ 6.35 million).

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 2.47 million (staff: US\$ 720 000; activities: US\$ 1.75 million).

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

All levels of the Organization.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

If “no”, indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

Yes.

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

The gap is estimated at US\$ 1.3 million. Potential sources of funds include: The Global Environment Facility, which is the financial mechanism for the Minamata Convention; and through an Organization-wide coordinated resource mobilization plan to deal with funding shortfalls in the Programme budget 2014–2015.

Dr BAYE LUKONG (Cameroon), speaking on behalf of the Member States of the African Region, said that all necessary measures should be taken to reduce and prevent exposure to mercury and mercury compounds, since it had grave consequences for human health. She commended the collaboration between United Nations bodies that had led to the formation of the UNEP Global Mercury Partnership, a vehicle for immediate action to reduce mercury pollution, and to the adoption in October 2013 of the Minamata Convention on Mercury. In the context of the Libreville Declaration on Health and Environment in Africa, WHO and UNEP had developed a framework to reduce chemical risks. Under the UNEP Global Mercury Partnership, and in collaboration with WHO,

UNIDO had coordinated a project on improving the health and environment of artisanal and small-scale gold mining communities by reducing mercury emissions and promoting sound chemical management in Burkina Faso, Mali and Senegal; the project would assist countries in developing strategic plans for sound mercury management.

However, many challenges remained. Mercury emissions continued to be an environmental and an occupational health issue, and implementation of the WHO Global Plan of Action on Workers' Health (2008–2017) was progressing slowly in Africa. Better mercury emission controls were required in sectors such as artisanal and small-scale gold mining, while the phasing out of products and devices containing mercury or mercury compounds would necessitate the development of cost-effective, affordable and clinically effective alternatives. Despite existing political will, governments did not have the resources to engage in a multisectoral approach. She urged the Secretariat to organize regional consultations to galvanize Member States into action.

Mr LUTZOW STEINER (Mexico) welcomed the report and was pleased to note that the Minamata Convention on Mercury had been opened for signature. Recalling that the objective of that Convention was to reduce the harmful effects on human health and the environment of exposure to mercury and mercury compounds, he said the Mexican Ministry of Health had already begun efforts in that regard and would continue to work to meet its obligations under the Convention. Mexico wished to sponsor the draft resolution.

Dr NOOR HISHAM ABDULLAH (Malaysia) commended WHO's commitment to protecting human health from risks associated with mercury exposure. Malaysia was committed to tackling the issues addressed in the Minamata Convention on Mercury and supported the initiatives taken by WHO. However, the report had not mentioned exposure from consumption of traditional medicines and herbal remedies. As Annex A to the Convention included exemptions for products used in traditional and religious practices, it should be stated that mercury should not be included in the manufacture and trade of traditional medicines for commercial reasons, at whatever dosage. An effective response required collaboration between the health and environment sectors, and for that reason he supported the draft resolution.

Ms DUSSEY-CAVASSINI (Switzerland) welcomed the adoption of the Minamata Convention on Mercury, a treaty to which her country had been an early signatory. Although the signing of the Convention represented a decisive first step, much progress was still required to achieve the sound management of waste and chemical products. For the Convention to have an impact, Parties' health and environment sectors would need to collaborate in a similar fashion to WHO and UNEP at the international level. Switzerland wished to sponsor the draft resolution and urged all actors to work together towards the implementation of the Convention.

Dr OMI (Japan), recalling the suffering of the people of Japan as a result of the enormous damage caused by Minamata disease, fully supported the draft resolution. Japan wished to be added to the list of sponsors.

Ms DUPUY (Uruguay)¹ welcomed the involvement of WHO and health ministries in implementing the Minamata Convention on Mercury and in providing scientific and technical advice and information on mercury exposure and the associated health risks. The health-related provisions contained in Article 16 of the Convention included promoting health care services for affected populations and establishing or strengthening institutional and health professional capacities. The Convention contained numerous other references to human health. Mercury exposure had harmful effects on many parts of the body, and particularly affected fetal and infant development. It was

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

therefore important to raise public awareness, guide health authorities and train health care personnel, while providing appropriate care at all times. Health ministries would play a fundamental role in implementing the Convention and should begin to build related national capacities before the Convention entered into force, with support from WHO. The Secretariat should consult Member States and carry out those actions considered to be a priority. The Convention's implementation would require collaboration between relevant national ministries, as well as between international organizations such as WHO, UNEP and ILO.

In addition to the sponsors listed, the draft resolution was supported by the countries of the Group of the Americas and the Union of South American Nations. Following informal consultations, two amendments had been agreed to the draft resolution: the fourth preambular paragraph, following the words "other competent sectors" would be amended to read: "...including the progressive phase-out resulting from banning the manufacture, import or export by 2020 of mercury thermometers and sphygmomanometers, of mercury-containing cosmetics, including skin-lightening soaps and creams, and mercury-containing topical antiseptics,...". The rest of that paragraph would remain unchanged. The end of paragraph 2(5) would be amended, following the words "mercury or mercury compounds", to read: "including effective risk communication strategies targeted at vulnerable groups such as children and women of child-bearing age, especially pregnant women".

The draft resolution adhered to the provisions of the Minamata Convention on Mercury, without duplicating or superseding decisions taken within other international bodies. It clearly demonstrated the need to introduce health in all policies, and as such she called for its adoption.

Mr COTTERELL (Australia) welcomed the report on the Minamata Convention on Mercury and the inclusion of health aspects in other multilateral agreements related to chemicals, under the auspices of UNEP. The protection of human health and the environment was common to those agreements, and Australia supported the action taken by the Secretariat to identify priorities in regard to the sound management of chemicals, including mercury. He congratulated Uruguay on its leadership in developing the draft resolution, which his delegation supported.

Mr PALOPOLI (Argentina) agreed that a plan to reduce and replace mercury in the health sector should be developed. It was essential to monitor and control at-risk situations; as well as to adopt measures for the early diagnosis, treatment and rehabilitation of affected persons and polluted environments. Argentina was committed to developing and implementing legislation aimed at prohibiting the import, extraction, production and sale of mercury and mercury products. MERCOSUR countries had successfully worked together to eliminate mercury, actively influencing global processes and participating in the intergovernmental negotiating committee to prepare a global legally binding instrument on mercury. He supported the draft resolution and the proposal made by the representative of Uruguay to include a reference to the public health impacts of exposure to mercury and to incorporate the conclusions of the fifth session of the intergovernmental negotiating committee.

Mr KLEIMAN (Brazil) welcomed the explanation of the role of WHO and health ministries in the implementation of the Minamata Convention on Mercury, as contained in the report. Having participated in the negotiations of that Convention, he recognized the link between environment and health, and reiterated the importance of a legally binding instrument that would protect both of those areas. The Secretariat had an important role to play in supporting Member States in the implementation of the Convention through technical advice, support and cooperation, and through greater collaboration with UNEP and other relevant bodies. Brazil supported and wished to sponsor the draft resolution.

Professor KULZHANOV (Kazakhstan),¹ supporting the draft resolution and the report, said that they would help to improve intersectoral collaboration in Kazakhstan, where steps had already been taken to reduce the risks associated with the production and use of mercury. Kazakhstan also wished to sponsor the draft resolution.

Mrs ANDRIENKO (Ukraine)¹ said that Ukraine wished to sponsor the draft resolution.

Dr FONES (Chile)¹ said that implementation of the Minamata Convention on Mercury and attainment of its objective required coordinated multisectoral collaboration, and health ministries and the health sector had specific roles to play. Welcoming the draft resolution, he said that Chile wished to be added as a sponsor.

Mrs FERNÁNDEZ DE LA HOZ ZEITLER (Spain),¹ supporting the draft resolution, said that it was important to ratify the Convention, which was the first of its kind to include a specific health-related article. Mercury did not stop at international borders, and as such global strategies were required to reduce environmental pollution and human exposure to mercury. Spain also wished to sponsor the draft resolution.

Ms BOTERO HERNANDEZ (Colombia)¹, speaking as a sponsor of the draft resolution, reiterated the need for partnerships and collaboration in health and the environment to reduce the impact of mercury. It was important to strengthen cooperation, through regional offices, between the health and environment sectors at the country level, and between international organizations, as well as to encourage participation by the health sector in implementing international chemicals conventions.

Dr VALLEJO (Ecuador)¹ said that the draft resolution, which was based on an environmental convention, demonstrated the importance of collaboration between health and other sectors in combating mercury exposure. The wide-ranging support for the draft resolution indicated its relevance, as well as the close link between health and the environment. That link was further demonstrated by the inclusion of health provisions in the Convention, and by the disaster at Minamata, which illustrated that environmental protection could not be separated from health care, especially for vulnerable groups. During negotiations on the Convention, the Region of the Americas had proposed the inclusion of Article 16, and for that reason he supported the draft resolution. The Secretariat should support Member States in the provision of better treatment to populations affected by mercury exposure. Ecuador had committed to the goal of “zero mercury” and had begun the process of ratifying the Convention.

Mr HU Xiaomeng (China)¹ supported the Minamata Convention on Mercury adopted in October 2013, despite the fact that some of its provisions were not binding. In China, government departments were preparing to implement the Convention to better manage mercury and its compounds and to seek alternative technologies. Owing to the size of its mercury industry and production, China faced significant challenges in implementing the Convention, and it would require financial and technical assistance. Finally, he proposed amending the paragraphs in the operative part of the draft resolution to include the need for capacity-building in developing and least developed countries and for technology transfer.

Dr NARVAEZ (United Nations Environment Programme), recalling the objective of the Convention, said that it currently had 94 signatories and one Party. It would enter into force following the deposition of the 50th instrument of ratification. She welcomed WHO’s collaboration in the

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

development of the Convention, and in the earlier Global Mercury Assessment. The Convention was unique as it included an article on health, which encouraged Parties to take health-related actions at the national level and encouraged WHO and ILO to collaborate with the intergovernmental negotiating committee and the Conference of the Parties to the Convention. She welcomed the draft resolution and emphasized the importance of early ratification and implementation of the Convention. She looked forward to further strengthening collaboration with WHO in that regard.

Mr BENDER (Consumers International), speaking at the invitation of the CHAIRMAN, urged the Secretariat to collaborate with the governing body of the Minamata Convention on Mercury, support the implementation of the health-related aspects, and report on progress made. Member States should also work to implement the Convention, facilitating close cooperation between health, environment and other relevant ministries. Member States should develop programmes to protect at-risk populations from exposure to mercury through the development and implementation of health-based guidelines. Furthermore, products containing mercury should be phased out, use of dental amalgam should be reduced, and public health strategies should be developed to reduce mercury use in artisanal and small-scale gold mining. Although progress had been made concerning prevention and awareness strategies, the Secretariat and Member States should collaborate further on testing and publicizing mercury levels in fish and seafood; developing national fish consumption advisories; promoting risk communication strategies; and conducting biomonitoring, which would assist in identifying and characterizing exposure and evaluating the success of the Convention.

Dr TIN Chung Wong (FDI World Dental Federation), speaking at the invitation of the CHAIRMAN, said the Minamata Convention on Mercury would protect the environment and health. Welcoming the planned reduction in the use of dental amalgam, she acknowledged the need – identified in Annex A to the Convention – for prevention, education, research, good management practices and financial incentives. Her organization was investigating new prevention and dental restoration methods, and collaboration with ministries of health and environment would further improve compliance with the provisions of the Convention. Her organization would support WHO and UNEP, in particular through development of guidelines for the dental profession on the use of dental amalgam.

Dr NEIRA (Public Health, Environmental and Social Determinants) reiterated the major risk posed by mercury exposure. She noted that Member States had encouraged the Organization to continue to work closely with UNEP and other bodies. She welcomed the useful comments made by Member States and said the Secretariat would continue to strengthen multisectoral efforts with regard to existing instruments such as the Libreville Declaration on Health and Environment in Africa, as well as supporting the implementation of the Minamata Convention.

Ms RU Lixia (China)¹ proposed adding the word “technical” before “support” in the first line of paragraph 3(1) of the draft resolution.

The CHAIRMAN took it that the Board wished to take note of the report.

The Board noted the report.

The CHAIRMAN took it that the Executive Board agreed to adopt the draft resolution, as amended, on public health impacts of exposure to mercury and mercury compounds: the role of WHO and ministries of public health in the implementation of the Minamata Convention.

The resolution, as amended, was adopted.²

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

² Resolution EB134.R5.

2. NONCOMMUNICABLE DISEASES: Item 7 of the Agenda (continued)

Maternal, infant and young child nutrition: Item 7.2 of the Agenda (continued from the fourth meeting, section 2) (Document EB134/15)

The CHAIRMAN drew attention to a draft decision on maternal, infant and young child nutrition proposed by Croatia on behalf of the 28 Member States of the European Union, which read:

The Executive Board, having considered the report of the Secretariat on maternal, infant and young child nutrition,

(1) noted the report on the progress in carrying out the comprehensive implementation plan on maternal, infant and young child nutrition and achieving the six Global Nutrition Targets endorsed by the Health Assembly in resolution WHA65.6; on the global strategy for infant and young-child feeding endorsed in resolution WHA55.25 in 2002; and on the status of national measures to give effect to the International Code of Marketing of Breast-milk Substitutes, adopted in resolution WHA34.22 in 1981 and updated through subsequent related World Health Assembly resolutions;

RECOMMENDED to the Sixty-seventh World Health Assembly to consider to:

(2) request the Director-General to convene informal consultations with Member States to complete the work, before the end of 2017, on risk assessment and management tools for conflicts of interest in nutrition, for consideration by Member States at the Sixty-ninth World Health Assembly;

(3) decide to endorse the seven indicators of global targets as part of the core set of indicators of the global monitoring framework on maternal, infant and young child nutrition and request the Director-General to establish a working group composed of representatives and experts appointed by Member States and United Nations bodies to complete the work, before the end of 2015, to develop a core set indicators for the Comprehensive Implementation Plan on Maternal Infant and Young Child Nutrition, building on tracer indicators for policy and programme implementation in health and other sectors relevant to the achievement of global nutrition targets, as well as to develop an extended set of indicators to track processes that have an impact on global targets in specific country settings, for consideration by Member States at the Sixty-eighth World Health Assembly;

(4) note the work carried out by the WHO Secretariat in response to resolution WHA65.6, requesting the Director-General “to provide clarification and guidance on the inappropriate promotion of foods for infants and young children cited in resolution WHA63.23, taking into consideration the ongoing work of the Codex Alimentarius Commission” and recalling resolution WHA63.23, urging Member States “to end inappropriate promotion of food for infants and young children” and request the Director-General to complete the work, before the end of 2017, on the development of recommendations for Member States on how to ensure appropriate marketing of complementary foods, for consideration by Member States at the Sixty-ninth World Health Assembly;

The Executive Board, taking note of the decision of FAO Council in December 2013 requesting the FAO secretariat to work closely with the World Health Organization in developing the road map that would allow for both an intergovernmental process and consultation with civil society and private sector organisations, for the development of an outcome document for the 2nd International Conference on Nutrition, containing general principles on how to reshape the food system to better respond to the needs of the world population, considering emerging health, nutritional and environmental challenges and a framework for action for different sectors;

- (1) requests the Director-General to work with the Director-General of FAO, taking into account the guidance of the Executive Board, to set up a Joint Working Group and develop modalities for its work, for the development, by the end of September 2014, of a draft outcome document on the basis of a zero draft prepared by the two Secretariats;
- (2) recommends that the Joint Working Group has a balanced participation from both WHO and FAO and that WHO Member States are represented by one or two members from each WHO region as well as by one of the two co-chairs of the Joint Working Group;
- (3) calls for developing the draft outcome document in a fully transparent manner engaging with Member States through appropriate measures, including video conferences and public web consultations;
- (4) requests the Director-General to work with the Director-General of FAO, to jointly explore the possibility to convene, within the available resources, one meeting of an open-ended working group of Member States for the finalisation of the outcome document;
- (5) requests the Director-General to work jointly with the Director-General of FAO to ensure consultations with all relevant stakeholders, including nongovernmental organizations and the private sector, before the draft outcome document is submitted to the open-ended working group;
- (6) requests the Director-General to report, for further guidance, to the Sixty-seventh World Health Assembly on WHO's role and progress made in the preparation for the 2nd International Conference on Nutrition; and
- (7) further requests the Director-General to report to the Sixty-eighth World Health Assembly on the outcome of ICN2 through the 136th session of the Executive Board.

The financial and administrative implications of the draft decision for the Secretariat were:

<p>1. Decision: Maternal, infant and young child nutrition</p>				
<p>2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)</p> <p>Category: Noncommunicable diseases</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Programme area: Nutrition</td> <td style="width: 50%;">Outcome: 2.5</td> </tr> <tr> <td></td> <td>Output: 2.5.1</td> </tr> </table> <p>How would this decision contribute to the achievement of the outcome(s) of the above programme area(s)?</p> <p>The decision would allow the Secretariat to complete three pending tasks relating to the comprehensive implementation plan on maternal, infant and young child nutrition: developing multisectoral policies on food and nutrition (through the Second International Conference on Nutrition), providing guidance on the marketing of complementary foods and developing an accountability framework (through work on the global monitoring framework for maternal, infant and young child nutrition).</p> <p>Does the programme budget already include the outputs and deliverables requested in this decision? (Yes/no)</p> <p>Yes.</p>	Programme area: Nutrition	Outcome: 2.5		Output: 2.5.1
Programme area: Nutrition	Outcome: 2.5			
	Output: 2.5.1			
<p>3. Estimated cost and staffing implications in relation to the Programme budget</p> <p>(a) Total cost</p> <p>Indicate (i) the lifespan of the decision during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).</p> <ol style="list-style-type: none"> (i) Two years (covering the period 2014–2015) (ii) Total: US\$ 1.87 million (staff: US\$ 690 000; activities: US\$ 1.18 million) 				

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 1.87 million (staff: US\$ 690 000; activities: US\$ 1.18 million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

Headquarters.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

If “no”, indicate how much is not included.

(c) Staffing implications

Could the decision be implemented by existing staff? (Yes/no)

Yes.

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

The gap is estimated at US\$ 780 000. It will be tackled as part of the Organization-wide coordinated resource mobilization plan to deal with funding shortfalls in the Programme budget 2014–2015.

Professor OSTOJIC (Croatia), speaking on behalf of the European Union and its Member States, said that fruitful and constructive input had been received from Member States following submission of the draft decision, in light of which he wished to put forward some amendments.

Referring to the recommendations to the Sixty-seventh World Health Assembly, he proposed changing the timeframe by replacing “2017” in paragraphs (2) and (4) with “2015”; and replacing “2015” in paragraph (3) with “2014”.

Referring to the preambular paragraph preceding the seven Executive Board actions, he proposed including the words “taking into account the WHO rules and regulations concerning engagement with non-State actors,” after the words “private sector organizations”.

The first word in each of the seven Executive Board actions should be placed in the past tense, and the first line of the third action should begin: “called for the development of the draft outcome document ...”. The words “other United Nations organizations working in the field of nutrition” should be added after “relevant stakeholders, including” in the fifth Executive Board action; and the words “as appropriate,” inserted after “the private sector”. He proposed to insert a standard footnote in the text that would read: “and, where applicable, regional economic integration organizations”, and to provide details of its insertion to the Secretariat in writing.

Mr COTTERELL (Australia) asked whether there were any budgetary implications to the proposal to amend the dates for completion of the informal consultations and the working group to develop core set indicators. Following discussions held under the auspices of FAO, he sought assurance from the Secretariat that FAO and WHO had a shared understanding of both the scope and the process outlined in the draft decision regarding development of the draft outcome document.

Dr CHESTNOV (Assistant Director-General), responding to the first question posed by the member for Australia, said there would be no significant budgetary implications resulting from the amendments proposed. Responding to the second question, he assured the Executive Board that the

Secretariat was working with FAO in order to ensure that actions were synchronized. Any joint action required collaboration; but despite each organization having its own approaches and regulations governing interaction with the private sector, the work was on the right track.

The DIRECTOR-GENERAL said she had attended bilateral strategic discussions with the Director-General of FAO, and both organizations were committed to working together to support Member States. However, it was also essential for ministries of health and agriculture to work together at the national level.

The CHAIRMAN took it that the Board wished to take note of the report.

The Board noted the report.

The CHAIRMAN took it that the Executive Board agreed to approve the draft decision, as amended, on maternal, infant and young child nutrition.

The decision, as amended, was adopted.¹

3. HEALTH SYSTEMS: Item 9 of the Agenda

Traditional medicine: Item 9.1 of the Agenda (Document EB134/24)

The CHAIRMAN drew attention to a draft resolution on traditional medicine proposed by China, Malaysia and the Republic of Korea, which read:

The Executive Board,
Having considered the report on traditional medicine,²

RECOMMENDS to the Sixty-seventh World Health Assembly, the adoption of the following resolution:

The Sixty-seventh World Health Assembly,

PP1 Recalling resolutions WHA22.54, WHA29.72, WHA30.49, WHA31.33, WHA40.33, WHA41.19, WHA42.43, WHA44.34, WHA54.11, WHA56.31, WHA61.21, and in particular WHA62.13 on traditional medicine, which requested the Director-General, inter alia, to update the WHO traditional medicine strategy 2002–2005, based on countries' progress and current new challenges in the field of traditional medicine;

PP2 Affirming the growing importance and value of traditional and complementary medicines in the provision of health care nationally and globally, and that such medicines are no longer limited exclusively to any particular regions or communities;

PP3 Noting the heightened level of interest in aspects of traditional and complementary medicine practices and in their practitioners, and related demand from consumers and governments that consideration be given to integration of those elements into health service delivery;

¹ Decision EB134(2).

² Document EB134/24.

PP4 Noting also that the major challenges to the area of traditional and complementary medicine include deficiencies in: knowledge-based management and policy, appropriate regulation of practices and practitioners; monitoring and implementation of regulation on products; and appropriate integration of traditional and complementary medicine services into health care service delivery and self-health care;

OP1 TAKES NOTE of the WHO traditional medicine strategy: 2014–2023, and its three objectives of building the knowledge base for active management of traditional and complementary medicine through appropriate national policies; strengthening quality assurance, safety, proper use and effectiveness of traditional and complementary medicine by regulating traditional and complementary medicine products, practices and practitioners; and promoting universal health coverage by integrating traditional and complementary medicine services into health care service delivery and self-health care;

OP2 URGES Member States, in accordance with national capacities, priorities, relevant legislation and circumstances:

- (1) to adapt, adopt and implement, where appropriate, the WHO traditional medicine strategy: 2014–2023 as a basis for national traditional and complementary medicine programmes or work plans;
- (2) to report on progress in implementing the WHO traditional medicine strategy: 2014–2023 to WHO;

OP3 REQUESTS the Director-General:

- (1) to facilitate Member States' implementation of the WHO traditional medicine strategy: 2014–2023, supporting their formulation of related knowledge-based national policies, standards and regulations, and strengthening national capacity-building accordingly through information sharing, networks and training workshops;
- (2) to continue to provide policy guidance to Member States on how to integrate traditional and complementary medicine services within their national health care system, as well as the technical guidance that would ensure the safety, quality and effectiveness of such traditional and complementary medicine services;
- (3) to continue to promote international cooperation and collaboration in the area of traditional and complementary medicine in order to share evidence-based information, taking into account the traditions and customs of indigenous peoples and communities;
- (4) to monitor the implementation of the WHO traditional medicine strategy: 2014–2023;
- (5) to report to the Seventy-second World Health Assembly, through the Executive Board, on progress made in implementing this resolution.

The CHAIRMAN further noted that informal discussions had already been held on the draft resolution and that the resulting amended text had been made available, which read:

The Executive Board,
Having considered the report on traditional medicine,¹

RECOMMENDS to the Sixty-seventh World Health Assembly the adoption of the following resolution:

¹ Document EB134/24.

The Sixty-seventh World Health Assembly,

PP1 Recalling resolutions WHA22.54, WHA29.72, WHA30.49, WHA31.33, WHA40.33, WHA41.19, WHA42.43, WHA44.34, WHA54.11, WHA56.31, WHA61.21, and in particular WHA62.13 on traditional medicine, which requested the Director-General, inter alia, to update the WHO traditional medicine strategy 2002–2005, based on countries' progress and current new challenges in the field of traditional medicine;

PP2 Affirming the growing importance and value of traditional and complementary medicines in the provision of health care nationally and globally, and that such medicines ~~isare~~ no longer limited exclusively to any particular regions or communities;

PP3 Noting the heightened level of interest in aspects of traditional and complementary medicine practices and in their practitioners, and related demand from consumers and governments that consideration be given to integration of those elements into health service delivery;

PP4 Noting also that the major challenges to the area of traditional and complementary medicine include deficiencies in: knowledge-based management and policy, appropriate regulation of practices and practitioners; monitoring ~~theand~~ implementation of regulation on products;and appropriate integration of traditional and complementary medicine services into health care service delivery and self-health care;

(OP1) 1. TAKES NOTE of the WHO traditional medicine strategy: 2014–2023, and its three objectives **and relevant strategic directions and strategic actions to guide traditional and complementary medicine sector on how traditional and complementary medicine should be further developed and advanced over the next decade; of building the knowledge base for active management of traditional and complementary medicine through appropriate national policies;** ~~strengthening quality assurance, safety, proper use and effectiveness of traditional and complementary medicine by regulating traditional and complementary medicine products, practices and practitioners; and promoting universal health coverage by integrating traditional and complementary medicine services into health care service delivery and self health care;~~

(OP2) 2. URGES Member States, in accordance with national capacities, priorities, relevant legislation and circumstances:

- (1) to adapt, adopt and implement, where appropriate, the WHO traditional medicine strategy: 2014–2023 as a basis for national traditional and complementary medicine programmes or work plans;
- (2) to report on progress in implementing the WHO traditional medicine strategy 2014–2023 to WHO;

(OP3) 3. REQUESTS the Director-General:

- (1) to facilitate Member States' implementation of the WHO traditional medicine strategy: 2014–2023, supporting their formulation of related knowledge-based national policies, standards and regulations, and strengthening national capacity building accordingly through information sharing, networks and training workshops;
- (2) to continue to provide policy guidance to Member States on how to integrate traditional and complementary medicineservices within their national health care system, as well as the technical guidance ~~that would ensure~~ **relating to** the safety, quality and effectiveness ~~of~~ **in providing** such traditional and complementary medicine services;
- (3) to continue to promote international cooperation and collaboration in the area of traditional and complementary medicine in order to share evidence-based

information, taking into account the traditions and customs of indigenous peoples and communities;

(4) to monitor the implementation of the WHO traditional medicine strategy: 2014–2023;

(5) to report to the Seventy-second World Health Assembly, through the Executive Board, on progress made in implementing this resolution.

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

<p>1. Resolution: Traditional medicine</p>		
<p>2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)</p> <p>Category: 4. Health systems</p> <table> <tr> <td>Programme area: Access to medicines and health technologies and strengthening regulatory capacity</td> <td>Outcome: 4.3 Output: 4.3.1</td> </tr> </table> <p>How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?</p> <p>The objectives of the WHO traditional medicine strategy: 2014–2023 are in line with the vision and priorities set out in the Twelfth General Programme of Work, 2014–2019 and reflected in the Programme budget 2014–2015. The implementation of the traditional medicine strategy will contribute to the achievement of the outcomes of the programme areas for integrated, people-centred health services and access to medicines and health technologies and strengthening regulatory capacity, as described in the Programme budget 2014–2015.</p> <p>Does the programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)</p> <p>Yes.</p>	Programme area: Access to medicines and health technologies and strengthening regulatory capacity	Outcome: 4.3 Output: 4.3.1
Programme area: Access to medicines and health technologies and strengthening regulatory capacity	Outcome: 4.3 Output: 4.3.1	
<p>3. Estimated cost and staffing implications in relation to the Programme budget</p> <p>(a) Total cost</p> <p>Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).</p> <p>(i) Ten years (covering the period 2014–2023)</p> <p>(ii) Total: US\$ 26.11 million (staff: US\$ 20.11 million; activities: US\$ 6.00 million)</p> <p>(b) Cost for the biennium 2014–2015</p> <p>Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).</p> <p>Total: US\$ 5.2 million (staff: US\$ 4.0 million; activities: US\$ 1.2 million)</p> <p>Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.</p> <p>All levels of the Organization, including headquarters and all regional offices, with the involvement of country offices determined region by region.</p> <p>Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)</p> <p>Yes.</p> <p>If “no”, indicate how much is not included.</p> <p>(c) Staffing implications</p> <p>Could the resolution be implemented by existing staff? (Yes/no)</p> <p>Yes.</p> <p>If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.</p>		

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

Funding gap: US\$ 1.97 million.

Expected sources of funds: US\$ 1.10 million from the Government of China, the Government of Macao Special Administrative Region (China) and the Government of India; US\$ 866 000 through fund raising efforts and financial dialogue.

Mr BAE Kyung-taek (Republic of Korea) said that the WHO traditional medicine strategy: 2014–2023 would ensure a safer and more effective use of traditional medicine, which could enhance the quality of health care. Research and development would modernize traditional medicine and facilitate future convergence with Western medicine. However, before traditional medicines could be incorporated into national health care systems, there was a need to analyse the current status of those medicines, prove their safety and effectiveness, and enhance mutual understanding. As experience of traditional medicine differed in each country, Member States should share experiences and models for integration into health care systems, supported by the Secretariat through the development of a road map. The WHO traditional medicine strategy should form the basis of national policies, and the Secretariat should provide technical support in that regard. He supported the draft resolution.

Mr COTTERELL (Australia) said that Australia wished to be added as a sponsor of the draft resolution. He asked that the words “ensuring safety, quality and efficacy” be reinstated in the revised draft resolution, as those aspects had always been a key part of Australia’s approach to traditional medicine.

Dr NOOR HISHAM ABDULLAH (Malaysia) said that a clear and comprehensive policy would help to chart the growth and development of traditional medicine products, practices and practitioners, particularly in societies with a rich cultural heritage. Increased global awareness of the potential health benefits of traditional medicine had led to efforts to professionalize it, with emphasis on evidence-based practice and quality assurance. Member States should research traditional medicine in their respective regions to help bridge the gap between such practices and modern science, and facilitate their integration into health care systems. He therefore, supported the draft resolution and the implementation, where appropriate, of the WHO traditional medicine strategy: 2014–2023.

Mr AL-MARRI (Qatar), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that traditional medicine was widely used outside national health systems in the Region, with limited regulatory control. Unregulated herbal remedies were available in most Member States. Registration of such medicines was not enforced, and written requirements and procedures were insufficient. Some Member States were developing legislation in that regard, and the League of Arab States had begun to develop a model law on traditional medicine. WHO had launched its traditional medicine strategy: 2014–2023 in October 2013, and he welcomed the strategic direction towards strengthening national medicines regulatory authorities, including capacity for quality control of herbal medicines, and regulating traditional and complementary medicine practices and practitioners. He urged the Secretariat to provide technical support in that regard.

Dr KARGBO (Sierra Leone), speaking on behalf of the Member States of the African Region, said that between 2001 and 2012, countries in the Region had implemented the first regional strategy on traditional medicine, leading to significant developments in policy, strategic planning, regulation and research. The Regional Committee for Africa at its sixty-third session had adopted the updated regional strategy, which built on the successful promotion of the positive aspects of traditional medicine in national systems, as part of the decade of African traditional medicine. Despite the

progress made, countries faced various challenges, including limited stewardship and governance, inadequate regulation and law enforcement, and insufficient human and financial resources for research in and production of traditional medicine products. He urged Member States to utilize traditional medicine in accordance with WHO guidelines, and encouraged WHO to continue to promote international cooperation and collaboration in traditional medicine.

Mr SIDIKOV (Uzbekistan) said that traditional medicine complemented Western medicine, and experience accumulated in the field of traditional medicine in countries such as China, Republic of Korea and Malaysia would help others to implement such practices to a greater level. He supported the draft resolution and requested that Uzbekistan be added as a sponsor.

Ms MATSOSO (South Africa) commended the WHO traditional medicines strategy: 2014–2023, which built on WHO's normative work in that field. Moreover, she hoped it would strengthen the technical basis for the adaptation and implementation of Member States' activities relating to traditional medicine. She encouraged the Secretariat to support further efforts at country and regional levels. South Africa wished to be added to the list of sponsors of the draft resolution.

Dr MYINT HTWE (Myanmar) said that traditional medicine was important in Member States, particularly in rural areas, and he therefore welcomed the WHO strategy. In order to achieve the second objective of strengthening quality assurance, safety, proper use and effectiveness by regulating traditional and complementary medicine products, there was a need to increase research capacity, especially at the country level, and he asked the Secretariat to develop a road map and work plan to that end as soon as possible. The Secretariat should also share best practices of regulatory mechanisms and frameworks. He asked how much funding had been allocated to traditional medicine from the Programme budget 2014–2015 at headquarters and in the regional offices, and whether voluntary funding had been received for the promotion of traditional medicine. If resources were insufficient, Member States should encourage greater voluntary funding to that area. In conclusion, the WHO traditional medicine strategy could help to fine tune existing policies, regulatory mechanisms and implementation frameworks at the country and regional levels.

Dr OMI (Japan) said that traditional medicine, including Chinese herbal medicine, acupuncture, moxibustion and Judo therapy had long been a part of the national health system in Japan. It was important for Member States to incorporate and utilize traditional medicines, knowledge and practices, on the basis of evidence of their safety and efficacy. He supported the draft resolution.

Dr ASADI-LARI (Islamic Republic of Iran) welcomed the proposal to update the strategy on traditional medicine and the draft resolution, which his country also wished to sponsor. He agreed that Member States needed to develop national policies and work plans, as well as regulatory mechanisms that would ensure the quality, safety and efficacy of traditional medicine products. It was important to develop academic programmes in order to train physicians and to ensure their ongoing evaluation. Member States should recognize the right of patients and physicians to choose treatment methods, and traditional medicine should be acknowledged as part of universal health coverage. Clinical trials should produce scientific evidence. Furthermore, WHO and WIPO should provide support to ensure that intellectual property rights were correctly awarded. A surveillance system was required to monitor the side effects of traditional medicine products and practices.

The inclusion of evidence-based traditional medicine interventions in Iran's health care system was permitted, in accordance with national guidelines and regulations. He welcomed the WHO traditional medicine strategy: 2014–2023; however, the document had some shortcomings and lacked information on traditional medicine in Iran and other countries.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that implementation of the WHO traditional medicine strategy: 2002–2005 had led to significant progress, particularly in the regulation of herbal medicine and of traditional and complementary medicine practice and practitioners. Traditional

medicine was fully integrated into the Cuban health system, being provided at primary health care centres and pharmacies, alongside Western medicine. The updated strategy aimed to deal with needs identified by Member States, focusing on priority-setting in health systems and services, including traditional and complementary medicine products, practices and practitioners. Cuba wished to sponsor the draft resolution.

Mr RI Jang Gon (Democratic People's Republic of Korea) said that, despite its long history, use of traditional medicine was limited and was generally seen only as an alternative medicine. Standardization of traditional medicine and related research and quality control were needed, as well as increased production and effective utilization of products, especially in the treatment of chronic diseases. In his country, production of Koryo medicines was being increased and efforts were being made to improve standardization and quality assurance. He supported the draft resolution.

Dr BEJTJA (Albania) welcomed the draft resolution but shared the concern expressed by the member for Australia: the need for sound standards and regulations relating to efficacy, safety, quality assurance and monitoring should be clearly formulated in the draft resolution.

Professor LOUME (Senegal) said that his country wished to be added as a sponsor of the draft resolution, although he would prefer to retain the phrase "traditional medicine" throughout the document, since references to "complementary medicine" could lead to confusion.

Dr BAYE LUKONG (Cameroon) supported the draft resolution.

Dr ZHU Haidong (China)¹ thanked Board members for their support for the draft resolution. He recalled that in 2010 WHO had launched a global survey of traditional medicine and had received national reports from 130 Member States. Analysis of those reports and supplementary information had formed the basis of the new traditional medicine strategy, which highlighted three objectives, six strategic directions and other strategic actions. Those objectives were focused and forward-looking, and the proposed monitoring indicators made it possible to evaluate the strategy's implementation. The new strategy would provide a sound basis for Member States to work together to address global challenges.

Turning to the draft resolution, in the second preambular paragraph he proposed replacing "medicines" by "medicine", as the latter was understood to have a broader meaning than just medication. In paragraph 1, he proposed deleting the unnecessary reference to the content of the three objectives contained in the WHO traditional medicine strategy: 2014–2023, which appeared after the words "three objectives", and then adding "... and the relevant strategic directions and actions to guide traditional medicine sector on how traditional medicine should be further developed and advanced over the next decade". In paragraph 3(2), the words "ensure the safety", which had been taken out, should be retained and the paragraph would therefore read: "...technical guidance that would ensure the safety, quality and effectiveness of such traditional and complementary medicine services".

At the invitation of the CHAIRMAN, Ms ROSE-ODUYEMI (Office of the Governing Bodies and External Relations) read out the amendment to paragraph 1 of the draft resolution, which would read: "TAKES NOTE of the WHO traditional medicine strategy: 2014–2023, and its three objectives, and relevant strategic directions and strategic actions to guide the traditional medicine sector on how traditional medicine should be further developed and advanced over the next decade."

Mr RAZAFINDRAZAKA (Madagascar)¹ said that people used traditional medicine in Madagascar as a cost-saving measure. A national consultative committee for traditional medicine had

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

been created within the Ministry of Health and there were communal consultative committees to register traditional medicine practitioners, control traditional medicine practice, protect professional ethics and regulate the sale of medicinal plants. The WHO traditional medicine strategy: 2014–2023 would guide Member States wishing to use traditional medicine as an additional health care tool. He supported the draft resolution.

Mr MISHRA (India)¹ welcomed the WHO traditional medicine strategy: 2014–2023, which had been overdue. Traditional medicine had long been used in India and complemented the national health care system. He encouraged Member States to adopt and adapt the WHO strategy and said that India would share its experiences in that regard. Recognizing that the strategy encouraged regional cooperation, India had hosted an international conference on traditional medicine, in collaboration with the Regional Office for South-East Asia, which had issued a declaration encouraging cooperation and mutual support. He urged other regions to take similar action. India would continue to explore the role of traditional medicine as an integrated element in disease control.

Professor TJANDRA YOGA ADITAMA (Indonesia)¹ said that various types of traditional medicines were used widely in his country and the Ministry of Health had established a special programme for strengthening its herbal Jamu products, called “herbal scientification”. Indonesia wished to sponsor the draft resolution.

Dr SAMMAK (Syrian Arab Republic)¹ said that, as he understood it, traditional medicine referred to the formal practice of medicine as internationally recognized, whereas the current discussion was focused on popular or folk medicine. Regulation of the latter would be difficult in any country, particularly in the Eastern Mediterranean Region, and the more so in the prevailing exceptional circumstances. People resorted to popular medicine because conventional or Western medicine was costly and because treatment support in some specialties was lacking. He had known patients with dermatological conditions who had been successfully treated with popular medicine where conventional medicine had failed. Appreciated as they might be, attempts to regulate practices older than Western civilization would be problematic.

Professor KULZHANOV (Kazakhstan)¹ said that the traditional medicine system had often developed outside official health systems, and it was therefore important to ensure that it was equally well regulated. Often, those who worked in traditional medicine did not have the required level of education or training, so it was crucial that the sector was subject to effective monitoring and control and that there was proper training and certification of practitioners. It was just as important to conduct scientific studies on traditional medicines as it was for conventional medicines, in order to understand a product’s effectiveness.

It would be helpful to bring together people who worked with traditional medicine in professional associations or organizations so that they could learn from each other, although he recognized that many people in that area often preferred to work alone, or at least not in such a structured system. Kazakhstan wished to be added as a sponsor of the draft resolution.

Mr KOLKER (United States of America)¹ commended the draft resolution and would support its submission to the Health Assembly. Many Asian countries had spoken of the role that complementary and traditional medicines played in their health systems and, similarly, the United States was pleased to have established some years ago a national centre for alternative and complementary medicine. That centre had worked actively with WHO in developing the updated strategy on traditional medicine for 2014–2023. However, while the strategy acknowledged that the greatest obstacle for policy development in countries was the lack of scientific evidence, the United States felt that greater emphasis could be

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

placed on the need for rigorous research, objectivity and a strong evidence base. He would submit his proposed changes to the strategy to the Secretariat in writing.

Mr JONES (Canada)¹ expressed support for the draft resolution but proposed that two amendments be made to paragraph 3(2): the words “and/or subnational” should be inserted after “national” and “system” should be replaced with “systems”. The changes were aimed at reflecting the fact that in federated States such as Canada, the relevant health care services and systems might not operate at the national level.

The CHAIRMAN, referring to Canada’s second proposed amendment, said that it would be better if the final “s” of “systems” was shown in brackets, to reflect the fact that, for many countries, there would not be more than one system.

Dr VALLEJO (Ecuador)¹ said that his country was an intercultural and plurinational State, within which there were a number of different indigenous populations. As such, the use of traditional medicines was deep-rooted in Ecuador. All countries needed to work to recover and strengthen ancestral health practices. People had the right to choose the type of treatment that they wanted, and it was the role of the State to guarantee that different types of treatment were safe and effective. It was essential to promote international documentation of traditional medicines and thus establish the progress made in regulating them, in order to strengthen the practice of traditional medicine within national health systems. Political will in Ecuador was focused on defending the right to choose traditional medicines and the country was party to all relevant agreements on the issue at the international level. He supported the draft resolution.

The CHAIRMAN took it that the Board wished to consider the amendments proposed by the representative of Canada.

Ms MATSOSO (South Africa) seconded the amendments proposed by the representative of Canada.

Dr KIENY (Assistant Director-General) said that she looked forward to receiving the proposed changes to the text of the strategy in writing. The Secretariat would look into the suggestion made by the member for Myanmar regarding research, but since nothing could be added to the Programme budget for the current biennium, the proposal would be considered for inclusion in the budget for the following biennium.

The CHAIRMAN took it that the Board wished to take note of the report.

The Board noted the report.

The CHAIRMAN further took it that the Board wished to adopt the draft resolution on traditional medicine, as amended.

The resolution, as amended, was adopted.²

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

² Resolution EB134.R6.

Substandard/spurious/falsely-labelled/falsified/counterfeit medical products: Item 9.2 of the Agenda (Document EB134/25)

The CHAIRMAN drew attention to the report of the second meeting of the Member State mechanism on substandard/spurious/falsely-labelled/falsified/counterfeit medical products, which was contained in the Annex to document EB134/25. The mechanism, whose second meeting had taken place in November 2013, had requested the Director-General to transmit the report to the Sixty-seventh World Health Assembly through the Executive Board at its present session.

Dr SHAKEELA (Maldives) said that the public health problem posed by substandard/spurious/falsely-labelled/falsified/counterfeit medical products affected millions of people, in developing and developed countries. However, the problem was worse in countries where resources were limited and where there was poor regulatory capacity and weaknesses in the supply chain. Controlling and preventing such products necessitated efficient coordination and communication among all stakeholders; regional collaboration mechanisms needed to be established to facilitate the sharing of information; and regional action would benefit countries that did not have the means to act on their own.

Mr PIPPO BRIANT (Argentina) said that ensuring access to safe, quality-assured, effective and affordable medicines was a critical step towards universal health coverage. He commended the work done by Brazil in chairing the open-ended working group to identify actions, activities and behaviours that resulted in substandard/spurious/falsely-labelled/falsified/counterfeit medical products, and he welcomed the non-exhaustive list that had been identified.

He appreciated the confidence that had been placed in his country to lead technical discussions on the formulation of recommendations to assist health authorities in detecting and addressing actions, activities and behaviours. His delegation would make available online a reference document that would form the basis for the discussions, in which he encouraged all Member States to participate. He also supported the work plan of the mechanism and urged Member States to engage actively in formulating actions to give effect to it. He called for a meeting of the Steering Committee to be held after the Sixty-seventh World Health Assembly and before its formal meeting in October 2014, in order to discuss proposals as to how pending actions would be carried out.

Dr AZODOH (Nigeria), speaking on behalf of the Member States of the African Region, said that the production and marketing of substandard/spurious/falsely-labelled/falsified/counterfeit medical products posed a major threat to public health outcomes throughout the Region. Africa continued to advocate for strong regulatory mechanisms. Various measures had been taken in the Region to advance the prevention and control of such products, including increasing the quality and quantity of data, training country focal points on the WHO rapid alert system and developing a technical document on building capacity for regulation. Work was being done to establish an African medicines agency. Many Member States were amending their anti-counterfeiting legislation in order to make supply chains more secure and to serve as a greater deterrent to offenders. New technologies had also been deployed, such as a hand-held device that could be used at borders to determine the quality of medicines.

The African Region remained concerned, however, at the lack of harmony among national regulatory systems and integrity of supply systems. The Secretariat should take all necessary steps to support countries in improving the harmonization of systems, in order to ensure effective coordination and cooperation globally. The Region was also concerned by the lack of sufficient funding for the Member State mechanism and encouraged the Secretariat and Member States to ensure that the necessary resources were made available.

Dr BARBOSA DA SILVA (Brazil) welcomed the various important decisions that had been taken at the second meeting of the Member State mechanism on the governance of the mechanism and its work plan, as well as the non-exhaustive list of actions, activities and behaviours prepared by the

open-ended working group. Other tools and projects developed or being developed by WHO, including the project for the surveillance and monitoring of substandard/spurious/falsely-labelled/falsified/counterfeit medical products, had to be in line with the approaches and definitions established by the mechanism, and appropriate consultation with Member States on such projects should be undertaken.

Dr TAKASAKI (Japan) welcomed the progress made in the discussions of the open-ended working group and at the second meeting of the Member State mechanism. Comprehensive measures were still needed, aimed at ensuring the integrity of supply chains, raising awareness among the general public and strengthening health systems. The first was of particular importance, as substandard/spurious/falsely-labelled/falsified/counterfeit medical products could be purchased through various unauthorized supply channels, including online. However, combating those products should not hinder the proper trading of legitimate generic products.

Ms DÁVILA CHÁVEZ (Mexico) expressed support for the work plan of the Member State mechanism; her country was committed to monitoring and following up its outcomes. She agreed with the member for Nigeria that in order for the mechanism's work plan to be implemented, sufficient funds would need to be made available. It would be useful to provide a timeline for activities to be carried out and to outline how resources would be allocated according to the objectives of the work plan, in order to better monitor those activities.

Dr MEMISH (Saudi Arabia), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that substandard/spurious/falsely-labelled/falsified/counterfeit medical products posed a significant danger to public health all over the world, although more particularly in developing countries. The WHO project for the surveillance and monitoring of such medical products was to be welcomed, especially in the light of the 60 or so reports of such products over a 12-month period. He encouraged Member States to participate in and contribute to that project in order to safeguard public health. Those States with free trade zones, in particular, should ensure that proper training was provided in the use of WHO alert forms and in surveillance and monitoring procedures. WHO should also provide technical support to national medicines regulatory authorities in order to build capacity for combating the circulation of such products within their markets.

Mr BAE Kyung-taek (Republic of Korea) said that the rise in e-commerce and trade liberalization had increased the risk of sales of substandard/spurious/falsely-labelled/falsified/counterfeit medical products. However, given the cross-border nature of the Internet, a single country would face limitations in its ability to counter the situation; it was therefore essential that international discussions and cooperation were expanded. A more focused and viable plan needed to be established, under the auspices of WHO, that sought long-term solutions to the problem.

Dr VALVERDE (Panama) welcomed the report and the process that was under way, which would increase Member States' capacity to deal with substandard/spurious/falsely-labelled/falsified/counterfeit products. Panama's Ministry of Health had established an online notification system for falsified pharmaceutical products, which allowed individuals to announce the possible sale of or other activities relating to falsified medical products within the country. The authorities were able to access the information immediately, process it and share it with members of an inter-agency committee that dealt with falsified medical products.

Dr MAO Zhenbin (China)¹ noted the many positive outcomes achieved in recent times in preventing and controlling substandard/spurious/falsely-labelled/falsified/counterfeit products, not

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

least the establishment of the Member State mechanism. He supported the need for the exchange of information between monitoring and regulatory authorities as it would enhance effective cooperation among those authorities and increase global capacity to prevent and control such products. Further attention should be paid to the standards for notification of information and evidence to law enforcement authorities, in particular related to product testing, so as to increase the accuracy of information provided.

Ms WIDIYARTI (Indonesia)¹ said that her country had high expectations that the Member State mechanism could strengthen international cooperation and collaboration to control and prevent substandard/spurious/falsely-labelled/falsified/counterfeit medical products. She therefore welcomed and supported the proposed work plan and hoped that there would be further discussions in the open-ended working group. She reiterated Indonesia's commitment to combating substandard/spurious/falsely-labelled/falsified/counterfeit medical products.

Mr MISHRA (India)¹ expressed appreciation of the progress made by the Member State mechanism. At the mechanism's second meeting in November 2013, India had recognized the need to identify activities and behaviours that fell outside the mandate of the mechanism and had agreed to lead technical discussions on the issue with Argentina. His country had taken a number of measures to control substandard/spurious/falsely-labelled/falsified/counterfeit medical products, including amending relevant legislation, establishing special courts to fast-track trials for drugs-related offences, ensuring appropriate systems for whistle-blowing, and strengthening regulatory systems.

Dr VALLEJO (Ecuador)¹ said that his country had experienced the effects of substandard/spurious/falsely-labelled/falsified/counterfeit medical products and, as a result, its penal code had been amended to make it an offence to manufacture or market substandard or falsified products. As part of reforms to the health code, the country had also prohibited the import, production, manufacture, marketing, storing and distribution of substandard medical products and it was developing a mechanism for the control and surveillance of falsified products. He supported the proposed work plan of the Member State mechanism and advocated the strengthening of health authorities in order to better control the products in question.

Mr MITURA (International Pharmaceutical Students' Federation), speaking at the invitation of the CHAIRMAN, said that with the increasing prioritization of universal health coverage, especially in the context of the post-2015 development agenda, it was more important than ever to find effective solutions to the threat of substandard/spurious/falsely-labelled/falsified/counterfeit medical products. Investment in health services would be of value only if they were strong enough to provide quality-assured medicines and ensure patient safety. The Federation welcomed the work plan of the Member State mechanism and hoped it would pave the way for increased patient safety through promotion of vigilance and awareness-raising among patients, health professionals and industry, an approach that was already practised by the Federation through various anti-counterfeit initiatives. Pharmacists had a key role to play in the area of quality assurance, and the Federation called for them to be better equipped with the technical solutions to facilitate the authentication of all medical products. Countries should also provide tools for patients to verify the legitimacy of pharmaceutical businesses, given the increasing number of illicit online pharmacies that obtained and supplied medical products of questionable quality and safety.

Ms KUSYNOVÁ (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN and also on behalf of the World Health Professions Alliance, welcomed the Member State mechanism's work plan but was concerned that its financing had not yet been secured. That,

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

coupled with the fact that the mechanism only met once a year, meant there was a risk that little progress would be made in the near future, despite the strong need for global action following the various cases of detection of substandard/spurious/false-labelled/falsified/counterfeit medical products in 2013. Several positive government initiatives had been taken in countries in recent times, but further support from WHO and the mechanism was required, and appropriate funding needed to be allocated, if political will was to be translated into effective action. The Alliance hoped that the mechanism would consider enabling nongovernmental organizations in official relations with WHO to observe meetings of its Steering Committee.

Dr KIENY (Assistant Director-General) acknowledged the work of the Steering Committee of the Member State mechanism on substandard/spurious/false-labelled/falsified/counterfeit medical products and confirmed that the Secretariat would be happy to continue supporting the mechanism, as requested by a number of Member States. However, discussions would be needed on funding for the mechanism as, to date, only 10% of the US\$ 12 million required for 2014–2015 was available. Fundraising, which had been strongly endorsed by the Steering Committee in the work plan, was being undertaken for the remainder.

The CHAIRMAN took it that the Board wished to take note of the report.

The Board noted the report.

Strengthening of palliative care as a component of integrated treatment throughout the life course: Item 9.4 of the Agenda (Document EB134/28)

The CHAIRMAN drew attention to a draft resolution proposed by Australia, Chile, Colombia, Ghana, Libya, Malaysia, Panama, South Africa, Spain, Switzerland, Turkey and United States of America, and which read:

The Executive Board,

Having considered the report on strengthening of palliative care as a component of integrated treatment throughout the life course,¹

RECOMMENDS to the Sixty-seventh World Health Assembly the adoption of the following resolution:

The Sixty-seventh World Health Assembly,

PP1 Recalling resolution WHA58.22 on cancer prevention and control, especially as it relates to palliative care;

PP2 Taking into account the Commission on Narcotic Drugs' resolutions 53/4 and 54/6 respectively entitled "Promoting adequate availability of internationally controlled licit drugs for medical and scientific purposes while preventing their diversion and abuse" and "Promoting adequate availability of internationally controlled narcotic drugs and psychotropic substances for medical and scientific purposes while preventing their diversion and abuse";

PP3 Acknowledging the special report of the International Narcotics Control Board entitled Report of the International Narcotics Control Board on the Availability of Internationally Controlled Drugs: Ensuring Adequate Access for Medical and Scientific Purposes,² and the WHO guidance document entitled Ensuring balance in national policies on

¹ Document EB134/28.

² Document E/INCB/2010/1/Supp.1.

controlled substances: guidance for availability and accessibility of controlled medicines;

PP4 Also taking into account resolution 2005/25 of the United Nations Economic and Social Council on treatment of pain using opioid analgesics;¹

PP5 Bearing in mind that palliative care is an approach that improves the quality of life of patients (adults and children) and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual;

PP6 Recognizing that palliative care, when indicated, is fundamental to improving quality of life, well-being, comfort and human dignity for individuals, being an effective person-centred health service that values patients' need to receive adequate, personally and culturally sensitive information on their health status, and their central role in making decisions about the treatment received;

PP7 Affirming that access to palliative care and to essential medicines for medical and scientific purposes manufactured from substances under control, including opioid analgesics such as morphine, in line with the three United Nations international drug control conventions,² contributes to the realization of the right to the enjoyment of the highest attainable standard of health and well-being;

PP8 Acknowledging that palliative care is an ethical responsibility of health systems, and that it is the ethical duty of health care professionals to alleviate pain and suffering, whether physical, psychosocial or spiritual, irrespective of whether the disease or condition can be cured, and that end-of-life care for individuals is among the critical components of palliative care;

PP9 Recognizing that more than 40 million people currently require palliative care every year, foreseeing the increased need for palliative care with ageing populations and the rise of noncommunicable and other chronic diseases worldwide, considering the importance of palliative care for children, and in respect of this acknowledging that Member States should have sufficient estimates of the internationally controlled medicines needed, including medicines in paediatric formulations;

PP10 Realizing the urgent need to include palliation across the continuum of care, especially at the primary care level, recognizing that inadequate integration of palliative care into health and social care systems is a major contributing factor to the lack of equitable access to such care;

PP11 Noting that the availability and appropriate use of internationally controlled medicines for medical and scientific purposes, particularly for the relief of pain and suffering, remains insufficient in many countries, and highlighting the need for Member States, with the support of the WHO Secretariat, UNODC, and the International Narcotics Control Board, to ensure that efforts to prevent the diversion of narcotic drugs and psychotropic substances under international control pursuant to the United Nations international drug control conventions do not result in inappropriate regulatory barriers to the medical access to such medicines;

PP12 Taking into account that the avoidable suffering of treatable symptoms is perpetuated by the lack of knowledge of palliative care, and highlighting the need for continuing education and adequate training for all hospital- and community-based health care providers and other caregivers, including nongovernmental organization workers and family members;

¹ Document EDM/QSM/2000.4, Revised 2011.

² United Nations Single Convention on Narcotic Drugs, 1961, as amended by the 1972 Protocol; United Nations Convention on Psychotropic Substances, 1971; United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.

PP13 Recognizing the existence of diverse cost-effective and efficient palliative care models, acknowledging that palliative care uses an interdisciplinary approach to address the needs of patients and their families, and noting that the delivery of quality palliative care is most likely to be realized where strong networks exist between professional palliative care providers, support care providers (including spiritual support and counselling), volunteers and affected families, as well as between the community and acute and aged care providers;

PP14 Recognizing the need for palliative care across disease groups (noncommunicable diseases, and infectious diseases, including HIV and multidrug-resistant tuberculosis), and across all age groups;

PP15 Welcoming the inclusion of palliative care in the definition of universal health coverage and emphasizing the need for health services to provide integrated palliative care in an equitable manner in order to address the needs of patients in the context of universal health coverage;

PP16 Recognizing the need for adequate funding mechanisms for palliative care programmes, including for medicines and medical products, especially in developing countries;

PP17 Welcoming the inclusion of palliative care actions and indicators in the WHO comprehensive global monitoring framework for the prevention and control of noncommunicable diseases and in the global action plan for the prevention and control of noncommunicable diseases 2013–2020;

PP18 Noting with appreciation the inclusion of medicines needed for pain and symptom control in palliative care settings in the 18th WHO Model List of Essential Medicines and the 4th WHO Model List of Essential Medicines for Children, and commending the efforts of WHO collaborating centres on pain and palliative care to improve access to palliative care;

PP19 Noting with appreciation the efforts of nongovernmental organizations and civil society in continuing to highlight the importance of palliative care, including adequate availability and appropriate use of internationally controlled substances for medical and scientific purposes, as set out in the United Nations international drug control conventions;

PP20 Recognizing the limited availability of palliative care services in much of the world and the great avoidable suffering for millions of patients and their families, and emphasizing the need to create or strengthen, as appropriate, health systems that include palliative care as an integral component of the treatment of people within the continuum of care;

(OP1)1. URGES Member States:¹

(1) to develop, strengthen and implement, where appropriate, palliative care policies to support the comprehensive strengthening of health systems to integrate evidence-based, cost-effective and equitable palliative care services in the continuum of care, across all levels, with emphasis on primary care, community and home-based care and universal coverage schemes;

(2) to ensure adequate domestic funding and allocation of human resources, as appropriate, for palliative care initiatives, including development and implementation of palliative care policies, education and training and quality improvement initiatives, and support the availability and appropriate use of essential medicines, including controlled medicines for symptom management;

¹ And, where applicable, regional economic integration organizations.

- (3) to provide basic support, including through multisectoral partnerships, to families, community volunteers and other individuals acting as caregivers, under the supervision of trained professionals, as appropriate;
- (4) to aim to include palliative care as an integral component of the ongoing education and training offered to care providers, in accordance with their roles and responsibilities, according to the following principles:
 - (a) basic training and continuing education on palliative care should be integrated as a routine element of all undergraduate medical and nursing professional education, and as part of in-service training of caregivers at the primary care level, including health care workers, caregivers addressing patients' spiritual needs and social workers;
 - (b) intermediate training should be offered to all health care workers who routinely work with patients with life-threatening illnesses, including those working in oncology, infectious diseases, paediatrics, geriatrics and internal medicine;
 - (c) specialist palliative care training should be available to prepare health care professionals who will manage integrated care for patients with more than routine symptom management needs;
- (5) to assess domestic palliative care needs, including pain management medication requirements, and promote collaborative action to ensure adequate supply of essential medicines in palliative care, avoiding shortages;
- (6) to review, and, where appropriate, revise national and local legislation and policies for controlled medicines, using WHO policy guidance¹ to improve access and rational use of pain management medicines, in line with the United Nations international drug control conventions;
- (7) to update, as appropriate, national essential medicines lists, in the light of the recent addition of sections on pain and palliative care medicines to the WHO Model List of Essential Medicines and the WHO Model List of Essential Medicines for Children;
- (8) to foster partnerships between governments and civil society, including patients' organizations, to support, as appropriate, the provision of services for patients requiring palliative care;
- (9) to implement and monitor palliative care actions included in WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2020;

(OP2)2. REQUESTS the Director-General:

- (1) to ensure that palliative care is an integral component of all relevant global disease control and health system plans, including those relating to noncommunicable diseases and universal health coverage, as well as being included in country and regional cooperation plans;
- (2) to update or develop, as appropriate, evidence-based guidelines and tools on palliation, including pain management options, in adults and children, including the development of WHO guidelines for the pharmacological treatment of pain, and ensure their adequate dissemination;
- (3) to develop and strengthen, where appropriate, evidence-based guidelines on the integration of palliative care into national health systems, across disease groups and levels of care, that adequately address ethical issues related to the provision of comprehensive palliative care, such as equitable access, person-centred and respectful care, and community involvement, and to inform education in pain and symptom management and psychosocial support;

¹ Ensuring balance in national policies on controlled substances: guidance for availability and accessibility of controlled medicines. Geneva: World Health Organization; 2011.

- (4) to continue, through WHO's Access to Controlled Medicines Programme, to support Member States in reviewing and improving national legislation and policies with the objective of ensuring balance between the prevention of misuse, diversion and trafficking of controlled substances and appropriate access to controlled medicines, in line with the United Nations international drug control conventions;
- (5) to explore ways to increase the availability and accessibility of medicines used in palliative care through consultation with Member States and relevant networks and civil society, as well as other international stakeholders, as appropriate;
- (6) to work with the International Narcotics Control Board, the United Nations Office on Drugs and Crime, ministries of health and other relevant authorities, in order to promote the availability and balanced control of controlled medicines for pain and symptom management;
- (7) to further cooperate with the International Narcotics Control Board to support Member States in establishing accurate estimates to enable the availability of medicines for pain relief and palliative care including through better implementation of the guidance "Guide on Estimating Requirements for Substances under International Control, developed by the International Narcotics Control Board and the World Health Organization for use by Competent National Authorities (2012)";
- (8) to collaborate with UNICEF and other relevant partners in the promotion and implementation of palliative care for children;
- (9) to monitor the global situation of palliative care, evaluating the progress made in different initiatives and programmes in collaboration with MS and international partners;
- (10) to work with Member States to encourage adequate funding and improved cooperation for palliative care programmes and research initiatives, in particular in resource-poor countries, in line with the approved Programme budget 2014–2015, which addresses palliative care;
- (11) to encourage research on models of palliative care that are effective in low- and middle-income countries, taking into consideration good practices;
- (12) to report back to the Sixty-ninth World Health Assembly in 2016, through the Executive Board, on progress in the implementation of this resolution.

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

1. Resolution: Strengthening of palliative care as a component of integrated treatment within the continuum of care	
2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)	
Category: 2	
Programme area: Noncommunicable diseases	Outcome: 2.1 Output: 2.1.1
How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?	
It would support achievement because palliative care is part of the continuum of care required for tackling noncommunicable diseases, particularly cardiovascular disease, cancer, chronic respiratory disease and diabetes. It is one of the activities included in the global action plan for the prevention and control of noncommunicable diseases 2013–2020. An indicator for tracking access to palliative care is also included in the action plan's global monitoring framework.	
Does the programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)	
Yes.	

3. Estimated cost and staffing implications in relation to the Programme budget**(a) Total cost**

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) Implementation would cover, and continue beyond, the seven remaining years of the global action plan for the prevention and control of noncommunicable diseases 2013–2020

(ii) Total: US\$ 20 million (staff: US\$ 10 million; activities: US\$ 10 million)

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 1 million (staff: US\$ 600 000; activities: US\$ 400 000)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

All levels.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

If “no”, indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No, but the cost of filling the necessary positions has been included in the programme budget.

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

In the next biennium, at least one additional staff member at grade P.5 would be needed at headquarters together with one at grade P.4 in each of the regional offices.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

The funding gap is US\$ 640 000. It will be tackled through the Organization-wide coordinated resource mobilization plan to deal with funding shortfalls in the Programme budget 2014–2015.

Mr CORRALES (Panama) said that the draft resolution sought to respond to the fact that few countries had sufficiently integrated palliative care into their health care systems and that no responsibility had been taken at the global level for overcoming the lack of access to pain relief medicines. The resolution also mandated the Director-General to work with UNODC, the International Narcotics Control Board and Member States' health ministries in order to ensure a balance between the availability and control of drugs; the Organization was best placed from the perspective of public health and human dignity to take the necessary action.

As a sponsor of the draft resolution he proposed two amendments to the text: in preambular paragraph 13, the words “as needed” should be inserted after “counselling”, and in paragraph 1(6) the word “using” should be replaced with “with reference to”.

Dr MATCHOCK-MAHOURI (Chad), speaking on behalf of the Member States of the African Region, said that given the increase in chronic diseases in Africa and the lack of adequate human resources, there was a great need to develop a robust community-wide approach to the provision of palliative care as a component of integrated treatment. The lack of national policies on palliative care

services was a major challenge. The situation was exacerbated by the limited availability of pain relief medication, a poor doctor-to-patient ratio, a lack of training in palliative care among health personnel, a lack of research and poor understanding of such care among the public, despite convincing evidence of patients' need for pain management. The African Region supported the draft resolution.

Dr KAMALIAH MOHAMAD NOH (Malaysia) said that she was pleased with the interest shown by Member States since the Sixty-sixth World Health Assembly in strengthening palliative care, as it was fundamental for improving the quality of life and dignity of individuals with life-threatening illnesses. She supported the four broad policies for expanding palliative care as outlined in the report and believed that many States were already within reach of being able to provide the necessary services and interventions. With the increasing prevalence of noncommunicable diseases and an ageing global population, it was no longer an option to take no action. Malaysia supported the draft resolution.

Ms MATSOSO (South Africa) said that, despite the various international agreements and bodies focused on noncommunicable diseases, cancer control and narcotic drugs, the availability and accessibility of palliative care services in low- and middle-income countries were still limited. She commended the commitment of nongovernmental organizations and civil society to advocating for accessible, integrated and sustainable palliative care and recognized the support of WHO in including palliative care in the definition of universal health coverage. She further commended the inclusion of medicines needed for pain relief and symptom control in palliative care settings in the 18th edition of the WHO Model List of Essential Medicines and the 4th edition of the WHO Model List of Essential Medicines for Children.

Ms PENEVEYRE (Switzerland) welcomed the report, which illustrated the large gap that existed globally between the need for and availability of palliative care services. There was a considerable lack of access to such services and to appropriate levels of training for health personnel. She welcomed the call to improve access to palliative care while respecting the need to control certain medicines to avoid their abuse. The Secretariat and the Member States aspired to achieve full physical, mental and social health and well-being for all people, but it had to be acknowledged that there were situations where individuals would not be able to regain their full health. In those cases, it was the absence of suffering and a state as close to full health as could be achieved that were sought by patients; the appropriate palliative care could reduce any suffering and bring a significant level of comfort to patients.

Mr COTTERELL (Australia) commended Panama's leadership in preparing the draft resolution and expressed support for the proposed amendments. It was important to acknowledge the growing need for quality palliative care services, not least because increasing global life expectancy brought with it higher rates of chronic disease and serious life-threatening conditions. Appropriate care at the end of life provided dignity for individuals and could reduce both their suffering and that of their families. He welcomed the reference in the draft resolution to ensuring access to medicines for pain relief while maintaining appropriate controls.

Dr MYINT HTWE (Myanmar) noted that the WHO definition of palliative care covered several technical areas, including physical, psychosocial and spiritual aspects, and commended the Secretariat's efforts in highlighting the need for a public health approach when addressing palliative care. He welcomed the four broad policy areas outlined in the report and the eight proposed actions to be taken at country level. WHO support was essential in moving ahead on the issue, and he believed it would be practical to appoint a specific technical focal point or regional adviser to coordinate actions to promote palliative care. The role of civil society organizations should also be promoted, as they were often very active in countries and needed to be provided with updated technical information.

Dr ASADI-LARI (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed the attention that had been drawn to the disparity in palliative care services between low- and middle-income countries and high-income ones. The growing prevalence of noncommunicable diseases and ageing populations around the world meant that there was an increasing need for palliative care services in all countries. Strong partnerships between health care providers and communities were vital to ensuring greater access to palliative care services, and the Secretariat should support Member States in developing roadmaps to integrate those services into health care systems. Such support was particularly important given the different obstacles faced by countries depending on their capacities, awareness, legislation, health system structure and financial and human resource constraints. Countries needed to commit themselves to updating national policies in order to integrate palliative care services and to ensure appropriate training of health personnel. He was pleased that implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020 would largely cover the need for the integration of palliative care services. His country wished to sponsor the draft resolution.

Dr AMMAR (Lebanon) said that the magnitude of the unmet need for palliative care in developing countries was due to both supply and demand issues. In some countries, patients were content to accept suffering as the price for technical advances that prolonged life. Thus, there was often insufficient demand for palliative care services, which was exacerbated by a lack of both appropriate training for health care professionals and of guidelines on treatment.

Furthermore, health service delivery systems were often fragmented, with no guarantee of a continuum of care, which hindered palliative care from being integrated as a multidisciplinary approach. Such care should be ensured as part of the universal accessibility of health services, with the necessary provision of psychological and spiritual support, together with pain management and symptom control. Adequate financing mechanisms were needed in order to develop palliative care services. The time had come to ensure that they were included as a priority within policies, action plans and other tools under development at all levels. Lebanon also wished to sponsor the draft resolution.

Dr AZODOH (Nigeria) asked for Nigeria to be added to the list of sponsors of the draft resolution, as amended by Panama. There was an increasing need for surgical interventions as part of treatment to reduce suffering and save lives throughout the life course; that need had grown as a result of the increasing prevalence of noncommunicable diseases, conflicts and disasters, and such surgical interventions usually required anaesthesia. He therefore encouraged the Executive Board to consider developing a draft resolution in the future on surgery and anaesthesia and called on the Secretariat to provide the appropriate technical information that would help to guide the Board in such discussions.

Dr BEJTJA (Albania) said that Albania also wished to sponsor the draft resolution and affirmed its support for the proposed amendments. Emphasizing that palliative care concerned the human rights and dignity of individuals, he drew attention to the fact that each patient exhibited a variety of symptoms, all of which needed to be treated appropriately through palliative care.

Ms DÁVILA CHÁVEZ (Mexico) expressed support for the draft resolution and welcomed Panama's work to develop and enrich the text. It was essential that the provision of palliative care services was standardized in order to ensure greater access. Amendments to normative frameworks would provide the necessary legal certainties to both service providers and those who required palliative care.

Mr PALOPOLI (Argentina) said that in his country the national cancer institute had implemented a palliative care model for patients, through which the specific needs of each patient and his or her family were considered at each stage of the disease before the appropriate care interventions were made. Argentina was also working to ensure the provision of up-to-date information on the availability of funds for palliative care services, specific care needs and barriers to access. He

supported the recommendations in the report, which were consistent with actions taken at national level. He also supported the draft resolution, not least because the increasing prevalence of noncommunicable diseases required stronger palliative care services and improved quality of life for patients and their families.

Mr BAE Kyung-taek (Republic of Korea) expressed support for the draft resolution and urged countries that had not yet done so to integrate the delivery of palliative care within their national health systems, beginning with diseases such as cancer, whose late stages were predictable. The provision of proper medical treatment throughout the life course would require changes to legal and institutional systems, as well as raising awareness about palliative care. To that end, the Secretariat should provide the necessary support to Member States and should consider developing disease-specific guidelines for palliative care policy. Monitoring of access to palliative care should also be strengthened.

Dr TAKASAKI (Japan) commended the placing of palliative care on the agenda, as recognition needed to be given to the importance of such care for patients who suffered from chronic and life-threatening conditions and their families, not only in reducing physical pain but also in addressing the mental, psychological and social effects of illness or disease. Systems needed to be established that provided health promotion, prevention, early detection and treatment, rehabilitation and the enhanced integration of palliative care. The latter was especially important in the context of combating noncommunicable diseases and achieving universal health coverage. Palliative care should be provided not only when an illness reached the terminal stage but from the early stages of treatment, according to the patient's symptoms. Access to essential medicines, including opioid analgesics that could be used in palliative care, also needed to be assured and health professionals should be trained in order to handle such medicines properly.

Dr BARBOSA DA SILVA (Brazil) welcomed the report, its description of the current global situation regarding palliative care and the measures that would be vital in improving that care in a public health context. He shared the concerns raised about improving the quality of life of those individuals with chronic and life-threatening conditions and commended Panama's efforts in having tirelessly promoted and led the discussion on the subject. Brazil supported and wished to sponsor the draft resolution.

Dr SHAKEELA (Maldives) welcomed the discussion on the topic of palliative care, which had long been neglected or underdeveloped in many countries. Such care concerned patients' dignity and human rights and encompassed all elements of a health care system, as it involved patients of all ages with diverse diagnoses. Effective palliative care should contribute to the quality and cost-effectiveness of overall health care. However, the sector faced a number of challenges, including lack of awareness of the need for palliative care, those care needs not being tackled in many national health policies, inadequate research and training, misconceptions about palliative care, and cultural beliefs about dying. A truly strategic approach for people approaching the end of life made political and economic sense; with many people living longer but with life-limiting conditions, there was an ever-growing demand for palliative care. With proper planning, the provision of such care would ensure a better quality of life for patients and allow many to die in the care setting of their choosing. Maldives supported the draft resolution and wished to be listed as a sponsor.

Ms GONZÁLEZ (Uruguay)¹ welcomed Panama's leadership in the discussions and the preparation of the draft resolution. Uruguay supported the draft resolution and wished to sponsor it.

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

Ms BOTERO HERNANDEZ (Colombia)¹ commended Panama's call for discussions on the issue of palliative care and emphasized that such care did not constitute a single service but should be integrated into all services provided throughout a health care system, according to the needs of the patient.

Professor KULZHANOV (Kazakhstan)¹ said that his country had taken various measures in recent years to improve the provision of palliative care services, including amending legislation to define palliative care as an integral part of medical assistance, developing standards and norms, and establishing hospital departments focused on palliative care. However, Kazakhstan still faced challenges such as improving access, especially to paediatric palliative care. Research in the area of palliative care needed to be expanded, as did the provision of training for specialists, especially those who worked in oncology departments and other primary health care facilities. Multisectoral cooperation was required, as it was important to ensure that there was collaboration with narcotic drugs control organizations and civil society organizations, and that palliative care was not provided solely by family members. All parts of the health sector needed to ensure the quality of life of all patients, including those with terminal conditions. Kazakhstan wished to be added as a sponsor of the draft resolution.

Ms FERNÁNDEZ DE LA HOZ ZEITLER (Spain)¹ welcomed the worthwhile attention being paid to integrating palliative care into treatment throughout the life course. Achieving that objective would only be possible through policies that promoted health system strengthening and incorporated palliative care at all levels, including paediatric settings.

Her country's palliative care strategy focused on establishing an integrated care model, offering ongoing professional training, promoting a multidisciplinary approach and providing evidence-based care, regardless of age or gender. Spain supported the draft resolution and the amendments that had been proposed.

Mrs ANDRIENKO (Ukraine)¹ commended Panama's efforts in leading the preparation of the draft resolution and said that Ukraine wished to be added as a sponsor.

Ms BURRIS (United States of America)¹ also commended Panama's leadership in developing the draft resolution on palliative care, as such care was an integral part of any health system to which many people still did not have access. Palliative care was rightly included in the definition of universal health coverage and should be integrated into the continuum of care at all levels. Effective training and support of all caregivers, whether in the home, community or health centres, would be required. Countries should expand palliative care programmes, ensuring better access to medicines for pain relief in a manner that prevented the abuse of such substances and in accordance with relevant international conventions on narcotic drugs control.

Dr JIAO Yahui (China)¹ welcomed the report and its description of the demand for and benefits of palliative care. China had developed a number of policies on increased access to necessary painkillers, guidance for pain relief and palliative care, although more work needed to be done, especially regarding care for patients with chronic diseases. Each country had different public health priorities, and palliative care needs would thus vary depending on national situations. All countries, however, should take appropriate measures to ensure the rapid and effective provision of palliative care services. The report would serve as useful guidance, especially with regard to training health professionals and regulating the drugs to be used in palliative care. She encouraged the Secretariat to increase its financial support and guidance to low- and middle-income countries.

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

Ms MORTON DOHERTY (Union for International Cancer Control), speaking at the invitation of the CHAIRMAN and on behalf of the NCD Alliance, welcomed the report and congratulated Panama on its leadership of an open and transparent process to develop a draft resolution that would help to drive national action to reduce the number of barriers to the availability and accessibility of palliative care. The NCD Alliance would continue to support WHO in ensuring that no person in need of palliative care would have to suffer unnecessarily.

Dr LUYIRIKA (The Worldwide Palliative Care Alliance), speaking at the invitation of the CHAIRMAN, welcomed the report. Palliative care was an essential health service that cut across disease groups. Although palliative care services could be implemented at a relatively low cost, less than 10% of needs were being met. Barriers included the lack of access to essential medicines for severe pain and other symptoms, education at all levels of professional training, resources for implementation, and policies that integrated palliative care into national health care systems. The draft resolution provided a unique opportunity to overcome those barriers.

Dr CHESTNOV (Assistant Director-General), congratulating the member for Panama on her perseverance, reassured members that palliative care was among the indicators within the global monitoring framework, as well as the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020. Palliative care was part of combatting any disease and was one of the key areas of WHO's work. Adopting the resolution would ensure a better future for palliative care within the bigger process.

The CHAIRMAN took it that the Board wished to take note of the report.

The Board noted the report.

The CHAIRMAN further took it that, in the absence of further comment, the Board wished to adopt the draft resolution on the strengthening of palliative care as a component of integrated treatment within the continuum of care, as amended.

The resolution, as amended, was adopted.¹

The meeting rose at 12:55.

¹ Resolution EB134.R7.

NINTH MEETING

Thursday, 23 January 2014, at 14:30

Chairman: Professor J. HALTON (Australia)

1. HEALTH SYSTEMS: Item 9 of the Agenda (continued)

Regulatory system strengthening: Item 9.5 of the Agenda (Document EB134/29)

The CHAIRMAN drew attention to a draft resolution on biological medicines: access to medicines and ensuring safety, quality and efficacy, proposed by Argentina, Colombia, Costa Rica, Paraguay and Uruguay, which read:

The Executive Board,
Having considered the report on Regulatory system strengthening,

RECOMMENDS to the Sixty-seventh World Health Assembly the adoption of the following resolution:

The Sixty-seventh World Health Assembly,

PP1 Considering that health is a fundamental human right recognized in various international human rights treaties;

PP2 Recalling United Nations Human Rights Council resolution A/HRC/RES/23/14, which stressed “the responsibility of States to ensure the highest attainable level of health for all, including through access, without discrimination, to medicines, in particular essential medicines, that are affordable, safe, efficacious and of quality”;

PP3 Recalling resolution WHA55.14 on ensuring accessibility of essential medicines, which recognizes “the responsibility of Member States to support solid scientific evidence, excluding any biased information or external pressures that may be detrimental to public health”;

PP4 Further recalling that resolution WHA55.14 urged Member States, inter alia, “to reaffirm their commitment to increasing access to medicines, and to translate such commitment into specific regulation within countries, especially enactment of national drug policies and (...) into actions designed to promote policy for, access to, and quality and rational use of, medicines within national health systems”;

PP5 Considering that resolution WHA66.7 on implementation of the recommendations of the United Nations Commission on Life-Saving Commodities for Women and Children recognized that millions of women and children die needlessly every year from conditions that are easily prevented by the use of existing inexpensive medical commodities, and further recognized the need to overcome the barriers that prevent women and children from accessing and using appropriate commodities;

PP6 Considering that one of the objectives of pharmaceutical regulation is the assurance of the quality, safety and efficacy of pharmaceutical products through the regulatory processes of authorization, vigilance and monitoring;

PP7 Considering also that national pharmaceutical regulation should contribute to the sustainability of health systems and the general welfare of society;

PP8 Considering that an update of the norms and standards applicable to medicines is required in the light of advances made in biotechnology, and the new generation of medicines introduced as a result, in order to ensure the entry into the market of medicines that are affordable, safe, efficacious, of good quality and accessible in a timely and adequate fashion;

PP9 Recognizing that, although the use of such medicines has a positive impact on morbidity and mortality rates, their high cost could affect access to them and the sustainability of health systems;

PP10 Conscious that biological medicines proposed as being similar to medicines taken as comparators could be more affordable and offer better access to new treatments of biological origin, while maintaining quality, safety and efficacy,

(OP1) 1. URGES Member States:

- (1) to provide appropriate national regulatory frameworks for the health regulation of medicines of biological origin, with a view to meeting the needs of public health, in particular of medicines of biotechnological origin developed to be similar to medicines taken as comparator in terms of quality, safety and efficacy;
- (2) to ensure that the introduction of new national regulations applicable to the medicines referred to in the paragraph above does not constitute a barrier to access to medicines that are affordable, safe, efficacious and of quality;

(OP2) 2. REQUESTS the Director-General:

- (1) to support Member States in strengthening their capacity in the area of the health regulation of medicines of biological origin, and in particular of biotechnology medicines developed to be similar to medicines taken as comparator in terms of quality, safety and efficacy;
- (2) to encourage and support the development of health regulation frameworks consistent with access to medicines that are affordable, safe, efficacious and of quality.

In addition, the CHAIRMAN stated that the document detailing the financial and administrative implications of the draft resolution for the Secretariat would be provided at a later date.

She also drew attention to a draft resolution on regulatory system strengthening for medical products proposed by Australia, Colombia, Mexico, Nigeria, South Africa, Switzerland and United States of America, which read:

The Executive Board,
Having considered the report on regulatory system strengthening,¹

RECOMMENDS to the Sixty-seventh World Health Assembly the adoption of the following resolution:

The Sixty-seventh World Health Assembly,
(PP1) Welcoming the efforts of the Director-General, and recognizing the pivotal role that WHO plays in supporting countries in strengthening their regulatory systems of medical products for human use;¹

¹ Document EB134/29.

(PP2) Recalling the WHO Constitution, which affirms that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

(PP3) Recalling also United Nations General Assembly Resolution 67/81 on global health and foreign policy, which recognized the importance of universal coverage in national health systems, especially through primary health care and social protection mechanisms, to provide access to health services for all, in particular for the poorest segments of the population;

(PP4) Recalling further resolutions WHA45.17, WHA47.17, WHA52.19, WHA54.11, WHA59.24, WHA63.12, and WHA65.19, all of which encompass aspects of the need to promote the quality, safety, efficaciousness and affordability of medicines, including blood products;

(PP5) Recognizing that effective regulatory systems are an essential component of strong health systems and contribute to better public health outcomes, that regulators are an essential part of the health workforce, and that inefficient regulatory systems themselves can be a barrier to access to safe, effective and quality medical products;

(PP6) Recognizing also that effective regulatory systems are necessary for implementing universal health coverage, responding to the dual burden of infectious and noncommunicable diseases, and achieving Millennium Development Goals 4, 5 and 6;

(PP7) Aware that health systems need to avoid the lack of access to essential medicines and the proliferation of substandard, spurious, falsely-labelled, falsified, and counterfeit (SSFFC) medical products in order to ensure universal access to health care, rational use of medicines and the sustainability of health systems, and aware that urgent action is needed by the international community, Member States and relevant actors in health systems;

(PP8) Very concerned by the impact on patients of unsafe, poor quality medical products in terms of poisoning, inadequate or no treatment, contributions to drug resistance, the related economic burden, and erosion of public trust in the health system;

(PP9) Aware of the ever-increasing complexities of medical product global supply chains;

(PP10) Emphasizing WHO's role in strengthening regulatory systems for medical products from a public health perspective;

(PP11) Recalling the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property, in particular element three, which calls for establishing and strengthening regulatory capacity in developing countries as one effective policy for building and improving innovative capacity, and element six, which promotes establishing and strengthening mechanisms to improve ethical review and regulate the quality, safety and efficacy of health products and medical devices;

(PP12) Welcoming the many national and regional efforts to strengthen regulatory capacity (including through a variety of models), improve regulatory coherence and convergence among regulatory authorities, and enhance good governance, including transparency in decision-making, leading to improved availability of quality, safe, efficacious and affordable medical products, such as the European Union regulatory framework for medical products, work under way in PAHO following its 2010 resolution CD50.R9, the African Medicines Regulatory Harmonization Initiative, and the regulatory harmonization and cooperation work in the Association of Southeast Asian Nations (ASEAN);

(PP13) Also welcoming the intensive and ongoing collaboration between national regulatory authorities in setting standards including the International Conference on

¹ For the purpose of this resolution, medical products include medicines, vaccines, diagnostics, and medical devices.

Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH) among others, and encouraging a continued emphasis of effort in developing better regulatory systems;

(PP14) Recognizing the significant investments made in the procurement of medicines through global health initiatives, national health budgets, and in particular the essential role of WHO's prequalification programme and national regulatory systems in assuring the safety, quality, and efficacy of these medical products;

(PP15) Recalling the WHO and ICH good clinical practices that focus on the protection of human research subjects;

(PP16) Recalling WHO's ongoing reform agenda and welcoming in this regard the establishment in November 2012 of the Health Systems and Innovation cluster,

(OP) 1. URGES Member States:¹

- (1) to strengthen national regulatory systems by, as appropriate:
 - (a) undergoing self-evaluations, including through WHO-coordinated evaluations, to identify the strengths and opportunities for improvement in regulatory system functions, as a first step towards formulating plans for regulatory systems strengthening, including through WHO-coordinated institutional development plans;
 - (b) collecting data on regulatory systems performance to enable analysis and benchmarking for improved systems in the future;
 - (c) developing strong legal foundations and political leadership to underpin a regulatory system with a clear focus on patient safety and transparency in decision-making;
 - (d) identifying and developing a core set of regulatory functions, including with reference to WHO-identified functions, to meet country and/or regional needs (e.g. market control, postmarket surveillance);
 - (e) developing needed competencies as an integral part of the health workforce, and encouraging the development of the regulatory field as a profession;
 - (f) implementing relevant guidance and science-based outputs of international regulatory harmonization and convergence efforts including the *Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH)*;
 - (g) implementing strategies to address the increasing complexities of global supply chains;
- (2) to engage in global, regional and subregional networks of national regulatory authorities, as appropriate, recognizing the importance of networking approaches to pool regulatory capacities to promote greater access to quality, safe, efficacious and affordable medical products;
- (3) to strengthen international cooperation, convergence and information sharing, including through electronic platforms, to achieve the common goal of securing supply chains for and access to quality, safe, efficacious and affordable medical products;
- (4) to support regulatory systems for medical products with appropriate funding as an essential component of the health system;
- (5) to support regulatory systems strengthening as an essential prerequisite to the development or expansion of local or regional production of medical products meeting international standards for quality, safety and efficacy;

¹ And, where applicable, regional economic integration organizations.

- (6) to achieve access to and rational use of quality essential medicines, noting the growing emergence of resistance, and as a foundation for achieving broader access to quality, safe, efficacious and affordable medical products;
- (7) to support WHO's institutional capacity relating to promoting access to and rational use of quality, safe, efficacious and affordable medical products in the context of universal health coverage;
- (8) to support WHO in its efforts to strengthen its prequalification programmes, including exploring modalities in consultation with Member States¹ for improved sustainability of this critical programme, while also focusing on [supporting] national and regional initiatives to improve regulatory capacity for medical products;
- (9) to identify the need to strengthen regulatory systems capacity, collaboration and convergence in the technically complex areas where substantial gaps may still exist such as regulation of [**biotherapeutic products that are similar in terms of quality, safety and efficacy to a licensed reference biotherapeutic products**], blood products, and in vitro diagnostics;
- (10) to engage in international networks of national regulators to monitor development of new medicines for human use based on gene therapy, somatic-cell therapy and tissue engineering in order to identify at an early stage the need to develop or adapt regulatory environments;

(OP) 2. REQUESTS the Director-General:

- (1) to continue to support countries in the area of regulatory systems strengthening through developing and promoting relevant global norms and standards taking account the standards created by existing regional and international initiatives; continue evaluating national regulatory systems; continue applying and improving WHO evaluation tools; continue generating and analysing evidence of regulatory systems performance; continue facilitating the formulation and implementation of institutional development plans; and continue providing technical support to national regulatory authorities and governments;
- (2) to ensure that all relevant parts of the organization at all levels are actively engaged and coordinated in the carrying out of WHO's mandate pertaining to regulatory systems strengthening as an integrated part of health systems development, recognizing that WHO's support on this critical area, particularly for developing countries, may be required, as appropriate, well into the future;
- (3) to prioritize support to establishing and strengthening regional and subregional networks of regulatory authorities as appropriate, including strengthening areas of regulation of health products which are the least developed such as regulation of medical devices including diagnostics;
- (4) to promote the greater participation of Member States in existing international and regional initiatives for collaboration, harmonization and convergence;
- (5) to strengthen the integration and coherence among WHO's prequalification programmes as an aid to securing safe supply of quality medical products, engaging with Member States in the further refinement and improvement of the global prequalification model, while in parallel supporting the development of functional national and regional regulatory bodies and networks, leading to more global participation in the global prequalification programme;

¹ And, where applicable, regional economic integration organizations.

- (6) to increase support for and recognition of the significant role of the International Conference of Drug Regulatory Authorities (ICDRAs) in promoting the exchange of information and collaborative approaches among drug regulatory authorities, and as a resource to guide and facilitate further development of and regulatory harmonization and convergence among these authorities;
- (7) to engage the relevant global donor community and global health programmes on the importance of strong regulatory systems within the health systems context;
- (8) to assess the role that regulatory systems have played in implementation of the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property when following up on instructions from the 133rd Executive Board in reviewing and evaluating the success of the GSPOA;
- (9) to increase support and guidance for strengthening the capacity to regulate increasingly complex biological products with the focus on [**biotherapeutic products that are similar in terms of quality, safety and efficacy to a licensed reference biotherapeutic products**], blood products and associated in vitro diagnostics, and where appropriate on new medicines for human use based on gene therapy, somatic-cell therapy and tissue engineering;
- (10) to report to the Seventieth and Seventy-second World Health Assemblies, through the Executive Board, on progress on the implementation of this resolution.

She also stated that the document detailing the financial and administrative implications of the draft resolution for the Secretariat would be provided at a later date.

Dr MYINT HTWE (Myanmar) commended WHO's facilitation of an exchange of regulatory information and its enhancement of international collaboration among regulators, adding that a dynamic and responsive networking mechanism must be introduced to share information among Member States if the regulatory system was to be further strengthened. He noted with great satisfaction the joint activities between WHO and PAHO, and expressed the hope that the outcomes of their activities would be shared with other regions, in particular the South-East Asia Region, whose regional regulatory initiatives were in the process of being established or implemented.

Ms DUSSEY-CAVASSINI (Switzerland) called for a strengthening of national regulatory systems, particularly in low- and middle-income countries, and an increase in collaboration and networking between regulatory authorities. Appropriate structures should be established at all levels to enable policies concerning medical products and devices to be implemented effectively and the corresponding regulations and laws to be applied. The draft resolution on regulatory system strengthening encompassed those objectives and her country had consequently decided to sponsor it. The Government of Switzerland had taken concrete steps to strengthen regulatory systems and access to health care, particularly in sub-Saharan Africa, and had recently signed a new partnership agreement with the Bill & Melinda Gates Foundation. The principal objective of the agreement was to improve access to health care by making registration and licensing procedures more efficient in countries that lacked resources.

Dr EZZAT (Egypt), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that strong regulatory systems were essential for improving access to safe, effective and good-quality medical products and for implementing universal health coverage. Each Member State should establish its own regulatory framework and priorities according to existing and anticipated health risks and adapt continuously to changing needs. National regulatory authorities held responsibility for safeguarding public health, and financial sustainability was a critical factor in their functions. A major difficulty faced by numerous regulatory authorities in the Eastern Mediterranean Region was a shortage of qualified personnel. Inadequate regulation of medical products could result in substandard, counterfeit medical products, which could cause serious harm to the health of the

wider population. Many countries would need WHO support to devise adequate regulatory mechanisms and strengthen their national regulatory bodies in order to ensure the development, production, procurement and dispensing of safe, efficacious and quality-assured medical products.

Dr USHIO (Japan) welcomed the report and said that the globalization of the medical products supply chain represented a great challenge to national regulatory systems; collaboration among regulatory authorities was therefore of paramount importance. He fully supported the role of WHO as a leader in strengthening regulatory systems through a range of existing frameworks, such as the International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use, and expressed the wish for his country to be added as a sponsor of the draft resolution on regulatory system strengthening.

Ms MATSOSO (South Africa), speaking on behalf of the Member States of the African Region, said that the importance of strengthening regulatory systems had been highlighted in numerous Health Assembly resolutions and had been included in discussions between the Regional Office for Africa and the African Union. She fully supported the information contained in the report and emphasized the need for the Secretariat to provide adequate technical support to Member States, particularly those with weak regulatory systems. She encouraged WHO and other partners to work closely with subregional groups to assist in implementing global, regional and subregional initiatives for regulatory system strengthening. She urged Member States, other partners and the Secretariat to give consideration to the components of the WHO global strategy and plan of action on public health, innovation and intellectual property related to regulatory strengthening and also to the ethical review of clinical trials. She applauded the east African community for its concerted efforts to achieve regulatory harmonization and fully supported the draft resolution on regulatory system strengthening.

Dr NOOR HISHAM ABDULLAH (Malaysia) reaffirmed Malaysia's support for WHO's initiatives to strengthen regulatory systems and the good governance initiative aimed at the pharmaceutical sector. He welcomed the WHO proposal to design core curricula to be used as a modular training tool for regulators and the suggestion that national drug regulatory authorities form networks to share information and expertise so as to avoid duplication in the assessment of medical products. The Secretariat should, however, support Member States in finding appropriate partners to cooperate with them in such endeavours. He strongly endorsed the convergence of regulatory requirements and agreed on the need to draft, under the auspices of WHO, a comprehensive and up-to-date assessment tool that could be used with minimal adjustments by regulatory authorities working in diverse regulatory environments. Recognizing the limitations on extending the WHO prequalification programme to cover all products of public health importance, he agreed that other solutions should be found for countries with limited regulatory capacity and without access to WHO prequalified products.

Dr REYNDERS (Belgium) welcomed the report on regulatory system strengthening and recognized the importance of the regulatory system for medical products. However, he expressed concern at the lack of information on the financial and administrative implications of the draft resolutions.

Dr HE Li (China)¹ welcomed the report and the draft resolutions but expressed reservations on certain sections of the report. She noted that paragraph 2 contained reference to the functions of regulatory authorities, which did not apply to China as it currently had no laws or regulations to license the promotion of medical products. She suggested that the second sentence in paragraph 5, which began "According to the Institute of Medicine ...", should be deleted, as an independent WHO report should not use the findings of an external institution's research to make comments on the

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

regulatory capacities of emerging economies. She also recommended that in paragraph 11 the phrase “make use of the international regulatory guidance and instruments” should be amended to read “take reference of the international regulatory guidance and instruments” and the last two sentences starting with “In the future, therefore, rather than ...” should be deleted. She stressed that Member States were sovereign States and should be able to act in accordance with national requirements and enjoy the right to choose the international regulatory guidance they followed. Lastly, she suggested that in the second sentence of paragraph 13 the phrase “respecting the respective laws and regulations concerning the regulatory realities in the Member States” should be added.

The CHAIRMAN noted that it was not the function of the Board to edit a Secretariat report.

The DIRECTOR-GENERAL added that the report on regulatory system strengthening had not been prepared for consultations and Member State input, but rather to highlight the findings of the Secretariat on the matter. If the Executive Board noted the report, it did not imply that Member States must implement all of its recommendations at national level. Any Member State’s concerns or comments on the contents of the report would appear in the summary records of the meeting.

Ms DÁVILA CHÁVEZ (Mexico) welcomed the report and said that one of her country’s priorities was to ensure the continuity of strategies that delivered access to high-quality medicines. Regulations on the manufacture, distribution and use of medical products were an essential part of building effective health care systems and were an important tool for providing universal coverage and achieving specific public health objectives. She welcomed the positive direction of the discussions on strengthening regulatory systems at global level, which reflected the clear will of Member States to focus on the coordination and exchange of regulatory best practices at all levels.

Mr KOTALWAR (India)¹ welcomed the report and thanked all the sponsors of the draft resolution for their work in drafting the document.

Mr McIFF (United States of America)¹ expressed support for the report and the draft resolutions and recalled that the crucial role of regulatory authorities had not always been so well appreciated and understood. Regulatory systems must be strengthened in order to implement universal health coverage, respond to the dual burden of communicable and noncommunicable diseases and address the Millennium Development Goals. Appropriate policy choices must be made to foster conditions for stronger regulatory oversight. It was therefore hoped that the relevant draft resolution would create a favourable policy climate and political leadership to strengthen regulatory systems globally, building on the sound foundation of existing global and regional initiatives, and would guide and encourage Member States in their preparation and implementation of regulatory strategies.

Ms MUTIARANI (Indonesia)¹ said that she recognized the importance of strengthening regulatory systems as part of efforts to guarantee access to safe and effective medicines and that the Government of Indonesia had actively supported and improved its own national regulatory system. Her country was in the process of devising an action plan for national health care research, which covered the development of medicines, biological products, medical devices and food formulas, in an attempt to control the use of medicines and medical products more effectively. Successful implementation of health care regulations would rest on the monitoring and evaluation of policy implementation, particularly in Indonesia, where the population and regions varied so greatly. She therefore called on the Secretariat to design tools and mechanisms to assess regulatory performance, in partnership with Member States, and to provide technical support and facilitate coordination between stakeholders.

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

Dr BARBOSA DA SILVA (Brazil) said that the increasing number of countries involved in the production and supply of medical products made coordinated action and information-sharing between health authorities imperative. His country had designed initiatives to strengthen joint global efforts, acknowledging the key role that WHO and its regional offices played in such processes. A global regulatory system that recognized national regulatory capabilities and built mutual respect and confidence could indeed be established, but managing regulation required a sense of international commitment among Member States. Numerous challenges remained in strengthening regulatory systems, particularly concerning the rapid advance of new technologies such as nanotechnology, and continued WHO-led coordination would be essential for achieving the objectives set out in the report. He fully supported the draft resolutions.

Mr ALIMUZZAMAN (Bangladesh)¹ said that the importance of strengthening regulatory systems could not be overemphasized and echoed the calls of the members for South Africa and Malaysia and the representative of Indonesia for technical support to be provided for resource-poor Member States to establish or maintain strong regulatory systems.

Ms BOTERO HERNANDEZ (Colombia)¹ said that strengthening regulatory systems was one of the most important issues to be taken up under the remit of WHO, as it played a central role in Member States' responsibility to provide access to medicines and universal health coverage and to ensure the financial sustainability of health care systems. She welcomed the draft resolution's direct reference to the rational use of medical products, particularly essential medicines, which underscored the need for appropriate regulations and monitoring frameworks as a means of ensuring safe access to medicines, reducing supply chain difficulties and avoiding negative effects on the coverage and financial sustainability of health care systems.

Dr LEGGE (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN and on behalf of the People's Health Movement, said that the report provided a clear overview of the various programmes commissioned by Member States to promote high-quality, safe and effective medical products. Unfortunately, however, the underfunding of such programmes, in particular WHO's rational use of medicines programme and its ethical criteria for medicinal drug promotion, had contributed to the crisis in antimicrobial resistance, which had been further exacerbated by aggressive marketing funded through monopoly prices derived from extreme intellectual property protection. The discussions regarding the strengthening of regulatory systems had identified shortfalls in national medicines regulation, which had been exploited by the so-called anti-counterfeiting movement. The recent attempts by global pharmaceutical companies to undermine the Government of South Africa's adoption of an intellectual property policy ensuring access to medical products while remaining fully compliant with its obligations under the Agreement on Trade-Related Aspects of Intellectual Property Rights highlighted the ongoing conflicts of interest with non-State actors. He therefore urged WHO to show public support for South Africa in the light of such actions.

Mr MALPANI (MSF International), speaking at the invitation of the CHAIRMAN, welcomed the report's confirmation of WHO as a leader in setting independent norms of quality control and its call for collaborative solutions to fill gaps in regulatory oversight for many products. Although supporting the report's suggestion of transitioning some activities of the WHO prequalification programme to regional regulatory systems, he warned of potential risks should such activities be transitioned prematurely. Close to one third of countries had very limited regulatory capacity, and they, as well as United Nations bodies and humanitarian organizations, would still require a strong WHO prequalification programme for the medium term. Member States should allow for a potential

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

expansion of the remit of the WHO prequalification programme to other critical life-saving products, including biotherapeutic products, complex products and critical anti-infective medicines at high risk of resistance. Member States should encourage recognition of WHO-prequalified products by national and regional regulatory authorities to ensure prompt registration of life-saving products. As new models of financing were being considered for the prequalification programme, he hoped that fees for service, if adopted, would be set at a level that did not discourage small companies from submitting dossiers. Donor support to the programme, preferably non-earmarked, would need to continue, to ensure that prequalification had sufficient flexibility to determine and tackle priority issues.

Mr McIFF (United States of America)¹ said that the overall aim of the draft resolution on regulatory system strengthening for medical products was to capture recent developments, particularly at regional and global levels, in terms of increased regulatory convergence and to promote greater sustainability, notably in regard to the WHO prequalification programme. The reference in the seventh preambular paragraph of the draft resolution to substandard, spurious, falsely-labelled, falsified and counterfeit medicines was an attempt to accurately reflect the linkages between the two issues, but the wording could be amended as appropriate. The reference in paragraphs 1(9) and 2(9) to strengthening capacity related to increasingly complex biological products, with a focus on biotherapeutic products that were similar to a licensed reference biotherapeutic product, was currently under review in an attempt to harmonize its wording with the draft resolution on biological medicines. Noting that additional amendments to the draft resolution had already been submitted, he would welcome the opportunity to incorporate them and then submit the amended draft resolution for further consideration.

Dr KIENY (Assistant Director-General) thanked Member States for their support for WHO in its work to strengthen regulatory systems and prequalify certain medical products. She apologized for the delay in providing costings for the two draft resolutions, which would be supplied at the earliest opportunity. Responding to the various comments regarding expansion of the WHO prequalification programme, she stressed that WHO's mandate covered products related to HIV, malaria and tuberculosis. WHO had neither the mandate nor the capacity to prequalify every medical product. It would, however, identify some additional essential and complicated medical products that might be incorporated into its prequalification programme. At the same time, it would increasingly rely on networks of strengthened regulatory authorities to carry out prequalification work in the future on its behalf and under its oversight.

Ms ALI (Maldives) asked the Secretariat to provide a comparative analysis of the draft resolution on regulatory system strengthening for medical products and the Member State mechanism that had been implemented in the South-East Asia Region, and to confirm whether there was any overlap in mandate between the two.

The Board took note of the report.

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

Health intervention and technology assessment in support of universal health coverage: Item 9.6 of the Agenda (Document EB134/30)

The CHAIRMAN drew attention to a draft resolution on health intervention and technology assessment in support of universal health coverage, proposed by Malaysia and Maldives, which read:

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

The Executive Board,
Having considered the report on health intervention and technology assessment in support of universal health coverage,¹

RECOMMENDS to the Sixty-seventh World Health Assembly the adoption of the following resolution:

The Sixty-seventh World Health Assembly,

PP1 Recalling World Health Assembly resolutions WHA52.19 on revised drug strategy, WHA58.33 on sustainable health financing, universal coverage and social health insurance, WHA60.16 on progress in the rational use of medicines, WHA60.29 on health technologies, WHA63.21 on WHO's role and responsibilities in health research, and WHA64.9 on sustainable health financing structures and universal coverage;

PP2 Recognizing the importance of evidence-based policy development and decision-making in health systems, including decisions on resource allocation, service system designs and translation of policies into practice, as well as reaffirming the roles and responsibilities of the World Health Organization in provision of support to strengthen information systems and health research capacity, and their utilization in Member States;

PP3 Noting that the efficient use of resources is a crucial factor in the sustainability of health systems' performance, especially when significant increases in access to essential medicines, including generic medicines, to medical devices and procedures, and to other healthcare interventions for prevention, diagnosis and treatment, rehabilitation and palliative care are pursued by Member States, as they move towards universal health coverage;

PP4 Noting that *The world health report 2010*² indicates that as high as 40% of spending on health is being wasted and that there is therefore, an urgent need for systematic, effective solutions to reduce such inefficiencies and enhance the rational use of health technology;

PP5 Acknowledging the critical role of independent health intervention and technology assessment, as multidisciplinary policy research, in generating evidence to inform prioritization, selection, introduction, distribution, and management of interventions for health promotion, disease prevention, diagnosis and treatment palliation, and patient rehabilitation;

PP6 Emphasizing that with rigorous and structured research methodology and transparent and inclusive processes, assessment of medicines, vaccines, medical devices and equipment, and health procedures, could help to address the demand for reliable information on the safety, efficacy, quality, appropriateness and efficiency dimensions of such technologies to determine if and when they are integrated into particular health interventions and systems;

PP7 Concerned that the capacity to assess, research and document the public health, economic, organizational, social and ethical implications of health interventions and technologies is inadequate in most developing countries, resulting in inadequate information to guide rational policy and professional decisions and practices;

PP8 Recognizing the importance of strengthened national capacity and regional and international networking and collaboration on health intervention and technology assessment to promote evidence-based health policy,

¹ Document EB134/30.

² The world health report 2010. Health systems financing: the path to universal coverage. Geneva: World Health Organization; 2010.

(OP1)1. URGES Member States:¹

- (1) to encourage the systematic utilisation of independent health intervention and technology assessment to inform policy decisions, including the priority-setting, selection, procurement supply system management and use of health interventions and/or technologies, as well as the formulation of sustainable financing benefit packages, medicines, benefits management including pharmaceutical formularies, clinical practice guidelines and protocols for public health programmes;
- (2) to consider in addition to the use of established and widely agreed methods, developing as appropriate national methodological and process guidelines and monitoring systems for health intervention and technology assessment in order to ensure transparency, quality, and policy relevance of related assessments and research;
- (3) to further consolidating and promoting health intervention and technology assessment into national frameworks, such as those for health system research, health professional education, health system strengthening and universal health coverage;
- (3*bis*) to consider strengthening national capacity for regional and international networking, to develop national know-how, avoid duplication of efforts and achieve better use of resources;
- (4) to consider collaborating with other Member States health organizations, academic institutions, professional associations and other key stakeholders in the country or region to collect and share information and lessons learned in order to formulate and implement national strategic plans concerning capacity building for and introduction of health intervention and technology assessment, and to summarize best practices on transparent evidence-informed health policy and decision-making;
- (5) to identify gaps with regard to promoting and implementing evidence-based health policy, as well as improving related information systems and research capacity, and consider seeking technical support and exchanging information and sharing of experiences with other Member States, regional networks and international entities, including WHO;

(OP2)2. REQUESTS the Director-General:

- (1) to assess the status of health intervention and technology assessment in Member States in terms of methodology, human resources and institutional capacity, governance, linkage between health intervention and technology assessment units and/or networks with policy authorities, utilization of assessment results, and interests in and impediments to strengthening capacity;
- (2) to raise awareness and to foster knowledge and to encourage practice of health intervention and technology assessment and its uses in decision-making among national policy-makers and other stakeholders, by drawing best practices from the operation, performance and contributions of competent research institutes and health intervention and technology assessment agencies and programmes, and sharing such experiences with Member States through appropriate channels and activities, including global and regional networks and academic institutions;
- (3) to integrate health intervention and technology assessment concepts and principles into the relevant strategies and areas of work of WHO, including, but not limited to, those on universal health coverage, including health financing, access to

¹ And, where applicable, regional economic integration organizations.

and rational use of quality-assured medicines, vaccines and other health technologies, the prevention and management of noncommunicable and communicable diseases, mother and child care, and the formulation of evidence-based health policy;

(4) to provide technical support to Member States, relevant intergovernmental organizations and global health partners, in order to strengthen capacity for health intervention and technology assessment, including, when appropriate, the development and use of global guidance on methods and processes based on internationally agreed practices;

(5) to ensure adequate capacity at all levels of WHO, and utilizing its networks of experts and collaborating centres other regional and international networks, in order to address the demand for support to facilitate evidence-based policy decisions in Member States;

(6) to support exchange of information, sharing of experiences and capacity-building in health intervention and technology assessment through collaborative mechanisms and networks at global, regional and country levels, as well as to ensure these partnerships are active, effective and sustainable;

(7) to report on progress in the implementation of this resolution, through the Executive Board, to the Sixty-ninth World Health Assembly.

She also stated that the document detailing the financial and administrative implications of the draft resolution for the Secretariat would be provided at a later date.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the report on health intervention and technology assessment was a key part of efforts to ensure that countries obtained the maximum health care benefits. He urged Member States to establish assessment frameworks in order to evaluate which health technologies would be the most cost-effective for their respective health care systems. The report recognized numerous initiatives to promote the development of robust and effective regulatory systems, but did not make reference to any of the successful work carried out in the Region of the Americas. He therefore urged the Secretariat to include in the report information on the progress achieved by the Argentine, Brazilian, Colombian and Cuban national regulatory authorities. The Cuban national regulatory authority had already carried out a number of health technology assessments, and the opening of its new headquarters in April 2014 would serve to strengthen such work. He suggested that the term “competent national regulatory authority” should be used rather than “effective regulatory authority”.

Dr SHAKEELA (Maldives) stressed the importance of taking a wider view of the impact of health intervention and technology assessment on efforts to reduce inequities in health systems and achieve efficiencies. She emphasized the need to strengthen individual countries’ evidence-based decision-making and policy-making capabilities, as well as urging better networking between Member States and WHO regional offices in sharing expertise on conducting health intervention and technology assessments to support universal health coverage.

Dr AMMAR (Lebanon), speaking on behalf of the Member States of the Eastern Mediterranean Region, expressed support for the report but said that although it was important to apply health technology assessments at the national level, countries with limited resources faced specific implementation challenges. A strong commitment to establishing national health technology assessment programmes in support of universal health coverage was essential, and health technology assessment initiatives must be linked to national regulatory functions. He recommended that health technology assessments should be incorporated within routine evaluation and registration of medical supplies, and that suitable implementation, monitoring and evaluation mechanisms should be established. The independence of health technology assessment agencies should be promoted, with due attention to conflicts of interest. WHO technical support would be needed in order to build the

capacity of health technology assessment agencies in areas including surveillance, traceability and recall procedures.

Dr REYNDERS (Belgium) said that changes should be made to the process of considering draft resolutions. The financial and administrative implications of resolutions should be submitted for Member State review at the same time as the draft resolution text.

The CHAIRMAN, responding to the observation of the member for Belgium, said that discussion of the report on health intervention and technology assessment in support of universal health coverage would continue, but consideration of the draft resolution would be deferred until such time as the financial and administrative implications had been submitted to Member States for review.

Dr AZODOH (Nigeria), speaking on behalf of the Member States of the African Region, said that health technologies were an important component of health service provision but they placed a substantial burden on health budgets – which could lead to inequities in the health system. Health technology assessment was therefore invaluable, to ensure that countries could take evidence-based policy-making decisions. In the African Region, access to health technologies had been constrained by a lack of legal and policy frameworks, availability of information and suitable organizational structures, and appropriate expertise and training. Decisions on health technology were therefore not driven by evidence or need but by pressures exerted by manufacturers and users, with rapid advances in technology placing the Region under global market pressure to import technologies for which there was no evidence of a country need. She called on WHO to support the African Region in establishing national health technology assessment policies that would enable African countries to purchase appropriate technology products while reducing costs and supporting local technology production and maintenance.

Mr COTTERELL (Australia) welcomed the report and draft resolution and stressed the importance of health intervention and technology assessment for the financial sustainability of health systems.

Dr USHIO (Japan) said that, although health technology assessment provided a useful means of identifying an appropriate range of services for universal health coverage, many countries experienced difficulties in building full capacity for assessment. He called for Secretariat support for such Member States and encouraged WHO to issue a model list of essential medical devices that took into account health technology assessment principles, so that individual countries could select medical devices appropriate for their needs.

Dr NOOR HISHAM ABDULLAH (Malaysia) said that he shared the concerns expressed in *The world health report 2010* regarding the high percentage of waste in health spending. Supporting the call for systematic and effective solutions to reduce such inefficiencies and enhance the rational use of health technology, he urged WHO to facilitate information exchange and capacity-building in health technology assessment, through collaborative mechanisms and networks at the global, regional and national levels. Malaysia wished to be added to the list of sponsors of the draft resolution.

Mr RI Jang Gon (Democratic People's Republic of Korea) welcomed the report and draft resolution and said that advances in health technologies offered an opportunity to establish more equitable access to health care. Information and communications technologies had been used successfully in the Democratic People's Republic of Korea to extend access to health care to include rural and remote regions. The delivery of health care services through the use of information and communications technologies had proved to be extremely cost-effective and he urged the Secretariat to continue with its promotion of such technological advances.

Dr VALVERDE (Panama) welcomed the draft resolution and said that capacity-building was required at global level to ensure that national decision-making processes for health intervention and technology assessment were transparent, would achieve the desired results and supported universal health coverage, in particular ensuring that all citizens had equitable access to the medicines and medical products that they needed. She called for further international support for low- and middle-income countries, to enable them to establish appropriate assessment, monitoring and evaluation mechanisms.

Ms MATSOSO (South Africa), recognizing the importance of health technology assessment to the financial sustainability and medical appropriateness of health systems, said that South Africa wished to be added as a sponsor of the draft resolution. Her country was in the process of implementing a national health insurance system and had worked to include health technology assessment in support of universal health coverage and evidence-based decision-making. She thanked WHO for its support in designing the country's essential equipment list and confirmed that the list would be updated regularly based on evidence gathered.

Dr MYINT HTWE (Myanmar) expressed support for the draft resolution and recalled that the Regional Committee for South-East Asia had in September 2013 adopted resolution SEA/RC66/R4 with the same title. He therefore requested clarification from the Secretariat as to whether the regional resolution would remain in force if the draft resolution currently under discussion was adopted by the Executive Board.

Mr PIPPO BRIANT (Argentina) welcomed the report and said that health intervention and technology assessment was fundamental to the health care decision-making process in a context characterized by ever more costly technologies, sometimes with only marginal increases in benefits. However, health care decisions must not be taken solely on the basis of health technology assessments; a range of different factors, such as ethical considerations, must also be considered. Member States should retain their sovereign right to decide their own respective health technology strategies, and he called on the Secretariat to provide guidance and technical support to enable them to do so effectively.

Ms DÁVILA CHÁVEZ (Mexico) expressed support for the report and wished to be added as a sponsor of the draft resolution. A specialized centre in Mexico ensured that health technology met the requirements of the population as cost-effectively and safely as possible, offering robust and objective assessments to be used in the decision-making process, with the central goal of improving the overall health of the population.

Mr BAE Kyung-taek (Republic of Korea) welcomed the report and the draft resolution and stressed the importance of incorporating health technology assessment into evidence-based policy-making. The related legal and institutional procedures of assessment must be clearly identified and should be carried out by an independent institution. In addition, each country should foster a research environment that allowed health experts to generate the evidence required. He recognized that many countries, particularly low- to middle-income countries, would find it difficult to implement health technology assessments immediately and urged Member States to establish their own assessment models to meet the requirements of their respective health systems.

Mr KOTALWAR (India),¹ noting that the majority of the world's population lacked access to affordable health care, said that efficient, sustainable and good-quality health systems must be established as a matter of urgency and made available to all segments of the population. To that end,

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

the public and private sectors must work in synergy and their roles and responsibilities must be harmonized. His Government had recently adopted a plan designed to promote knowledge-sharing and incorporate health technology assessment in support of universal health coverage. As many countries still faced difficulties in establishing financially sustainable health systems, he called on the Secretariat to provide further support and expertise, and on Member States and other organizations to guarantee the availability of resources, in order to ensure that universal health coverage became a global reality.

Dame Sally DAVIES (United Kingdom of Great Britain and Northern Ireland)¹ said that the outcomes of health intervention and technology assessment should be taken into account by decision-makers, along with social values. More efficient and equitable resource allocation would in turn make progress towards universal health coverage more sustainable. Transparent resource allocation would also contribute to meeting the growing demand for accountability to taxpayers in low- and middle-income and donor countries, as governments committed more resources to public health. The United Kingdom of Great Britain and Northern Ireland had a strong track record of using health technology assessment as part of the priority-setting process through the National Institute for Health and Care Excellence. Such priority-setting was not a one-time exercise, and countries required the institutional capacity to adjust spending decisions as the situation demanded. She called on the Secretariat and other organizations to provide support to countries that lacked the appropriate processes and institutions but wished to strengthen their capacity for equitable and efficient resource allocation as they moved towards universal health coverage.

Professor KULZHANOV (Kazakhstan)¹ welcomed the report and draft resolution, in the hope that the latter might encourage the introduction of more health technology assessment in the central Asian region, where it was not widely available. In view of the importance of training, attempts were being made to develop the necessary resources through conferences, seminars and workshops. But the process was costly, as indeed were the technologies themselves, and placed a heavy burden on national and local budgets. In November 2013, the authorities in Kazakhstan had organized a conference to celebrate the thirtieth anniversary of the Declaration of Alma-Ata that had included a session on technology, innovation and new medicines. The final conference statement recognized the need for health technology assessment throughout the region. Kazakhstan wished to be added to the list of sponsors of the draft resolution.

Ms NIU Hongli (China)¹ commended the report and draft resolution. Health technology assessment was an important tool for allocating limited resources in order to achieve universal health coverage. China was promoting health technology assessment, including by disseminating information and training personnel, in cooperation with international organizations. She urged the Secretariat to pass on Member States' experiences in establishing technology assessment institutions and to encourage Member States to make use of legislation and regulation to strengthen health technology assessment. The Organization should also enhance its financial and technical support to developing countries in order to improve their assessment capacity.

Mr ALIMUZZAMAN (Bangladesh)¹ welcomed the report and requested that Bangladesh be added to the list of sponsors of the draft resolution.

Ms WIDIYARTI (Indonesia)¹ supported the draft resolution.

Ms DAVIS (New Zealand)¹ commended the draft resolution. While welcoming WHO's efforts to build developing countries' capacity in health technology assessment, she urged the Organization to take into account the specific needs of Pacific island countries.

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

Mr MERLEVEDE (International Federation of Hospital Engineering), speaking at the invitation of the CHAIRMAN, placed emphasis on the need for health care facilities to be managed efficiently through integrated planning, design and evaluation, in order to keep infrastructure costs to a minimum. With its expertise in technical engineering, building concepts, energy and environmental matters, the International Federation of Hospital Engineering could offer valuable practical experience to Member States, for example in the areas of consumable water, safe operating theatres and delivery rooms, hospital structures, sustainable energy and increasing patient safety.

Professor NYSSSEN (International Federation for Medical and Biomedical Engineering), speaking at the invitation of the CHAIRMAN, called on WHO to continue to take the lead in strengthening health systems worldwide by providing benchmarks, standards and best practice guidelines, focusing on appropriate technologies and matching them with disease-related priorities, taking into account the convergence of computer and communications technologies with other forms of information technology, and making worldwide reporting more efficient. In all of those areas, the International Federation for Medical and Biomedical Engineering offered its independent expertise in health technology assessment, intending to be a resource partner for WHO.

Ms WANJAU (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, highlighted the role of universal health coverage in reducing health inequities and achieving health for all. Countries should design their own schemes for universal health coverage, in line with the relevant cultural and political context. They should also continue formulating and implementing national strategies and plans for the assessment of health technologies, calling on WHO to provide appropriate guidance. Correctly used technologies could significantly increase the efficiency and effectiveness of health care systems. Partnerships between governments and civil society, business and academia were essential for creating efficient technologies in health systems.

Dr DI GIROLAMO (Medicus Mundi International – International Organisation for Cooperation in Health Care) speaking at the invitation of the CHAIRMAN and also on behalf of the People's Health Movement, commended WHO's Guideline on Country Pharmaceutical Pricing Policies, adding that Board members should be aware of developments in current trade negotiations that seriously threatened Member States' ability to implement the Guideline. Drawing attention to the current negotiations on the Trans-Pacific Partnership Agreement, she pointed to the potential of certain provisions to delay the market entry of some generic medicines and prevent the use of cost-effective pricing in supply and reimbursement programmes, including through the use of health technology assessment. She therefore urged the Board to issue a strong statement urging rigorous health technology assessment and cost-effectiveness pricing for supply and reimbursement for pharmaceuticals, diagnostics and other medical products. Any such statement should include a specific mandate for the Secretariat to advise Member States on policy coherence between trade and health, in accordance with resolution WHA59.26 on international trade and health, and Member States should be urged not to compromise their capacity for health technology assessment and cost-effectiveness pricing when negotiating trade agreements.

Dr KIENY (Assistant Director-General) said that she had taken note of all the suggestions and requests for technical support. Replying to the member for Japan, she explained that an analysis of priority medical devices was currently in hand and drew attention to a publication entitled the Interagency List of Priority Medical Devices for Reproductive, Maternal, Newborn and Child Health, adding that similar work was being carried out on cancer. Responding to the member for Myanmar, she said that having a global recommendation as well as a regional one was not uncommon; for example, there was already a PAHO resolution on the same topic. The existence of a global resolution in fact encouraged institutions such as the United Kingdom of Great Britain and Northern Ireland's National Institute for Health and Care Excellence and others to pool their resources for the benefit of the wider community.

The Board took note of the report.

(For continuation of the discussion and adoption of a resolution, see the summary record of the twelfth meeting, section 2.)

Access to essential medicines: Item 9.7 of the Agenda (Document EB134/31)

Dr NCHABI KAMWI (Namibia), speaking on behalf of the Member States of the African Region, commended the report. Lack of access to essential medicines was a pressing matter in the Region and one that could determine whether a person lived or died. On the key issue of affordability, he drew attention to previous WHO resolutions, in particular resolution WHA61.21 on the global strategy and plan of action on public health, innovation and intellectual property. He called on the Secretariat to support Member States in safeguarding the use of flexibilities under the Agreement on Trade-Related Aspects of Intellectual Property Rights. Supporting the activities for promoting essential medicines outlined in the report, he urged WHO to note the strong need for technical support at country level to allow those actions, including developing appropriate information and monitoring systems, to be implemented. The regional budget might also need to be aligned in order to safeguard implementation of the global strategy and improve access.

Speaking as the member for Namibia, he said that his Government was aware that some Member States continued to be challenged by certain pharmaceutical companies in their efforts to implement WHO guidelines on pricing policies. For example, the Government of South Africa had previously been subject to a court challenge and was currently facing a campaign by the pharmaceutical industry designed to undermine the country's efforts to reform its intellectual property laws in order to promote public health. Namibia fully supported the Government of South Africa in its endeavours to ensure access to essential medicines, urging the Secretariat to continue providing support to Member States as outlined in document EB134/31.

Ms MATSOSO (South Africa) deplored the recent leak by the multinational pharmaceutical industry of the strategy written by Public Affairs Engagement (a lobbying consultancy based in Washington, DC, United States of America) to undermine her country's efforts to reform its intellectual property policy, one of whose objectives was to further protect and promote public health and access to medicines. It was not the first time that South Africa had been under such attack, despite facing devastating HIV and tuberculosis co-morbidities. In 2000, the cost of antiretroviral combination therapy had been US\$ 10 000 per person per annum; by 2010, it had dropped to about US\$ 1000. That had allowed 2.4 million people to receive treatment and had made it possible to expand treatment beyond HIV/AIDS, and to offer it to those with extensively drug-resistant tuberculosis. None of that would have been possible without generic competition. About 4% of South Africans were currently receiving second-line antiretroviral therapy; however, the percentage needed to be increased by 10% in order to cover those who had been on antiretroviral therapy for more than five years. Avoiding treatment failures and achieving good clinical and immunological outcomes would not be possible if the current cost remained two-and-a-half times higher than that of first-line therapy. The report contained in document EB134/12 referred to the multidrug-resistant tuberculosis crisis. Putting patients on a waiting list was not an option for South Africa. Competition had been the main driver for the production of affordable medicines, through early generic entry under the terms of the Bolar provision enshrined in the Agreement on Trade-Related Aspects of Intellectual Property Rights.

South Africa faced other barriers to access, but the policy under discussion would promote competition and create a level playing field. Patent examination was among the policy reforms that were being introduced, consistent with the practices outlined in a study by WHO, WIPO and WTO on promoting access to medical technologies and innovation.¹ It was common practice in Brazil, Europe,

¹ World Health Organization, World Intellectual Property Organization and World Trade Organization. Promoting access to medical technologies and innovation: intersections between public health, intellectual property and trade. Geneva: World Health Organization; 2012.

India and the United States of America to reject poor-quality patents, while South Africa granted 100% approval. She welcomed the support provided by WHO for intellectual property policies that maximized health-related innovations and promoted access to medicines for all, and its commitment to provide support consistent with the global strategy and plan of action on public health, innovation and intellectual property. She had been encouraged by the adoption of various resolutions, including United Nations General Assembly resolution 65/1. Participating in the intergovernmental negotiating process had also been a positive experience, and it was to be hoped that the same “spirit of Geneva” would continue to stand for truth and improving people’s lives. The Director-General understood the plight of the people of South Africa, and Member States had shown solidarity because they recognized the importance of ensuring treatment. In a relatively short time, South Africa had witnessed an increase in life expectancy, and, for that, she was grateful to WHO. (*Prolonged applause*)

Ms ALGOE (Suriname) commended the report. Suriname and other Caribbean countries were experiencing problems associated with the availability and affordability of essential medicines. In particular, the poor availability of essential medicines for treating noncommunicable diseases, such as cardiovascular diseases and cancer, meant that those countries would be unable to meet the targets set out in the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020. Despite support from international agencies and donor programmes, the rising cost of medicines and vaccines meant that it was difficult to maintain national lists of essential medicines. Some diagnostic tests and quality assured devices were unaffordable. Medicines such as parenteral antibiotics, which were on the WHO Model List of Essential Medicines, were also in short supply. Such shortages destabilized health systems and encouraged the irrational use of medicines and procurement of possibly substandard items, as well as increasing morbidity and mortality. She called on the Secretariat to investigate the reasons behind the shortages, to work on plans to mitigate them and their effects, and to introduce mechanisms to make essential medicines available and affordable, as well as working with Member States on clinical treatment guidelines based on the WHO Model List. She further requested the Secretariat to make available the package of essential technologies, medicines and prevention tools for the primary care of noncommunicable diseases, as mentioned in the report, as well as to support countries in generating financing for medicines, monitoring the quality, availability and price of essential medicines, and assessing the rational use of medicines for noncommunicable diseases.

Dr BARBOSA DA SILVA (Brazil) recalled that access to medicines had been a key element in the context of health technologies from a national, regional and global perspective for many years, as well as the subject of numerous Health Assembly and Executive Board discussions. Despite such attention, much remained to be done, including improving policies for the selection of essential medicines and strengthening communication and collaboration among Member States on best practices in developing and implementing such policies. From that standpoint, he welcomed the report and said that any draft resolution should be directed towards optimizing efforts to increase the availability of medicines, widen access and encourage more cost-effective use of health research. He expressed his support for the Government of South Africa and reaffirmed that the Agreement on Trade-Related Aspects of Intellectual Property Rights did not prevent Member States from taking measures to protect public health and guarantee access to essential medicines and treatments.

Mr ROMERO PUENTES (Cuba) observed that, despite the support Member States had received from the Secretariat over many years, the accessibility and affordability of essential medicines continued to be a problem for low- and middle-income countries. He reaffirmed that in order to prevent and effectively treat noncommunicable diseases, access to affordable, high-quality medicines, as well as vaccines, blood products, diagnostic tests and medical devices was crucial. He expressed his support for the Government of South Africa and the willingness of his own Government to back, in both the Board and the Health Assembly, whatever action it decided to take on essential medicines. The flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights

were broad enough to allow initiatives that lowered the cost of medicines and thereby improved the health of the population.

Mr PIPPO BRIANT (Argentina) thanked the Secretariat for supporting Member States in improving access to essential medicines and acknowledged the need for WHO to further strengthen its actions in that regard, in order to achieve the goal of universal health coverage. He outlined some of the steps taken in Argentina to broaden access to essential medicines, including offering free essential medicines in primary health centres, as well as free treatment for HIV/AIDS, tuberculosis and Chagas disease, and introducing legislation to encourage the use of generic medicines. In addition, the ministries of health and industry had adopted a resolution establishing scientific criteria for assessing pharmaceutical patent applications, which had led to a reduction in the number of applications where the patent had no inventive novelty but was intended only as a tool to protect monopoly. With regard to the high cost of medicines, a range of strategies were available to Member States to promote sustainable health systems, as identified in the recommendations of the Consultative Expert Working Group on Research and Development: Financing and Coordination, and through the ongoing work on implementation of the global strategy and plan of action on public health, innovation and intellectual property. He placed emphasis on the importance of national pharmaceutical regulatory systems and of updating them in order to ensure the affordability, quality, safety, effectiveness and accessibility of medicines. He assured the member for South Africa of the backing of the Government of Argentina.

Dr AZODOH (Nigeria) said that the subject of the report was of particular importance to clinicians, who possessed the necessary skills but were denied access to essential medicines. She expressed concern over the possible intimidation of a sovereign State by an interest group and called on the Secretariat to continue to support Member States in their engagement with stakeholders and interest groups. The incident underscored the need for a clearly defined strategy for engagement with interest groups, which otherwise could have a serious impact on public health outcomes. Her country expressed its solidarity with the Government and people of South Africa and stood ready to offer assistance.

Dr AL-THANI (Qatar), speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed WHO's strategy to improve access to essential medicines, which was underpinned by the principles of evidence-based selection of medicines at affordable prices, sustainable health financing, efficient procurement and distribution, and rational use of medicines. Such an approach – which had proved effective, particularly for developing countries – should be strengthened and advanced. Unfortunately, the approach was being undermined by international shortages of medicines due to factors such as concentration of production in a single plant, as well as market changes that particularly affected older generic medicines whose prices had become so low that companies had no incentive to produce them. Poor access to medicines against noncommunicable diseases and common conditions, such as curable cancers, cardiovascular diseases, chronic lung diseases and diabetes, as well as to medicines against hepatitis, represented a major global challenge to implementation of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020 and the Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. WHO needed to scale up its technical advice in support of countries' adoption of effective options to improve access, and pharmaceutical systems should also be strengthened to allow procurement and distribution systems to function efficiently.

Dr SUN Yang (China)¹ said that the United Nations Millennium Declaration called for affordable essential medicines to be made available in developing countries, and the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020 set a target of

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

80% availability of affordable essential medicines for treating major noncommunicable diseases in public and private institutions. Most low-income countries continued to face problems over the availability and affordability of essential medicines. In recent years, China had been reforming its health care system and establishing a national essential medicines policy. However, having formulated a national list of essential medicines, it was encountering a lack of capacity for evidence-based evaluation of medicines. A structure for an exchange of experience and best practices in research and development for the production and use of medicines was also lacking. Consequently China and the Republic of Korea would jointly table a draft resolution on access to essential medicines aimed at ensuring that the efforts of all parties concerned would serve to attract greater international attention to questions of availability, safety and affordability of essential medicines in order to enhance implementation of the Millennium Development Goals.

Mr KOTALWAR (India)¹ commended the report. In 2011, the Government of India had issued a national list of essential medicines, with particular emphasis on cost, safety and efficacy, in order to promote rational use and encourage prescription by generic names. However, as medicines still remained beyond the reach of poor people, the Government had introduced universal access to medicines and diagnostics and free essential generic medicines in public health facilities. It had procured medicines in bulk directly from manufacturers, under generic names. The activities of certain multinational pharmaceutical companies merited serious consideration. The Doha Declaration on the TRIPS Agreement and Public Health clearly reaffirmed the right of WTO members to make full use of flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights in order to protect public health and promote access to medicines for all. He strongly supported the Government of South Africa in its efforts to defend the spirit of the Declaration.

Mrs TAKAENZANA (Zimbabwe)¹ said that the attack on the Government of South Africa amounted to an attack on life itself in the interests of profit. In the light of such an incident, she urged WHO to be diligent in its approach to dealing with non-State actors. Public health must be protected. She expressed her support for the Government of South Africa on an issue that affected all Member States.

Dr BEJTJA (Albania) expressed solidarity with the Government of South Africa in its resistance to an assault on public health principles. He welcomed the report as it articulated an evolving challenge caused by the growing burden of noncommunicable diseases, in particular cancer. Paying for cancer treatment was a struggle for Albania's medical service. He thanked WHO for providing technical guidance on the rational use of medicines and health technology assessment. Including access to essential medicines as part of universal health coverage could encourage countries to change their practices.

Ms PACHECO (Plurinational State of Bolivia)¹ expressed her support for the Government of South Africa and the reforms it was implementing to improve access to essential medicines, which was also a priority for the Government of the Plurinational State of Bolivia.

Mr VELASQUEZ (South Centre), speaking at the invitation of the CHAIRMAN, expressed support for the efforts of the Government of South Africa to improve access to essential medicines, particularly in the context of the reform of the country's policy on intellectual property, including patent examination. He recalled that 14 years previously, South Africa's legislation on medicines, based on guidance from the Secretariat, had again been under attack by 39 pharmaceutical companies. It would therefore be opportune for the Board to send a message to the Government of South Africa supporting its reform of its patent laws. Developing countries should make full use of the flexibilities

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

in the Agreement on Trade-Related Aspects of Intellectual Property Rights in order to improve access to essential medicines for their populations.

Ms KUSYNOVÁ (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN and also on behalf of the International Pharmaceutical Students' Federation, commended the report, which identified issues preventing universal access to essential medicines and their responsible use. As governments began to implement universal health coverage, it was important to ensure that their investment led to positive health outcomes through the responsible use of medicines. In that regard, pharmacists had been identified as key contributors to achieving savings. The report also highlighted the complex challenge posed by shortages of medicines that affected both developed and developing countries. An international summit on medicines shortage, held in 2013, in which WHO had participated, had made six recommendations, including the development of a list of critical and vulnerable medicines, which would identify essential medicines at risk of becoming in short supply. She would value the opportunity of working with the Organization on implementation of those recommendations.

Dr LEGGE (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN and also on behalf of the People's Health Movement, said that, although seriously underfunded, WHO's essential medicines programme had made a significant contribution to universal access to treatment. He highlighted issues arising from the report that required more focused attention, namely the causes and management of shortages, the need to support technology transfer and local and regional production, and the need for greater investment in post-marketing surveillance of medicines, vaccines and diagnostics. He called on Member States to consider drafting a resolution authorizing the Secretariat to develop appropriate strategies and proposals. The consequence of WHO's funding crisis was evident in the failure to properly fund its rational use of medicines programme, a failure that was contributing to antimicrobial resistance. He recalled that the WHO List of Essential Medicines had been established in response to a request from low- and middle-income countries that were subject to aggressive pharmaceutical marketing and under pressure to stock the most recent and highly priced medicines. That situation still obtained.

Mr MALPANI (MSF International), speaking at the invitation of the CHAIRMAN, expressed concern at the lack of attention paid in the report to the impact of intellectual property on the affordability and accessibility of medicines. The intersection between intellectual property, innovation and public health was recognized in several Health Assembly resolutions and in the Agreement on Trade-Related Aspects of Intellectual Property Rights. Yet it remained difficult for Member States, especially developing countries, to use those flexibilities in the Agreement when drafting intellectual property policies aimed at promoting access to affordable essential medicines. Recent events in South Africa illustrated the lengths to which pharmaceutical companies would go to protect profit margins, even at the expense of people's lives. Such attacks on urgently needed reform were unacceptable in a country facing critical HIV and tuberculosis epidemics. Intellectual property clauses included in trade negotiations initiated by the United States of America and the European Union also gave cause for concern, in particular the Trans-Pacific Partnership Agreement and the TRIPS-plus provisions. The draft resolution on access to essential medicines would provide a timely opportunity for WHO to reaffirm its political commitment to promoting access to essential medicines through the use of flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights, and to strengthen its role in countering the industry's influence and safeguarding countries' ability to enact those flexibilities.

Ms TSENG Pei Chi (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, commended WHO's promotion of access to essential medicines through various means, including reference materials such as the WHO Model List of Essential Medicines, the WHO Guideline on Country Pharmaceutical Pricing Policies and the Health Products Information Portal. She had noted that, although patent life had lengthened, the innovation rate had not

matched that increase. Although more investment in research and development was needed, making that investment could contribute to increasing the cost of medicines. A mechanism for delinking the cost of research and development from the price of the products was therefore needed. Concepts such as open access, whose aim was to promote cooperation in research by diminishing academic boundaries, could be applied to research and development for new medicines.

The DIRECTOR-GENERAL said that the work on increasing access to essential, high-quality, effective and affordable medical products arose out of the Twelfth General Programme of Work, 2014–2019. It was thus a mandate from the Member States to the Secretariat.

With regard to the recent events in South Africa, as she had said in other contexts, no government should be intimidated by interested parties for doing the right thing in public health. The Government of South Africa, as it reformulated its intellectual property policy, had provided space for interested parties to give their views and defend their interests. WHO, at the request of the Government of South Africa, had also commented on the draft policy. She thanked Member States for their solidarity with South Africa. One of the important principles of equity was that nobody should be denied access to life-saving interventions or products, and the Organization would need to work very hard in providing support to the Government of South Africa in its endeavours.

However, if Member States approved a resolution on the extremely important topic of access to essential medicines, they would need to give thought to how the resultant work would be funded. Part of the reason for the financing dialogue and the reform of WHO was to address the issue that when the membership give an instruction to the Secretariat, there was always a cost attached to it, and Member States needed to reflect on how it was to be funded.

The Board took note of the report.

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

2. PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 8 of the Agenda (continued)

Contributing to social and economic development: sustainable action across sectors to improve health and health equity: Item 8.7 of the Agenda (Document EB134/54) (continued from the seventh meeting)

The CHAIRMAN drew attention to the amended draft resolution proposed by Argentina, China, Croatia, Czech Republic, Finland, Iceland, Latvia, Lithuania, Panama, Turkey and Ukraine, which read:

The Executive Board,

Having considered the report on contributing to social and economic development: sustainable action across sectors to improve health and health equity (follow-up of the 8th Global Conference on Health Promotion),¹

RECOMMENDS to the Sixty-seventh World Health Assembly, the adoption of the following resolution:

¹ Document EB134/54.

The Sixty-seventh World Health Assembly,

PP1 Reaffirming the principles of the Constitution of the World Health Organization stating that the achievement of any State in the promotion and protection of health is of value to all; and that governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures;

PP2 Reaffirming the right of every human being without distinction of any kind to the enjoyment of the highest attainable standard of physical and mental health, and to a standard of living adequate for the health and well-being of oneself and one's family, including adequate food, clothing, housing and to the continuous improvement of living conditions; (~~UNGA-res-68/98, PP4~~);

PP3 Recalling the Alma Ata Declaration, ~~the Primary Health Care Strategy and the Global Strategy of Health for All by the year 2000, and their calls for coordination, cooperation and intersectoral action for health among relevant sectors and aspects of national and community development;~~

PP4 Acknowledging the United Nations General Assembly document "The Future we want", and in particular its recognition that health is a precondition for and an outcome and indicator of all three dimensions of sustainable development and the call for the involvement of all relevant sectors for coordinated multisectoral action to address urgently the health needs of the world's population [~~66/288~~];

PP5 Recalling resolutions on health promotion, public information and education for Health,¹ ~~on health promotion,~~² ~~on health promotion and healthy lifestyles,~~³ ~~on health promotion in a globalized world,~~⁴ and **social determinants of health,**⁵ taking note of the outcome documents of the seven Global WHO Conferences on health promotion,⁶ ~~and their calls for strengthened health promotion~~ in particular the Ottawa Charter, Adelaide Statement and the Nairobi Call for Action;

~~PP6 Recalling the call of the Ottawa Charter for healthy public policies and supportive environments, the Adelaide Statement on Healthy Public Policies, and the Nairobi call to action for closing the implementation gap in health promotion;~~

PP76 Recognizing the Programme Budget of the World Health Organization for the biennium 2014–2015 and its category 3 "Promoting health through the life course";

~~PP87~~ Reaffirming commitments made with respect to considering global health in the context of foreign policy [~~A/RES/63/33~~] and reiterating recommendations to consider universal health coverage in the discussions on the post-2015 development agenda, ~~including~~ **also considering** broad public health measures, health protection and addressing determinants of health through policies across sectors [~~A/RES/67/81~~];

PP98 Recalling the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, which recognizes the primary role of Governments in responding to the challenge of noncommunicable diseases and the essential need for the efforts and engagement of all sectors ~~of the society~~ to generate responses for the prevention and control of

¹ Resolution WHA42.44.

² Resolution WHA51.12.

³ Resolution WHA57.16.

⁴ Resolution WHA60.24.

⁵ **Resolution WHA65.8.**

⁶ Ottawa, 1986; Adelaide, Australia, 1988; Sundsvall, Sweden, 1991; Jakarta, 1997; Mexico City, 2000; Bangkok, 2005; Nairobi 2009.

noncommunicable diseases, as well as the important role of international community and international cooperation in assisting the Member States in these efforts; ~~[A/RES/66/2];~~

PP109 Noting further the WHO global strategy for the prevention and control of noncommunicable diseases, which stresses that health gains can be achieved much more readily by influencing public policies in sectors like trade, taxation, education, agriculture, urban development, food and pharmaceutical production than by making changes in health policy alone ~~[A/61/8, P14]~~ as well as endorsement of the global action plan for the prevention and control of noncommunicable diseases 2013–2020; ~~[WHA 66.1.];~~

PP110 Noting that the health sector has a key role in working with other sectors in ensuring drinking water quality, sanitation, **food and nutritional safety**, air quality and limiting exposure to health-damaging chemicals and radiation levels, as recognized in World Health Assembly resolutions;¹

PP12 11 Recognizing that a number of mental disorders can be prevented and that mental health can be promoted in the health sector and in sectors outside health; ~~[WHA65.4]~~ and that global support is necessary for national and local work on mental health and development, including through the Mental Health Action Plan and the WHO MINDbank;

PP132 Noting further the relevance of the WHO Framework Convention on Tobacco Control for many sectors, ~~and related WHO strategies and action plans,~~ underscoring the importance of addressing common risk factors for noncommunicable diseases across sectors; ~~[WHA 65.3]~~ and the cooperation needs under International Health Regulations, including among the United Nations agencies, and between and within Member States;

~~PP14 Noting the cooperation needs under International Health Regulations, including among the United Nations agencies, and between and within Member States; PP15bis~~

PP13 Acknowledging the final report of the Commission on Social Determinants and Health “Closing the gap in a generation: ~~health equity through action on the social determinants of health~~” as a resource of evidence for action on social determinants of health and health inequities;

PP154 Acknowledging the Rio Political Declaration on Social Determinants of Health ~~and its determination~~ and its call for the development and implementation of robust, evidence-based, reliable measures of societal well-being, ~~building where possible on existing indicators, standards and programmes and across the social gradient, that go beyond economic growth [Rio political declaration],~~ and recognizing the important advocacy role of health ministries in this regard;

PP165 Recognizing that Health in All Policies refers to taking the health implications of decisions systemically into account in public policies across sectors, seeking synergies, and avoiding harmful health impacts, in order to improve population health and health equity through assessing consequences of public policies on determinants of health and well-being and on health systems;

PP176 Concerned of gaps in taking into account across government, at various levels of governance, impacts of policies on health, health equity and functioning of the health system,

(OP) 1. NOTES with appreciation the Statement of the 8th Global Conference on Health Promotion: Health in All Policies, held in Helsinki, and notes the ongoing work on the Framework for Country Action,

¹ Resolutions WHA59.15, WHA61.19, WHA63.25, WHA63.26, WHA64.15, WHA64.24.

- (OP) 2. URGES Member States:¹
- (a) to champion health and the promotion of health equity as a priority and take efficient action on ~~the~~ social, **economic and environmental** determinants of health **including and in** noncommunicable disease prevention;
 - (b) to take measures, including, where appropriate, effective legislation, **cross-sectoral** structures, processes and resources that enable societal policies which take into account and address their impacts on health determinants, health protection, health equity, (**including Urban HEART**) and health systems functioning, and to measure and track social determinants and disparities in health;
 - (c) to develop, as appropriate, and maintain adequate and sustainable institutional capacity and skills, **such as to assess health implications of policy initiatives of all sectors, explore cross-sectoral solutions and to negotiate policies across sectors**, including within the health authorities and relevant research and development institutes such as National Public Health Institutes, to achieve, ~~through actions across sectors~~, improved outcomes from the perspective of health, health equity and health systems functioning;
 - (d) to take action to enhance health and safeguard public health interests from undue influence by any form of real, perceived or potential conflict of interest, through management of risk, strengthening of due diligence and accountability and increasing the transparency of decision-making and engagement; [~~A/RES/68/98~~]
 - (e) to include, as appropriate, **relevant stakeholders, such as** local communities and civil society actors in the development, implementation and monitoring of policies across sectors, ~~including by mechanisms for community engagement and public participation~~;
 - (f) to contribute to the development of the post-2015 development agenda by emphasizing that policies in sectors other than health have a significant impact on health outcomes, and by identifying synergies between health and other sector policy objectives; [based on A61/8, P14]
- (OP) 3 REQUESTS the Director General:
- (a) to prepare, for the consideration, by the Sixty-eighth World Health Assembly, in consultation with Member States,¹ ~~and~~ United Nations organizations, **and other relevant stakeholders as appropriate**, and within existing resources, a Framework for Country Action, for adaptation to different contexts, taking into account the Statement of the 8th Global Conference on Health Promotion (Helsinki, 2013), aimed at supporting national efforts to improve health, ensure health protection, health equity and health systems functioning, including through action across sectors on determinants of health and risk factors ~~for~~ **of** noncommunicable diseases, based on best available knowledge and evidence;
 - (b) to provide guidance and technical assistance, upon request, to Member States in their efforts towards implementation of Health in All Policies, including through building necessary capacities, structures, mechanisms and processes for measuring and tracking social determinants and disparities in health;
 - (c) to strengthen WHO's role, capacities and knowledge-resources, **including by compiling and analysing good practices by Member States**, to give guidance and technical assistance for implementation of policies across sectors at the various levels of governance, and ensure coherence and collaboration with WHO's own initiatives requiring actions across sectors, including in the global response to the challenges posed by noncommunicable diseases;

¹ And, where applicable, to regional economic integration organizations.

- (d) to continue to work and provide leadership with the United Nations agencies, development banks, other international organizations and foundations, with the view of taking health considerations into account in major strategic initiatives and their monitoring, including the post-2015 development agenda, ~~promoting the incorporation of the approach of social determinants of health~~, and urge these organizations to achieve coherence and synergy with commitments and obligations related to health **and health determinants** in their work with member States;
- (e) to report back to the World Health Assembly on the progress made at the Sixty-ninth World Health Assembly (2016) through the Executive Board.

She added that the financial and administrative implications for the Secretariat remained unchanged.

Mr COTTERELL (Australia) said that in the light of the amendments made, he could now support the draft resolution. He hoped however, that the text would be simplified further before it was submitted to the Health Assembly in order to support efficient discussion.

Dr KAMALIAH MOHAMAD NOH (Malaysia) also supported the draft resolution as amended, but asked for clarification on whether the financial implications had been agreed in an earlier budget or were additional.

In reply, the DIRECTOR-GENERAL drew attention to the way in which the financial implications of the draft resolution were articulated (see pp. 121–122). Paragraph 3 showed a total cost of US\$ 1.45 million, including staff and activity costs. Because funding was not fully available at the beginning of a biennium, in this case the biennium 2014–2015, budget “space” of US\$ 980 000 had been allocated, even though, as indicated in paragraph 4, the amount would have to be mobilized. Although the financial implications of the resolution were modest, action on noncommunicable diseases, including social determinants of health, was always underfunded. She recalled that Member States had approved the Programme budget 2014–2015 during the Sixty-sixth World Health Assembly, yet they continued to request activities that had not been budgeted for. There were two ways to deal with such “unbudgeted” activities: Member States could provide additional resources or she could violate budget discipline. Since Member States would not want her to exceed the agreed budget, she would appreciate their not giving her conflicting instructions.

Part of the difficulty in allocating funding was attributable to WHO’s biennial budget cycles, whereas countries had annual cycles that were more manageable. The WHO reform process could provide an opportunity to reflect on better ways of managing the Organization in the future.

The CHAIRMAN said that if she heard no objection, she would take it that the Board wished to note the report and adopt the draft resolution, as amended.

The Board took note of the report.

The resolution, as amended, was adopted.¹

The meeting rose at 17:30.

¹ Resolution EB134.R8.

TENTH MEETING

Thursday, 23 January 2014, at 18:45

Chairman: Professor J. HALTON (Australia)

1. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 10 of the Agenda (continued)

Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits: Item 10.2 of the Agenda (Document EB134/33)

Dr KAMALIAH MOHAMAD NOH (Malaysia), noting the substantial amount of voluntary funding provided to the Partnership Contribution, said that the Pandemic Influenza Preparedness (PIP) Advisory Group would be expected to ensure transparency and equity in the distribution of those funds. She endorsed the Advisory Group's suggestions and looked forward to a successful conclusion of the Standard Material Transfer Agreement 2 (SMTA 2) negotiations with the remaining companies identified as receiving PIP biological materials outside the WHO Global Influenza Surveillance and Response System. She likewise endorsed the development of guidelines on issues relating to developments in synthetic biology, particularly with regard to public health, and deliberate misuse of influenza virus genetic sequence data from the Global Influenza Surveillance and Response System. She commended WHO's enhancement of the Influenza Virus Traceability Mechanism in order to track the movement of PIP biological materials. The various initiatives undertaken promised to ensure equal access to all benefits from the sharing of influenza viruses.

Dr CARBONE (Argentina), similarly endorsing the recommendations of the Advisory Group, emphasized that rapid sharing of viruses and information was essential to the development of candidate vaccine viruses and reference reagents, diagnostic tests and dissemination of information on risk assessment and pandemic preparedness actions. In Argentina, a national campaign for vaccination against influenza A(H1N1) had been in place since 2010 as part of an integrated prevention strategy involving the time-phased delivery of the vaccine, in accordance with the PIP Framework, and concerted efforts to ensure coverage of the most vulnerable populations. Overall coverage had risen with the subsequent inclusion in the vaccination programme of such groups as infants, pregnant women, health workers and people over 65 years old. Suspected and confirmed cases were monitored through a laboratory surveillance system, and the global situation should likewise be monitored through a virus surveillance network incorporating all countries. Timely and equal access to prevention tools must be provided to all countries alike and to priority population groups. The work to promote implementation of the PIP Framework should be pursued in cooperation with the industry and other stakeholders.

Mr COTTERELL (Australia) welcomed the satisfactory progress and transparency thus far achieved in implementing the PIP Framework. In 2013, his Government had made additional contributions in support of the WHO Shipping Fund Project and the SMTA 2 negotiations. He requested a progress report on that score and on the establishment of a technical working group on handling genetic sequence data in the context of the PIP Framework.

Dr BAYE LUKONG (Cameroon), speaking on behalf of the Member States of the African Region, commended the Pandemic Influenza Preparedness arrangements in place. It remained for Member States to scale up the implementation of all surveillance components, with a focus on the development of additional sentinel sites and situation monitoring and assessment systems; maintain existing influenza reference laboratories and, where possible, expand the network to other sites; update and monitor influenza preparedness and response plans; and work for the inclusion of influenza vaccination in national vaccination policies.

Mr KOLKER (United States of America)¹ expressed appreciation for the progress made in implementation and for WHO's determination to overcome the remaining challenges in that sphere. Taking into account the coordination and oversight demanded by the ambitious scope of the activities to be supported by partnership contributions, the PIP secretariat should be encouraged to expand its own capacity by using the allowable 10% of those contributions to assure sound management of the programme functions. Concerning the gap analysis and implementation plans, the newly specified timeline, budget and objectives were particularly welcome. Another highly valuable exercise was the active consultation between WHO and stakeholders in the implementation.

Mr HU Xiaomeng (China),¹ applauding the increasingly active role of the relevant countries in PIP Framework activities, said that the Government of China was coordinating communication between national vaccine manufacturers and WHO on the details of the conclusion of an SMTA 2. It was also encouraging partnership contribution payments from those manufacturers and advocated strict application of the definition of PIP biological materials in order to achieve the desired objectives and avoid jeopardizing collaboration between human and animal sector laboratories. In 2013, China's virus sharing mechanism had been instantly triggered by the detection of cases of avian influenza A(H7N9), and viruses had been promptly shipped to several research facilities around the world. In addition to continuing its active participation in global influenza surveillance activities, China was ready to share viruses and benefits and donate to the global vaccine stockpile. It also looked forward to WHO's ongoing support for the strengthening of its influenza laboratory and surveillance capacities. Other useful PIP input from WHO might include an analysis of the overall status of global vaccine manufacturers and the drafting of more precise rules in the interest of enhancing PIP Framework implementation.

Professor TJANDRA YOGA ADITAMA (Indonesia)¹ said that the PIP Framework remained extremely relevant to the existing global public health situation. Its spirit and principles continued to be upheld, notwithstanding the administrative and legal complexities relating to partnership contributions and the technical discussion surrounding the definition of PIP biological materials and the handling of genetic sequence data. Virus and benefit sharing, transparency and equity must remain the constant guiding principles for all PIP Framework processes, and must be adopted by all Member States in order to maintain their commitment to those principles.

Ms MEL'NIKOVA (Russian Federation)¹ said that the methodologies developed by the PIP secretariat and the PIP Advisory Group for the distribution of Partnership Contribution resources should continue to be applied and refined. The criteria developed by the Advisory Group for identifying priority countries in need of strengthened laboratory and surveillance capacities would ensure rational and equitable use of partner contributions. Her Government approved of the secretariat's efforts to implement SMTA 2s and supported the recommendation of the PIP Advisory Group that the participation of WHO consultant lawyers would streamline and accelerate the process of concluding SMTA 2s with pharmaceutical manufacturers. She supported the initiative of the secretariat and the PIP Advisory Group to develop guidance regarding the use of influenza virus

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

genetic sequence data within the PIP Framework, with Russian experts available to take part in the related technical expert working group.

Dr AUTTAKIAT KARNJANAPIBOOKWONG (Thailand)¹ commended the efforts of the Advisory Group, remarking in addition that the cooperation of vaccine manufacturers had contributed to the significant progress in implementation of the PIP Framework, for which he pledged and encouraged continuing support. He appealed for similar cooperation on the part of recipients of biological materials outside the Global Influenza Surveillance and Response System and called on WHO to monitor the use of resources from the Partnership Contributions for the benefit of the PIP Framework.

Dr FUKUDA (Assistant Director-General) said that the strong and positive response to the PIP Framework reflected the spirit of the negotiations undertaken to craft an agreement that now stood as a landmark achievement and model. Substantial progress had been achieved in many of the spheres mentioned by speakers. As a result of extensive negotiations with the private sector, for example, final partnership contributions in 2013 were estimated to reach about US\$ 23 million in cash for pandemic influenza capacity-building. The focus was on the projects soon to be implemented in that domain. SMTA 2 negotiations were under way between WHO and some 35 vaccine manufacturers and biotechnology companies and had already been completed with one large pharmaceutical company, one large developing-country company and one university; and they were soon to be completed with two other such companies. The reality was, however, that SMTA 2 negotiations involved immense legal complexities with no clear precedents in some aspects. One company had decided after several months of extensive negotiations that it would no longer manufacture influenza vaccines. The team conducting such one-to-one negotiations had therefore since been augmented by the services of consultant lawyers to facilitate and accelerate the intricate process to the greatest extent possible. Other complexities were created by the evolution of science and technology, whereby genetic sequence data could now be used instead of viruses to manufacture new vaccines. Some members of the PIP Advisory Group and some outside experts had been tasked with identifying the implications and issues raised by that particular scientific evolution and provide guidance as to how best to address them in the context of the PIP Framework. He thanked Member States for their strong and consistent support for the Framework and, among other things, providing the secretariat with critically needed financial resources.

The Board noted the report.

Smallpox eradication: destruction of variola virus stocks: Item 10.3 of the Agenda (Document EB134/34)

Mr LUTZOW STEINER (Mexico) said that it would be in the public health interest to retain a stock of variola virus for use in new research in the areas of diagnostics, vaccines and antiviral agents against smallpox. Such stocks should be stored in facilities with such a standard of security as to permit work to be carried out in controlled conditions. He suggested that a group of experts be established to study the potential threat of new strains being created through synthetic biology and make recommendations to the Executive Board by January 2015.

Dr ASADI-LARI (Islamic Republic of Iran), reaffirming the conclusions of the meeting of the Advisory Group of Independent Experts to review the smallpox research programme, held in November 2013, read out a statement on the current agenda item that had been delivered on behalf of

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

the Member States of the Eastern Mediterranean Region at the Sixty-fourth World Health Assembly.¹ He looked forward to further discussions and a final decision concerning the item at the Sixty-seventh World Health Assembly.

Ms MATSOSO (South Africa) reported that, in conformity with decision WHA64(11) reaffirming the decisions of previous Health Assemblies that the remaining stocks of variola virus should be destroyed, a process had been initiated in South Africa whereby, during the present month, WHO would witness the destruction of cloned variola virus DNA fragments that had been stored. She thanked WHO for its prompt response in that regard and looked forward to the updating of the certification procedure set out in the Report of the Meeting of the Ad Hoc Committee on Orthopoxvirus Infections in 1994.²

Dr MEMISH (Saudi Arabia) commended the comprehensive technical reports of the WHO Advisory Committee on Variola Virus Research and the Advisory Group of Independent Experts to review the smallpox research programme, as well as the recommendations of the Strategic Advisory Group of Experts on immunization, notably on the size of the WHO smallpox vaccine stockpile. He encouraged the continuation of efforts to develop more immunogenic vaccines against smallpox with fewer side effects than those currently available, and he respected the view that live variola virus would be useful in developing effective antiviral agents against smallpox. He welcomed the establishment of an ad hoc Independent Technical Group to agree a standard diagnostic method and favoured the continuation of biosafety inspections of the two repositories of variola virus, as well as efforts to confirm that no unauthorized repositories existed anywhere in the world.

Dr GRABAUSKAS (Lithuania) echoed the commendations of the previous speaker and paid tribute to the continuous work of WHO biosafety inspection teams; the rigid monitoring system in place undoubtedly served to foster a sense of safety. Rapidly advancing gene synthesis technologies nonetheless gave rise to concerns that complex viruses could be recreated without the need for seed stocks. Careful consideration must therefore be given to the implications of such potential risks for agreed variola virus research goals and for the adequacy of existing countermeasures. Preparedness offered the best solution for the elimination of smallpox risks. It might thus be premature to set a date in 2014 for the destruction of smallpox virus stocks held by the two authorized repositories of live variola virus.

Dr CARBONE (Argentina) said that, as the live variola virus was necessary for the continued development of antiviral compounds, her Government did not oppose the maintenance of WHO virus stock repositories, which enabled further research on diagnostics, smallpox vaccines and antiviral agents. Talks should continue with regulatory agencies of donor countries for the establishment of a regulatory framework for the donation of smallpox vaccines. Research on the virus needed to continue, as it was crucial to ensure an appropriate public health response in the event of an outbreak, which would be one of the most devastating in the history of humanity.

Dr AZODOH (Nigeria) expressed confidence in the work of the WHO Advisory Committee on Variola Virus Research and the Secretariat and in the work of the inspection teams. The very stringent monitoring system gave grounds for hope that there were no unofficial sources of variola virus in existence anywhere in the world. Her Government believed that it was premature to completely destroy the virus stocks, which needed to be held in reserve in order to build capacity and experience to respond to a potential outbreak.

¹ See document WHA64/2011/REC/3, summary record of the eleventh meeting of Committee A, section 2.

² Document WHO/CDS/BVI/94.3.

Dr SAKAMOTO (Japan) said that, although her Government supported the ultimate goal of destroying the remaining variola virus stocks in research institutes, the threat of bioterrorism and the need for further research on international health risk management made it premature to set a destruction date. Her Government was gravely concerned about the possible existence of undeclared stocks of variola virus and the possibility, which had dramatically increased in recent years, that smallpox could be recreated through synthetic biology. Considering that WHO's research oversight bodies had not fully considered those scenarios, she asked the Director-General to conduct a review of those developments.

Dr BEJTJA (Albania) said that his Government shared the expert opinion as expressed by the WHO Advisory Committee on Variola Virus Research in its report that live variola virus was still needed for the further development of antiviral agents. Monitoring of the two repositories of variola virus should continue in compliance with the approved protocols.

Mr COTTERELL (Australia) said that, in view of the conclusion of the WHO Advisory Committee on Variola Virus Research that live variola virus was still needed and of the concerns expressed by some Board members about advances in synthetic biology that could give rise to new smallpox strains, it was premature to consider the destruction of the stocks in the two authorized repositories. Research into the virus continued to be important and should be pursued in a responsible manner.

Dr KAMALIAH MOHAMAD NOH (Malaysia) said that major progress had been made in the development of antiviral agents, improved vaccines and sensitive diagnostic assays. However, developments in genomic technologies had made it possible to create a synthetic variola virus that could be used as a bioweapon and cause a catastrophic event for the global community. Only two antiviral agents with anti-variola virus activity were at advanced stages of development, and there was a possibility that resistance to both of them could occur *in vivo*. The variola virus could also be engineered to be resistant to those agents. She agreed with the Advisory Group of Independent Experts to review the smallpox research programme that additional compounds with alternative mechanisms of action should be developed. Furthermore, strategies for efficient immunization, including post-exposure vaccination or administration of anti-vaccinia immunoglobulin and monoclonal antibodies, should be developed. There was still a need for continued research before consensus could be reached on the destruction of remaining stocks, and she thus agreed with other Member States that it was premature to recommend destruction at the current time.

Mr CASALS ALIS (Andorra) said that, in light of technological advances and the development of genomic sequencing, it was premature to destroy the virus stocks. Meanwhile, security at the repositories should be strengthened.

Mr CORRALES (Panama), noting the concerns voiced by the other Board members, said that research still needed to continue for a time. He supported the establishment of a group of experts that could agree on rules for moving forward.

Dr BARBOSA DA SILVA (Brazil) said that it was premature to think about destroying the virus stocks and that further research on the virus would be highly beneficial. The stocks did not present a risk, as they were properly monitored, secured and maintained.

Ms MI Yanping (China)¹ said that the WHO Advisory Committee on Variola Virus Research, the Advisory Group of Independent Experts to review the smallpox research programme and the

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

Secretariat had been effective in monitoring and managing variola virus stocks and issuing valuable opinions on their destruction. The designated bodies of relevant countries had made important progress in biological and molecular research, as well as research into early and rapid diagnosis technology, antiviral agents and new vaccines. That work had provided important guarantees for detection, reporting, diagnosis and early-stage treatment of the disease. In order to prevent smallpox from recurring, she agreed with the proposal to stop using the live variola virus in research, to initiate, when appropriate, the process of destruction and to have a strict prohibition on the synthesis of the variola virus. Member States should receive prompt information from the Secretariat with regard to research findings and enjoy access on an equal footing to research findings related to diagnosis, treatment and vaccines.

Dr DAULAIRE (United States of America)¹ said that countermeasures were not yet robust enough to render retention of and research on variola virus unnecessary. He supported the continued retention of live variola virus stocks until the research authorized by the Organization was completed and public health officials had proven countermeasures in place to respond to a potential smallpox outbreak. The increasing emergence of monkeypox and related orthopoxviruses, and the ever-dwindling pool of individuals who had been vaccinated against smallpox, increased the likelihood of transmission. There had been significant advances in recent years in synthetic biology that had made it increasingly possible to recreate variola virus from readily available building blocks. Inevitably, technological advances would make such capacity widely accessible in the near future. The consequences in a largely unimmunized global population could be catastrophic.

He agreed with the conclusions of the WHO Advisory Committee on Variola Virus Research that live virus was still needed for the purposes of countermeasure research. His Government was committed to working in close partnership with the Secretariat and Member States to ensure that relevant research findings were made widely available. Some of the research already approved by the Advisory Committee sought to uncover and block the ways that variola virus disrupted the human immune response. Countermeasures resulting from such research could be broadly protective against engineered strains of the virus, and none of that research would require gain-of-function experiments using variola virus. He supported calls from Board members that the existing research agenda be reviewed to take account of those potential new threats and opportunities, and strongly encouraged the Director-General to conduct an additional review of recent scientific advances in gene synthesis technology and its implications for public health.

Ms MEL'NIKOVA (Russian Federation)¹ said that her Government was grateful for the Organization's consistent policy in the context of international agreements primarily aimed at ensuring the availability of and reliable access to antiviral agents against smallpox. As host to one of the two centres authorized to store the live variola virus and conduct research on the virus with oversight from the Organization, her country ensured compliance with stringent biosafety standards. Significant achievements had been made with respect to the development of diagnostic tests and the prevention and treatment of smallpox, benefiting the international community as a whole. A multiplex polymerase chain reaction assay had been created and registered at national level that could rapidly diagnose smallpox and distinguish variola virus from other orthopoxviruses that might infect humans. Her Government was prepared to supply the WHO smallpox laboratory network with those diagnostic tools. Two nationally registered second-generation vaccines, one in tablet form that was safe and effective, were already available. Development was continuing on a fourth-generation live smallpox vaccine for oral administration. Two medicinal products with different mechanisms of action, the effectiveness of which had been confirmed based on preliminary data, were under development. Convinced that it was justifiable and necessary to continue research using live virus until its completion, her Government was prepared to share the research findings for the common good.

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

Mr LINDGREN (Norway)¹ said that the report did not adequately address the fact that the technology needed for synthetic production of the smallpox virus existed. A laboratory-produced virus could potentially have the same capacities as the original virus. More information was needed about the implications of that development for public health preparedness against potential future outbreaks. He supported the proposal by the member for Mexico to establish an expert group to examine that issue.

Ms ST LAWRENCE (Canada)¹ supported the findings of the WHO Advisory Committee on Variola Virus Research and the Advisory Group of Independent Experts to review the smallpox research programme. Although her Government had concluded that the remaining stocks of variola virus were no longer required for public health research purposes, advances in synthetic biology had made the potential of de novo synthesis of the virus a reality that needed to be discussed; consequently, Canada was not ready to agree to the destruction of the remaining stocks until it could be verifiably established that proliferation and security concerns over the possible use of the virus as a biological weapon were resolved. Member States and the Secretariat, in considering the destruction issue at the Sixty-seventh World Health Assembly, would also need to discuss a mechanism whereby all Member States would be required to declare themselves free of unauthorized stocks of variola virus before destruction of the remaining stocks. It was also necessary to plan for the post-destruction era, which could include measures to ensure that the virus could not re-emerge.

Mrs BHATTACHARYA (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN and also on behalf of the People's Health Movement and the Third World Network, said that the destruction of variola virus stocks was one of the longest-standing issues on the agenda of the Health Assembly. Although the Organization had repeatedly concluded that the stocks should be destroyed, that finding had not been implemented. Most recently, the Advisory Group of Independent Experts to review the smallpox research programme had concluded that no public health reason remained to retain the stocks and that the research programme no longer needed live variola virus. If it had not been for the oversized representation of one Member State in the WHO Advisory Committee on Variola Virus Research, the Committee would have reached the same conclusion. The Board should recommend to the Health Assembly that it take an irrevocable decision to destroy the variola virus stocks and fix a destruction date, thereby bringing one of the Organization's greatest successes, the eradication of smallpox, to a final conclusion.

Dr FUKUDA (Assistant Director-General) said that smallpox was a sui generis issue and the subject of a long-running discussion among Member States in the Health Assembly. The topic would come up again at the forthcoming Health Assembly. He had noted that several Member States had raised concerns questioning the implications of biosynthetic technology, and that a request had also been made to the Director-General to establish an expert group to review that situation.

The DIRECTOR-GENERAL said that she had taken note of the concerns expressed by many Member States regarding biosecurity at the two repositories. The Organization would continue to make sure that the existing stocks were kept in appropriate conditions. Member States' concerns with synthetic biology reflected the speed with which science was moving forward. Resources would be found to organize a group of synthetic biology experts in line with the wishes of the Board to examine the issue and its implications for the future.

The Board noted the report.

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

2. MANAGEMENT, FINANCIAL AND LEGAL MATTERS: Item 11 of the Agenda**Evaluation:** Item 11.1 of the Agenda (Document EB134/38)

The CHAIRMAN, introducing the item, noted that the report of the Programme, Budget and Administration Committee on its discussion of the subject was contained in paragraphs 16 and 17 of document EB134/3.

Ms DÁVILA CHÁVEZ (Mexico) said that sharing the reports of the Global Network on Evaluation with regional and country offices would help to implement corrective actions in management frameworks. It was appropriate that the evaluation process would be a consultative one, including the creation of an evaluation registry platform and quality control of evaluation products. It was also welcome that the process would deal with gender equality and human rights issues, making the reports more comprehensive and more accurate. An evaluation culture needed to be instilled at all levels of the Organization, to ensure that the reports reflected the efficiencies, shortcomings and risks for the Secretariat, the regions and the Member States.

Mr BUTLER (Bahamas)¹ welcomed the report and looked forward to the Organization's continued progress in the field of gender equality.

The Board noted the report.

Amendments to the Financial Regulations and Financial Rules: Item 11.2 of the Agenda (Document EB134/40)

The CHAIRMAN drew the attention of the Board to paragraphs 3 and 4 of the report. In line with resolution WHA66.3 on amendments to the Financial Regulations and Financial Rules, the Board was invited to confirm the amendments of an editorial nature made by the Director-General to Financial Rule III in order to align it with the agreed changes to the Financial Regulations.

Mr COTTERELL (Australia) supported the amendments of an editorial nature and the proposed draft resolution in document EB134/40.

The CHAIRMAN took it that the Board wished to adopt the draft resolution.

The resolution was adopted.²

Real estate: update on the Geneva buildings renovation strategy: Item 11.3 of the Agenda (Document EB134/41)

The CHAIRMAN noted that the item had been discussed by the Programme, Budget and Administration Committee, whose report on it was contained in paragraph 18 of document EB134/3.

Ms DUSSEY-CAVASSINI (Switzerland) said that, as both a Member State and the host country, her Government was aware that funds were needed to enable the Organization to create the best possible working conditions for its employees and maintain its real estate in good condition. Her Government was participating in the renovation project, both as a member of the renovation steering

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

² Resolution EB134.R9.

committee, which included representatives from the Organization and the Swiss administrative organs, and by contributing financially to the redevelopment of the site and the appraisal of lot 406, which would help to partially finance the renovations. Following the entry into force of a relevant cantonal law, the requisite legal conditions were in place for appraisal of the land belonging to the Organization to be carried out. Her Government was examining the Organization's request for an interest-free loan of the funds required to complete the construction of a new building. It would take the decision as soon as possible and inform the Organization immediately.

Ms DÁVILA CHÁVEZ (Mexico) said that workplace safety was essential and that energy efficiency and low maintenance costs were also desirable. However, in view of health priorities and funding gaps, the need and urgency of the renovations of the headquarters needed to be assessed. She requested clarification of whether, if the Swiss authorities authorized the requested loan, a report would be needed to set out the terms of payment and the sources of financing to cover those payments.

Mr PRESTON (Operational Support and Services), responding to the query from Mexico, said that a full detailed specification of the building and the financing, including the repayment schedule on the loan (subject to the agreement of the Government of Switzerland), would be provided to the Sixty-eighth World Health Assembly in May 2015, when the decision would be sought.

The Board noted the report.

Hosted health partnerships: Item 11.4 of the Agenda (Document EB134/42)

The CHAIRMAN noted that the item had been discussed by the Programme, Budget and Administration Committee, whose report on it was contained in paragraphs 31 and 32 of document EB134/3.

Dr AZODOH (Nigeria), speaking on behalf of the Member States of the African Region, welcomed the efforts of the Secretariat to implement the previous decisions of the Board and sustain the important partnerships whose demise would significantly affect the work of the Organization and public health outcomes. The Organization was encouraged to develop a transparent and coherent framework that would enable full cost recovery, while ensuring that key strategic partnerships continued operations on the most cost-effective basis.

The Board noted the report.

Follow-up of the report of the Working Group on the election of the Director-General of the World Health Organization: Item 11.5 of the Agenda (Document EB134/43)

The CHAIRMAN invited the Board to provide comments and guidance on the clarity and completeness of the description of the process of election of the Director-General and to consider the proposals in paragraphs 17 and 18 in document EB134/43.

Mrs TAKAENZANA (Zimbabwe)¹ recommended that regional groupings be allowed more time to discuss the agenda item before providing comments.

Dr AZODOH (Nigeria), speaking on behalf of the Member States of the African Region, said that the regional group had not had an opportunity to discuss the item and would need more time.

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

The CHAIRMAN said that the agenda item would be taken up again the next day.

(For continuation of the discussion, see the summary record of the twelfth meeting, section 1.)

The meeting rose at 20:15.

ELEVENTH MEETING

Friday, 24 January 2014, at 09:05

Chairman: Professor J. HALTON (Australia)

1. ORGANIZATION OF WORK

The CHAIRMAN said that some Board members had raised concerns about the difficulty of dealing with draft resolutions when the associated financial and administrative implications were not available. In an attempt to expedite the Board's work, the Secretariat would by the following day provide a summary compilation of all the draft resolutions under consideration, together with their financial implications, indicating, *inter alia*, whether the Programme budget 2014–2015 already included the requested outputs and deliverables and what financing was already available.¹ If the Board so wished, a similar document could be prepared for all future meetings of the Programme, Budget and Administration Committee and the Board. Where draft resolutions were submitted at a late stage, the Board would at least have some idea of the overall budget position in relation to the funding requested.

Ms LANTERI (Monaco)² welcomed the provision of such a document but asked for advice from the Legal Counsel. The Health Assembly had already adopted the Programme budget 2014–2015 in its entirety. If funding not envisaged in that budget were requested, would the Health Assembly need to make a further decision, for instance by adopting an addendum to that budget?

The CHAIRMAN said that she would ask the Legal Counsel to respond to that question the following day, once the summary compilation had been made available.

2. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 10 of the Agenda (continued)

Implementation of the International Health Regulations (2005): Item 10.1 of the Agenda (Documents EB134/32 and EB134/32 Add.1)

The CHAIRMAN drew attention to the report by the Director-General contained in document EB134/32 and the draft resolution therein relating to international certificates of vaccination against yellow fever. The financial and administrative implications for the Secretariat of the draft resolution, should it be adopted, were set out in document EB134/32 Add.1.

Dr BAYE LUKONG (Cameroon), speaking on behalf of the Member States of the African Region, said that States Parties to the International Health Regulations (2005) must accelerate their efforts to establish their national core capacities under the Regulations by the deadline of 15 June 2014. In collaboration with WHO and other partners they should, first, revise their country

¹ See the summary record of the fourteenth meeting, section 2.

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

implementation plans in order to focus on the identified priorities and establish or strengthen institutional and human resources capacity, national health legislation, and monitoring and evaluation systems – which would allow them to meet the target date in June 2014. If they wished to request an extension, they must do so by 15 February 2014. Secondly, States Parties must mobilize the financial and human resources required for the full establishment and maintenance of minimum core capacities. Thirdly, they must strengthen coordination and collaboration among themselves and with relevant sectors and partners in order to develop, establish and maintain core public health capacities. Finally, they should promote cross-border collaboration on public health issues and risks of common concern, and fully implement and monitor national and international health regulations. She expressed support for the draft resolution.

Dr NIK JASMIN NIK MAHIR (Malaysia) commended the action taken by the Secretariat, within the framework of the International Health Regulations (2005), to respond to the emergence of the Middle East respiratory syndrome coronavirus (MERS-CoV), and agreed with the conclusion of the Emergency Committee for the Regulations that the conditions for declaring a public health emergency of international concern had not yet been met. WHO should coordinate formal, structured, multinational collaborative research studies to answer crucial questions about the virus and the associated disease, including the nature and route of transmission of infection in humans, in order to halt the spread of the virus. She endorsed the current criteria for the granting of extensions to the target date for establishment of core capacities. When granting an extension, the Review Committee for the Regulations should highlight the specific minimum capacities required by States Parties seeking an extension, in order to ensure that the core capacities were in place. She supported the draft resolution.

Mr KASE (Papua New Guinea) said that, in the Western Pacific Region, the Asia Pacific Strategy for Emerging Diseases and its 2010 update had served as a roadmap to help States Parties to meet their core capacity requirements. The areas where the greatest challenges persisted were preparedness, human resources, points of entry and chemical or radiological hazards. As a country of great cultural and geographical diversity, with significant resource constraints, Papua New Guinea faced challenges in meeting its capacity development requirements under the Regulations, particularly in the areas of human resources, owing to: an ageing health workforce and a shortage of new recruits; problems at the borders with neighbouring countries and other points of entry; the increased number of international travellers, due to the boom in mineral resource exploitation; and food safety issues. However, the country was taking steps to remedy the gaps in capacity, including new public health legislation, a new national food policy, an expanded mobile phone-based surveillance system and a field epidemiology training programme. He was confident that his country would meet the final core capacity deadline of 2016.

Mr COTTERELL (Australia) welcomed the Secretariat's efforts to support States Parties in achieving compliance with the Regulations and commended its efforts to strengthen preparedness for and surveillance of MERS-CoV infection in vulnerable countries and the timely and comprehensive distribution of information to all Member States. He further congratulated WHO and the Government of China on the comprehensive and transparent response to the outbreak of avian influenza A(H7N9). The sharing of information and viruses had been greatly appreciated. The issue underscored the importance of the Pandemic Influenza Preparedness (PIP) Framework and the Regulations. He supported the draft resolution.

Ms POLACH (Argentina), speaking on behalf of the Member States of the Region of the Americas, drew attention to decision CD52(D5), adopted by the 52nd Directing Council of PAHO (65th session of the Regional Committee for the Americas) in October 2013. The decision was summarized in the reports of the regional committees to the Board (document EB134/4, paragraphs 34 and 35). In particular, the Directing Council had recommended that requests for extension of the deadline for establishing core capacity should be submitted at least two months before the target date for implementation of the Regulations, 15 June 2014. The new criteria for granting extensions should

take into account elements (1) and (3) of the criteria proposed by the Secretariat in document A66/16, paragraph 37, which had been noted by the Health Assembly in May 2013.¹ The Directing Council had encouraged States Parties to include elements (2) and (4), but had noted that they would be optional. An additional criterion should be added, requiring the advice of the Review Committee for the Regulations to be taken into account.

Dr BARBOSA DA SILVA (Brazil) said that all States Parties were committed to full establishment of the basic core capacities for surveillance of and response to public health emergencies, with the technical support of WHO. The Organization had responded rapidly to the emergence of MERS-CoV and novel influenza virus strains, providing timely information and supporting risk assessments by States Parties. The Regulations were an effective platform for transparency and solidarity in the face of threats to global health. It was essential to detect disease outbreaks promptly, obtain high-quality information and circulate it rapidly. In particular, the Secretariat should work with Member States, through the WHO collaborating centres, to strengthen their response to specific needs, for example in relation to chemical and radiological events, which many countries had identified as a particular threat. Brazil had developed an integrated monitoring system in collaboration with Canada and PAHO, which it was ready to share with other Member States. He supported the draft resolution.

Dr SOE LWIN NYEIN (Myanmar) expressed appreciation of WHO's work to strengthen core capacity-building activities at country level. He suggested that details of the Secretariat's actions to deal with outbreaks of MERS-CoV infection should be shared with Member States in a form that could be used for training activities or workshops at country level. WHO's activities to strengthen global partnerships could also be replicated at country level: he was relying on his country's WHO Representative for support in that area. The two WHO web-based tutorials to train National IHR Focal Points in the use of Annex 2 of the Regulations² were a useful innovation that could be extended to other areas of the Regulations. He expressed support for the proposed criteria for extension of the deadline for meeting core capacity requirements and for the draft resolution.

Dr REFFAET (Egypt), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that, despite making progress in the development of their core capacities, notably in surveillance, laboratory capacity, coordination and food safety, many States Parties to the Regulations had reported relatively low capacity in relation to points of entry and to chemical and radiological events. Multisectoral coordination and communication, making full use of existing coordination mechanisms, were needed to improve cross-border collaboration. A mechanism should be established to facilitate the sharing of experiences between States Parties in the same region and between regions. The mobilization of technical and financial resources for the building of core capacities and the development and testing of national public health preparedness plans using an all-hazard approach remained a concern. The recent emergence of a novel coronavirus and of avian influenza virus A(H7N9) highlighted the importance of the Regulations. He therefore urged Member States and the Secretariat to scale up advocacy and raise awareness of the Regulations and the commitments associated with them. Early notification of events of potential international concern had improved, but more comprehensive reporting on such events was required. He believed that many States Parties would meet the June 2014 deadline for the establishment of core capacities. However, others might not meet that requirement even by the final deadline of June 2016 owing to internal instability. Many Member States of the Eastern Mediterranean Region were subject to acute or chronic emergencies that had a potentially negative effect on capacity-building. The possible solutions open to the States Parties concerned should be discussed as soon as possible if they were to meet the 2016 deadline.

¹ See document WHA66/2013/REC/3, summary record of the eighth meeting of Committee A, section 2.

² See document EB134/32, paragraph 26.

Ms MATSOSO (South Africa) requested clarification of the practical implications of the revision to Annex 7 of the Regulations proposed in the draft resolution. On the basis of her reading of the revision, vaccination certificates originally issued for 10 years would henceforth apparently be valid for the rest of the bearer's life. However, staff employed at points of entry might still be operating on the understanding that certificates were valid for only 10 years. Moreover, travellers whose certificates had been issued more than 10 years earlier might no longer have them in their possession. She suggested that WHO should prepare further guidance for staff working at points of entry, to make sure that they could reliably identify persons who had been adequately vaccinated. She also asked how regularly country risk profiles for yellow fever were drawn up and updated. Information on the high- or low-risk status of individual countries would likewise be useful for staff at points of entry.

Dr REYNDERS (Belgium) acknowledged the importance of the Regulations for the detection, surveillance and rapid mitigation of public health threats. The emergence of new influenza virus strains and the Middle East respiratory syndrome coronavirus had demonstrated the added value of the Regulations. He welcomed States Parties' efforts to move towards full implementation and regular reporting on their progress in developing core capacities. He supported the draft resolution, particularly since it had no financial or administrative implications for the Secretariat.

Dr AMMAR (Lebanon) said that, although many countries in the Eastern Mediterranean Region faced serious institutional and resource constraints, the main obstacles to progress in the establishment of core capacities were civil unrest and political instability. In some countries, the principal points of entry were subject to outbreaks of armed conflict and massive migration flows. The adverse conditions affected information flow and reporting, hindered capacity-building, particularly at points of entry, and affected the capacity to enforce the Regulations. Unfortunately, there was little prospect of the situation improving in the near future. Even the June 2016 deadline might not, therefore, be realistic for some of the countries concerned unless exceptional measures were taken, which would require additional resources and coordination at the political level. He called on WHO to play a more active role in that task. He supported the draft resolution.

Dr ASADI-LARI (Islamic Republic of Iran) welcomed the Secretariat's efforts to attract donor interest and funding in key areas of activity. Despite the progress made, early warning and response capacity needed to be further strengthened by increasing syndromic and event-based surveillance and laboratory capacity and by improving field epidemiology, risk management and communication, as well as through action at points of entry. The Secretariat's initiative to conduct ship inspection and ship sanitation workshops in the Eastern Mediterranean Region and other regions was welcome. Sanctions against States that had successfully implemented the International Health Regulations (2005) might slow down the strengthening of laboratory and response capacities and jeopardize the maintenance of capacities that had already been achieved, thus threatening global health security. WHO should do more to advocate for the acquisition by States Parties of more advanced capacities for implementation of the Regulations through actions involving all relevant sectors, such as intercountry meetings of officials from ministries of health and foreign affairs and other stakeholders. WHO should also support technology transfer, especially in the areas of influenza surveillance and production of vaccines and antiviral medicines, high-technology laboratory equipment and personal protective equipment. The transfer of modern equipment as a means of strengthening laboratory capacity was an issue that had not received sufficient attention in the past.

Information on advance agreements for vaccine distribution and delivery was included in the Pandemic Influenza Preparedness (PIP) Framework. WHO should conduct regional workshops on advance agreements and mechanisms for influenza vaccine delivery.

Dr VALVERDE (Panama) commended the Secretariat's efforts to promote implementation of the Regulations and combat the MERS-CoV epidemic, including the convening of an Emergency Committee. Welcoming the Director-General's appeal to Member States to organize a series of

high-level events to maintain the momentum for strengthening capacities, with emphasis on national engagement and a multisectoral approach, she called on States Parties to step up their implementation of the Regulations, in accordance with the commitments they had undertaken.

Ms ALGOE (Suriname) supported the suggestion that States Parties be allowed to request an extension of the core capacities deadline up to two months before the target date in June 2014, as put forward by the member for Argentina. A majority of States Parties had already requested an extension. Moreover, the response rate to the self-assessment questionnaire on implementation of the Regulations was low, at 48%. She urged the Secretariat to increase the support offered by regional and country offices to States Parties to help them to complete the questionnaire. Her country would not be in a position to meet the June 2014 deadline, despite the support it had received from PAHO, and would therefore be seeking an extension. In most Caribbean countries, the main challenges relating to core capacities were preparedness for chemical and radiological emergencies and human resources, which were best dealt with under a subregional approach, for instance by setting up a centre under the Caribbean Public Health Agency in collaboration with other international organizations like PAHO and IAEA. PAHO's continued support to the Caribbean Public Health Agency was needed in order to strengthen the latter's capacity to respond to public health emergencies in the Caribbean. She welcomed the proposal to establish country-twinning programmes to facilitate the exchange of best practices, which would likewise benefit small countries such as those in the Caribbean.

Dr SHAKEELA (Maldives) said that highly mobile populations and interdependent supply chains linking rural, exurban and urban communities increased the risk that any emerging infectious disease – whether naturally, accidentally or deliberately introduced – could spread between densely populated cities. The epidemic of severe acute respiratory syndrome and outbreaks of avian influenza A(H5N1) had highlighted the need to strengthen disease surveillance and response globally. She recommended the building of regional synergies in order to establish the necessary resource pool, rather than burdening individual countries with limited resources. She supported the draft resolution, which would undoubtedly protect travellers, make it easier for countries to comply with vaccination requirements and prevent the spread of yellow fever to countries where the disease was not endemic. In its latest self-assessment, her country had identified a need to strengthen public health legislation, preparedness and surveillance. Small countries like her own would also find their limited human resource capacity to be an obstacle to achieving the core capacities. Her country had recorded some progress in respect of points of entry, public health legislation and policy, coordination, and response, particularly public health laboratory capacity and infection control. However, much remained to be done to achieve the eight core capacities for implementation of the Regulations. The prototype costing tool referred to in paragraph 19 of document EB134/32 would be much in demand among States Parties for the purpose of establishing and maintaining their core capacities. She expressed appreciation of the Secretariat's continuous support for States Parties' efforts to comply with core capacity requirements.

Mr SIDIKOV (Uzbekistan) said that his country had requested an extension of the deadline for establishment of its core capacities until June 2014. Relevant legislation had been revised, and a decree on the implementation of the Regulations had been drawn up and was being agreed with interested ministries and departments. Uzbekistan had a system for prompt detection of MERS-CoV infection and the necessary capacity for laboratory diagnosis and, with the support of the Regional Office for Europe, was conducting year-round surveillance of acute pneumonia and severe acute respiratory infections. He supported the draft resolution.

Mr SAMAR (Algeria)¹ said that the table of national capacity monitoring scores in the Annex to document EB134/32 should be updated before the Sixty-seventh World Health Assembly in May 2014 to reflect all the replies received from States Parties. The Secretariat had been slow to provide the expertise requested for strengthening national capacities under the Regulations by the deadline in June 2014. The development of national capacity for the prevention and control of chemical, biological, radiological and nuclear risks was important but not a high priority for his country, as it had already set up cooperation projects with bilateral and multilateral partners in that area.

Ms MEL'NIKOVA (Russian Federation)¹ thanked the Secretariat for providing information, risk assessment measures and relevant guidelines and recommendations in response to the threat of MERS-CoV infection, which had enabled her country to take appropriate action. WHO's recommendations had been particularly useful in the case of those undertaking the hajj pilgrimage to Saudi Arabia. WHO should continue to raise awareness of the disease and the associated risks, provide support for affected countries, increase diagnostic and research capacity and ensure the timely exchange of information in accordance with the Regulations. Her country was preparing for various major events involving international participants, including the 2014 Winter Olympic Games in Sochi, Russian Federation, and the 2018 FIFA (Fédération Internationale de Football Association) World Cup. The issues of epidemiological evaluation, the potential risks associated with such events and the details of the required health protection measures were particularly important. Technical guidelines would need to be prepared for all participating countries, including versions in Russian. She expressed support for the draft resolution.

Dr AUTTAKIAT KARNJANAPIBOOKWONG (Thailand)¹ said that the capacity for response to public health emergencies must be urgently improved by means of multisectoral coordination. The Secretariat and Member States had done a great deal of work on monitoring and responding to the MERS-CoV epidemic within the framework of the Regulations. His own country had conducted active surveillance of the coronavirus, particularly among pilgrims returning from the hajj. Such surveillance required the timely and properly mobilized provision of essential resources and laboratory investigation tools. Thailand expected to establish its core capacities under the Regulations by the target date and accordingly would not be seeking an extension.

Ms MI Yanping (China)¹ said that the Secretariat's work to promote implementation of the Regulations had helped States Parties to improve their capacities in monitoring and evaluation, notification and reporting, and response to public health emergencies. With the emergence of cases of avian influenza A(H7N9) in humans in April 2013, her Government had exchanged information, engaged in technical cooperation and shared virus strains with the Secretariat and other Member States, and had acted in a robust, effective, orderly and proportionate manner to prevent an epidemic. China's government agencies were coordinating their efforts to meet their core capacity targets by June 2014. The Secretariat should provide States Parties with more guidance and tools in comparatively weak areas, such as training for health workers. The Secretariat should also maintain support for States Parties that had already reached their targets.

Professor TJANDRA YOGA ADITAMA (Indonesia)¹ observed that, with more than 17 000 islands, his country had many potential points of entry. Thirty-two port health offices had drawn up preparedness contingency plans, which they had tested in simulation and table-top exercises. Public health response contingency plans had been drawn up in 11 out of 33 provinces, and an early warning alert and response system had been set up in 24 provinces. Training programmes in field epidemiology and for epidemiology assistants had been established, in order to strengthen surveillance and human resources capacity.

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

Mr MAMACOS (United States of America)¹ commended WHO's efforts in convening an Emergency Committee and hosting regional meetings of public health experts and researchers in response to the MERS-CoV epidemic. His country supported the efforts of the Secretariat and all Member States to ensure that the Regulations were used as intended, as a globally binding framework to detect disease events and respond to public health risks and emergencies. In the light of the expected requests for extension of the June 2014 deadline by some States Parties, the Secretariat and States Parties must prioritize their commitment to the Regulations, in order to ensure global implementation and the maintenance of the required core capacities. The submission of requests for extension and for monitoring, evaluation and reporting under the Regulations were inextricably linked to enhanced capacity-building efforts. He called on the Secretariat, with the support and advice of the Review Committee, to lead States Parties in a collaborative review of current monitoring and reporting mechanisms for the period after 2016, which might include consideration of the decision by the PAHO Directing Council referred to by the member for Argentina. He supported the draft resolution.

Mr BOISNEL (France)¹ commended WHO's work to combat the frequent outbreaks of disease over the previous year. All Member States must continue to develop and maintain the capacities required for preparedness, early warning and response to events that might constitute a public health emergency. He supported the work done by the Secretariat at WHO headquarters and the WHO Lyon Office, particularly the training provided by the latter in the implementation of the Regulations. He expressed support for the draft resolution.

Dr VALLEJO (Ecuador)¹ said that the establishment of core capacities under the Regulations was a priority for Ecuador and the issue had been considered at the highest levels, including the joint meetings of the Presidents of Colombia and Peru. At the same time, his country was carrying out a reform of the health sector, which would have implications at national and subnational levels for the regulation and standardization of public health procedures relevant to the Regulations, as well as the development of the laboratory network, the establishment of a new health surveillance and research institute, and the establishment of a new health monitoring agency. Progress had been made in a number of areas, including the monitoring of events of public health concern, the development of laboratory capacity for specific diseases such as influenza, and the establishment of a surveillance system for communicable disease events, with a register of individual cases. His country supported the decision adopted by the PAHO Directing Council, including the proposal that any request for extension of the target date for establishment of core capacity should be admissible up to two months before the deadline and should be accompanied by a new implementation plan, clearly and specifically identifying those capacity elements that were missing or inadequate and describing a set of proposed actions that would be taken and a specified time frame. He supported the draft resolution.

Mr KOTALWAR (India)¹ said that his country was making good progress in the six areas of basic core capacity, with the support of WHO headquarters and the Regional Office for South-East Asia. The National IHR Focal Point, which was the National Centre for Disease Control in Delhi, had organized coordination meetings and training workshops. Thirty-four state governments, along with ministries and port and airport health authorities, had appointed their own focal points. A new public health bill would cover public health emergencies, including natural disasters, bioterrorism and epidemics. Contingency preparedness plans had been drawn up. However, core capacities still needed to be strengthened in a number of areas, including chemical and radiological events, food safety, points of entry and zoonotic diseases. His country had submitted a revised implementation plan with its request for extension of the target date for establishment of core capacity. Referring to the draft resolution, he agreed that travellers from countries in which yellow fever was endemic would not need to be revaccinated after 10 years. However, he requested clarification as to whether a booster dose of

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

the vaccine might be needed for travellers from countries where the disease was not endemic, including India, where the level of immunity might be lower owing to the absence of frequent exposure to the virus.

Mr ALIMUZZAMAN (Bangladesh)¹ said that his country had set up a national coordination committee, a technical committee and a core group for the Regulations and had designated the Institute of Epidemiology, Disease Control and Research as the National IHR Focal Point, responsible for assessing core capacities and reviewing relevant health legislation. A web-based integrated disease surveillance system, a two-year field epidemiology and laboratory training programme and a system for notification and management of potential public health emergencies of international concern had been introduced. For three points of entry, the Government had designated coordination committees to work on strengthening the core capacities. An agreement had been signed with the Government of Thailand and OIE on the diagnosis of zoonotic diseases. A national food safety laboratory had been set up, and the national food safety action plan had been drafted. His country still needed to develop a specific national plan for multisectoral public health emergency preparedness and response and to build the capacity for infection control and prevention, response to potential hazards, and relevant activities at points of entry. That task would require additional financial, human and material resources. Bangladesh's implementation plan had recently been updated, as part of its request for an extension of the core capacities target date.

Dr AL HINAI (Oman)¹ recalled the appreciation expressed at the most recent session of the Regional Committee for the Eastern Mediterranean to the Government of Saudi Arabia, which had implemented highly effective prevention measures to ensure the safety of pilgrims undertaking the hajj. The countries of the Region were grateful to Saudi Arabia for its contribution to strengthening global efforts in the area of health protection during mass gatherings.

Dr FUKUDA (Assistant Director-General), replying to the questions raised by the member for South Africa concerning how the adequacy of vaccination against yellow fever could be verified at points of entry and how often country risk assessments should be conducted, said that the Secretariat would prepare careful guidance on those issues. Replying to the question raised by the representative of India, he said that guidance would also be prepared on the potential need for booster vaccination for travellers from countries where yellow fever was not endemic.

The CHAIRMAN took it that the Board wished to adopt the draft resolution on proposed revisions to Annex 7 of the International Health Regulations (2005), contained in document EB134/32.

The resolution was adopted.²

The DIRECTOR-GENERAL thanked States Parties for their commitment to implementation of the Regulations. Vigilance was always required, as new viruses constantly emerged. On the question concerning risk profiles raised by the member for South Africa, the Regulations must be applied pragmatically and with flexibility. A country like Indonesia, for example, consisting of thousands of islands, could not have point of entry capacity for all of them. Risk assessment would be predicated on mapping its territory and determining the points where people, goods and services entered the country. Commenting on a point raised by the representative of the United States of America, she said that the Review Committee should meet regularly to review the scientific evidence relating to possible epidemics and provide expert guidance to help the Health Assembly make its decisions. However, it

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

² Resolution EB134.R10.

was important to balance the need for that expert advice with the cost of convening a Review Committee meeting, and carefully judge the optimum number of members.

The CHAIRMAN took it that the Board wished to take note of the report.

The Board noted the report.

3. STAFFING MATTERS: Item 12 of the Agenda (continued)

Statement by the representative of the WHO staff associations: Item 12.3 of the Agenda (Document EB134/INF./1)

Mr SIGURDSON (representative of the WHO staff associations), summarizing key issues from the statement, said that the latest Global Staff/Management Council meeting in October 2013 had been the occasion for a constructive and refreshingly positive dialogue with the newly appointed Director of Human Resources Management. The staff associations had identified three issues of urgent concern. First, the current approach to the WHO staff health insurance system was failing to meet the needs of many staff and represented a risk to the health and security of those working in the field in particular. Secondly, on the question of internal justice mechanisms, staff welcomed the Director-General's commitment to undertake a review and reform process and would give that process their full support. Thirdly, investment in career development and workforce management was a priority for any organization but was currently of particular importance for WHO owing to several factors, including the recent significant staffing changes at headquarters and in the Regional Office for Africa. Other related priorities included the large number of retirements projected to take place over the next 10 years, the opportunities represented by the staff mobility programme and the urgent need to overcome gender imbalances, particularly at senior levels of the Organization. Another staffing issue concerned the prospect of polio eradication. The staff associations supported all efforts to retain colleagues recruited under the Global Polio Eradication Initiative once its targets were achieved, as their skills would remain highly relevant. It was true that the associated staff-related future liabilities were not insignificant, but they should be seen in the context of overall investment in the eradication programme. All staff work carried out in relation to the Global Polio Eradication Initiative should be covered by WHO staff conditions of service, including pensions, health insurance, sick leave and annual leave.

The CHAIRMAN thanked the representative of the staff associations for the relevant points he had made and said that active engagement between the staff, on the one hand, and senior management and governing bodies, on the other, was important to the healthy functioning of an organization.

The DIRECTOR-GENERAL said that, although staff and senior management had different responsibilities, it was essential that they worked together in the interests of global health. Highlighting the issue of internal justice, she said that staff needed to work in a fair and ethical environment if they were to work well. Staff performance was another important issue, and she was gratified at the willingness expressed by the staff associations to engage in a dialogue on that subject. She had noted the other points raised, particularly: staff mobility, gender balance, and the staff of the Global Polio Eradication Initiative. It would be important to retain talented staff under the Initiative, even though some were approaching retirement age; that would be an exercise in succession planning and talent renewal.

The Board took note of the statement by the representative of the WHO staff associations.

Human resources: Item 12.4 of the Agenda (Documents EB134/49 and EB134/INF./2)

The CHAIRMAN drew attention to the recommendations of the Programme, Budget and Administration Committee concerning the revised human resources strategy, set out in paragraphs 19 to 23 of document EB134/3.

Ms MARTHOLM FRIED (Sweden),¹ speaking on behalf of the Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, said that a workforce with more flexibility and mobility was needed to enable WHO to achieve its reform objectives. She requested the Secretariat to report to the Sixty-seventh World Health Assembly on the possible implications of staff indemnity costs arising from closure of the Global Polio Eradication Initiative. She welcomed the revised human resources strategy, notably the focus on improving country-level performance, the new types of appointments, the shorter recruitment process, the expectation of mobility and the new approach to performance management. She sought clarification as to how long it would take to introduce changes in geographical origin in the different regions so that WHO became an international, rather than a regional, organization; and how the performance management system was used, whether it was applied to regional directors and assistant directors-general, and what percentage of staff exceeded expectations. With regard to pillar 3 of the strategy, on an enabling working environment, she said that, in addition to flexitime and teleworking arrangements, consideration might be given to other family-friendly measures, such as paid sick leave for staff when their children were ill. Lastly, she called for predictable and sustainable funding for WHO and the sustained commitment of all relevant stakeholders in order to facilitate the implementation of the human resources strategy.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland),¹ endorsing the comments of the previous speaker, said that, although she welcomed the three pillars of the revised human resources strategy, the section on implementation lacked vision and did not provide a clear way forward. Noting the importance of the management of staff for the success of any organization, she said that, in its Multilateral Aid Review Update: 2013, the United Kingdom had identified performance management of staff as a key challenge that WHO needed to tackle. Furthermore, in a recent letter from the Minister responsible for United Nations affairs to all executive heads across the United Nations system, human resources had been highlighted as one of the United Kingdom's reform priorities for the United Nations. She was concerned about the timeline in the human resources strategy and urged the Secretariat to advance more quickly on the important managerial reform and develop an improved implementation plan, with more clearly defined and tangible deliverables for the biennium 2014–2015.

Mr BOISNEL (France)¹ said that, although many Member States agreed with the direction and principles of the revised human resources strategy, the question of how that strategy was to be implemented had yet to be resolved. Noting that the document before the Board presented more questions than answers and more limitations than solutions, he said that account should also be taken of the high degree of regional autonomy in WHO. He called on the Secretariat to provide greater clarity and accelerate the implementation of the strategy.

Mr KUEMMEL (Germany),¹ endorsing the comments of the representative of Sweden, said that human resources reform was a priority for his Government. WHO staff were committed and flexible, and they generally viewed mobility as an opportunity. However, a comprehensive staffing model that set clear incentives for mobility and provided a clear and predictable career path was lacking. Such a model would help WHO to retain its best-performing and most highly committed staff. Drawing attention to Article 53 of the WHO Constitution, he highlighted the need to ensure a coherent and

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

streamlined approach to human resources policy throughout the Organization, and expressed concern about the small size of the Department of Human Resources Management at headquarters. He welcomed the information on human resources for the Global Polio Eradication Initiative, set out in the Annex to document EB134/49, and called for rapid progress in implementing effective measures to reduce potential indemnity costs associated with them. He looked forward to the preparation of a transparent report on measures taken in that regard, for consideration at the meetings of the governing bodies in May.

Mr VEGA MOLINA (Spain),¹ welcoming the revised human resources strategy, said that it was important to identify and prioritize specific actions that could effect change in the short term. Mobility was important for reform, and he looked forward to further developments in that regard in the future. Lastly, in view of the many elements they contained, reports concerning human resources should be even clearer and more comprehensive.

Ms NOCQUET (Human Resources Management) thanked speakers for their support of the revised human resources strategy. The Secretariat recognized the need for concrete results in the reform of the workforce in support of WHO reform and would keep the Board informed of progress.

Dr AYLWARD (Assistant Director-General) said that the concerns expressed by speakers with regard to the liabilities associated with the scale of the poliomyelitis eradication human resources infrastructure had been noted. The long-term human resources study carried out as a result of the Director-General's recognition of those liabilities had highlighted the need to plan for and manage the liabilities, and a four-pronged approach to that end had been discussed with the Programme, Budget and Administration Committee. The Secretariat would report further on the issue to the governing bodies in May.

The Board noted the reports.

Report of the International Civil Service Commission: Item 12.5 of the Agenda (Document EB134/50)

The Board noted the report.

Amendments to the Staff Regulations and Staff Rules: Item 12.6 of the Agenda (Documents EB134/51 and EB134/51 Add.1)

The CHAIRMAN drew attention to two draft resolutions contained in paragraph 12 of document EB134/51, and their financial and administrative implications for the Secretariat, were they to be adopted, in document EB134/51 Add.1. The Programme, Budget and Administration Committee, in paragraph 25 of its report (document EB134/3), had proposed an amendment to draft resolution 1, in the form of an additional paragraph that read: "REQUESTS the Director-General to convey to the International Civil Service Commission (ICSC) and the United Nations General Assembly the views of WHO Member States that rising staff costs are having a considerable budgetary impact on the Organization and request that the ICSC study the impact of their recommendations on the budgets of common system organizations particularly within the context of their ongoing comprehensive compensation review."

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

Ms BLACKWOOD (United States of America),¹ noting that the International Civil Service Commission's recommendations had a major financial impact on the specialized agencies, said that the United Nations common system organizations should have a voice in the decisions of the International Civil Service Commission and the United Nations General Assembly that had a direct impact on their budgets, in particular with regard to automatic, system-wide salary increases. She welcomed the proposed amendment to resolution 1, noting that similar language had recently been adopted in resolutions of FAO, IMO, WIPO and the Universal Postal Union.

The CHAIRMAN took it that, having considered the report of the Programme, Budget and Administration Committee and its proposed amendment, the Board wished to adopt the amended draft resolution 1 as contained in document EB134/3.

The resolution, as amended, was adopted.²

The CHAIRMAN further took it that the Board wished to adopt draft resolution 2 contained in document EB134/51.

The resolution was adopted.³

4. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 10 of the Agenda (resumed)

Antimicrobial drug resistance: Item 10.6 of the Agenda (Document EB134/37)

The CHAIRMAN drew attention to a draft resolution on combating antimicrobial resistance, including antibiotic resistance, proposed by Australia, China, Costa Rica, Ghana, Japan, Libya, Mexico, Netherlands, Qatar, Sweden, Thailand, United Kingdom of Great Britain and Northern Ireland, and United States of America, which read:

The Executive Board,
Having considered the report on antimicrobial resistance,⁴

RECOMMENDS to the Sixty-seventh World Health Assembly the adoption of the following resolution:

The Sixty-seventh World Health Assembly,
PP1 Recognizing WHO's leadership role in the containment of antimicrobial resistance;
PP2 Recalling resolutions WHA39.27 and WHA47.13 on the rational use of drugs, WHA51.17 on antimicrobial resistance, WHA54.14 on global health security, WHA58.27 on improving the containment of antimicrobial resistance, WHA60.16 on progress in the rational use of medicines and WHA66.22 on follow up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination;

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

² Resolution EB134.R11.

³ Resolution EB134.R12.

⁴ Document EB134/37.

PP3 Aware that access to effective antimicrobial drugs constitutes a prerequisite for most of modern medicine, and that hard-won gains in health and development, in particular those brought about through the health-related Millennium Development Goals, are at risk due to increasing resistance to antimicrobials;

PP4 Aware that the health and economic consequences of antimicrobial resistance constitute a heavy and growing burden on high-, middle- and low-income countries, requiring urgent action at national, regional and global levels, particularly in view of the limited development of new antimicrobial agents;

PP5 Recognizing that the main impact of antimicrobial resistance is on human health, but that the contributing factors and consequences, including economic and others, go beyond health and therefore there is a need for a coherent, comprehensive and integrated approach at global, regional and national levels, in the spirit of the "One Health" approach and beyond;

PP6 Noting that awareness of the broad scope and urgency of the threat posed has been limited and that previous resolutions of the Health Assembly and WHO's strategies for the containment of antimicrobial resistance have not yet been widely implemented;

PP7 Recognizing that antimicrobial resistance involves a wide range of pathogens including bacteria, viruses and parasites but that the development of resistance among some pathogens, particularly antibiotic-resistant bacteria, is of particular urgency and most in need of immediate attention;

PP8 Welcoming the establishment of the WHO Global Task Force on Antimicrobial Resistance and the tripartite collaboration between WHO, FAO and OIE,

(OP1) 1. URGES Member States:

- (1) to increase political awareness, engagement and leadership in order to accelerate efforts to secure access to effective antimicrobials and to use them responsibly;
- (2) to take urgent action at national, regional and local levels to strengthen infection prevention and control, by means that include application of basic hygiene measures;
- (3) to develop or strengthen national plans and strategies and international collaboration for the containment of antimicrobial resistance;
- (4) to mobilize human and financial resources in order to implement plans and strategies to strengthen the containment of antimicrobial resistance;
- (5) to strengthen overall pharmaceutical management systems, including regulatory systems and supply chain mechanisms, with a view to ensuring access to and availability of effective antimicrobial agents, taking into account financial and other incentives that might have a negative impact on policies for prescribing and dispensing;
- (6) to survey the extent of antimicrobial resistance and monitor regularly the use of antibiotics in all relevant sectors, in particular health and agriculture, including animal husbandry, and to share such information so national, regional and global trends can be detected and monitored;
- (7) to improve among all relevant care providers, the public and other sectors and stakeholders awareness of (i) the threat posed by antimicrobial resistance, (ii) the need for responsible use of antibiotics and (iii) the importance of infection prevention and control measures;
- (8) to encourage and support research and development, including new business models, to combat antimicrobial resistance, develop practical and feasible approaches for extending the lifespan of antimicrobial drugs and encourage the development of novel diagnostics and antimicrobial drugs;
- (9) to collaborate with the Secretariat in developing and implementing a draft global action plan to combat antimicrobial resistance including antibiotic resistance, which is based on all available evidence and best practices;

- (OP2) 2. REQUESTS the Director-General:
- (1) to ensure that all relevant parts of the Organization, at headquarters, regional and country levels, are actively engaged and coordinated in promoting work on containing antimicrobial resistance, including through the tracking of resource flows for research and development on antimicrobial resistance in the new global health research and development observatory;
 - (2) to set aside adequate resources for the work in the Secretariat, in line with the Programme budget 2014–2015 and the Twelfth General Programme of Work, 2014–2019;
 - (3) to strengthen the tripartite collaboration between WHO, FAO and OIE for combatting antimicrobial resistance in the spirit of the “One Health” approach;
 - (4) to explore with the United Nations Secretary-General options for a high-level initiative, including a high-level meeting, to increase political awareness, engagement and leadership on antimicrobial resistance;
 - (5) to develop a draft global action plan to combat antimicrobial resistance, including antibiotic resistance, which addresses the need to ensure that all countries, especially low and middle income countries, have the capacity to combat antimicrobial resistance and which takes into account all available evidence and best practice as well as the recommendations by the WHO AMR strategic technical advisory group and the 2011 WHO policy package, which asks Member States to:
 - (a) commit to a comprehensive, financed national plan with accountability and civil society engagement;
 - (b) strengthen surveillance and laboratory capacity;
 - (c) ensure uninterrupted access to essential medicines of assured quality;
 - (d) regulate and promote rational use of medicines, including in animal husbandry, and ensure proper patient care;
 - (e) enhance infection prevention and control;
 - (f) foster innovation and research and development for new tools;
 - (6) to apply a multisectoral approach to inform the drafting of the global action plan, by consulting Member States as well as other relevant stakeholders, especially other multilateral stakeholders, such as FAO and OIE;
 - (7) to submit to the Sixty-eighth World Health Assembly, through the Executive Board at its 136th session, a draft global action plan to combat antimicrobial resistance, including antibiotic resistance, together with a summary report on progress made in implementing the other aspects of this resolution.

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

1. Resolution: Combating antimicrobial resistance, including antibiotic resistance

2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)

Category: 5. Preparedness, surveillance and response

Programme area: Epidemic-prone and pandemic-prone diseases

In addition, combating antimicrobial resistance involves, and has implications for, a broad range of categories and programme areas.

How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?

The resolution is of direct relevance to the outcome “Increase the number of countries with a national antimicrobial resistance (AMR) action plan”.¹ The resolution will ensure global commitment by Member States and other organizations to achieve this outcome. The cross-cutting nature and health impacts of antimicrobial resistance mean that the resolution is also of direct relevance to outcomes and deliverables in other categories and programme areas.

Does the programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)

Yes. However, the Programme budget 2014–2015 does not cover the implementation of the draft global action plan mentioned in operative subparagraph 2(5).

3. Estimated cost and staffing implications in relation to the Programme budget**(a) Total cost**

Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) Two years (covering the period 2014–2015)

(ii) Total: US\$ 9.6 million (staff: US\$ 7.4 million; activities: US\$ 2.2 million)

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 9.6 million (staff: US\$ 7.4 million; activities: US\$ 2.2 million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

At headquarters and the six regional offices: all activity costs will be implemented through headquarters; staff costs will be US\$ 4.6 million at headquarters and US\$ 470 000 in each regional office.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

It is only partially included.

If “no”, indicate how much is not included.

Total: US\$ 7.8 million (staff: US\$ 6.6 million; activities: US\$ 1.2 million)

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No.

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

Under the planning assumption that existing staff will continue to be assigned to the activities planned under the current Programme budget, including on antimicrobial resistance, additional full-time equivalent staff members will be required in order to implement this resolution, comprising one full-time equivalent at each of the regional offices and four to six full-time equivalents at headquarters (staff in professional and higher category posts with expertise in health policy, communications and project management).

¹ As shown on WHO’s Programme budget web portal (available at <https://extranet.who.int/programmebudget>, accessed on 22 January 2014).

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

The funding gap is estimated at US\$ 8.8 million. It will be tackled through the Organization-wide coordinated resource mobilization plan to deal with funding shortfalls in the Programme budget 2014–2015.

Mr COTTERELL (Australia) said that the draft resolution set out a process for developing a global action plan to combat antimicrobial resistance, including antibiotic resistance, for consideration by the Sixty-eighth World Health Assembly in 2015. Following informal consultations, he proposed the following amendments to the draft resolution. In the third preambular paragraph, the term “drugs” should be replaced by “agents”, and the following phrase should be added at the end of the paragraph: “and that antimicrobial resistance threatens the sustainability of the public health response to many communicable diseases, including tuberculosis, malaria and HIV/AIDS;”. The last part of the fifth preambular paragraph should be amended to read: “in a “One Health” approach and beyond involving different actors and sectors such as human and veterinary medicine, agriculture, environment and consumers;”. A footnote, reading “And, where appropriate, regional economic integration organizations” should be added to the introductory line of paragraph 1, “URGES Member States”. In subparagraph 1(6), “survey” should be replaced by “monitor”. The first part of subparagraph 1(8), before the phrase beginning with the words “develop practical and feasible approaches”, should be amended to read: “to encourage and support research and development, including by academia and through new collaborative and financial models, to combat antimicrobial resistance and promote responsible use of antimicrobials;”. In subparagraph 2(5) the words “existing action plans and” should be added after “which takes into account”.

Professor OSTOJIĆ (Croatia), speaking on behalf of the European Union and its Member States, acknowledged the urgent need to tackle the growing threat of antimicrobial resistance, and especially antibiotic resistance, globally. He welcomed the recommendation of the Strategic and Technical Advisory Group on Antimicrobial Resistance concerning the development of a global action plan and emphasized the importance of WHO’s leadership in that regard. Surveillance of antimicrobial resistance and monitoring of the use of antibiotics and antimicrobial agents in human health should be undertaken as part of WHO’s regular epidemiological surveillance, taking into account the work of other relevant international partners. The Secretariat should also support the efforts of Member States to prevent infections acquired in health care settings and mitigate the risks of further antimicrobial resistance. Having highlighted the importance of a “One Health” approach, with engagement from all relevant sectors, and the need for a multisectoral perspective at global, country and local levels, he said that the European Union was implementing an integrated action plan to deal with antimicrobial resistance in the areas of both human and animal health. The European Union and its 28 Member States wished to sponsor the draft resolution, with the amendments read out by the member for Australia.

Dr NIK JASMIN NIK MAHIR (Malaysia) commended the leadership role of WHO in the containment of antimicrobial resistance. Although the main impact of antimicrobial resistance was on human health, the contributing factors and consequences went beyond health, requiring an integrated approach at global, regional and national levels. Her country fully supported the draft resolution and wished to be added to the list of sponsors.

Dr EZZAT (Egypt), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the issue of antimicrobial resistance was a priority for the Region and had been

discussed at the sixtieth session of the Regional Committee in October 2013. Egypt supported the draft resolution and wished to be added to the list of sponsors.

Dr AMMAR (Lebanon) said that the international spread of drug resistance could constitute a serious threat to global health security and necessitated a global response that must be led by WHO. Noting that the global strategy for containment of antimicrobial resistance, published by WHO in 2001, had not achieved its intended objectives, he said that a global action plan required strong commitment from Member States, intersectoral collaboration between the human and animal health sectors and the food industry, and more active engagement of WHO with FAO and OIE. Accordingly, he strongly supported the recommendations of the Strategic and Technical Advisory Group on Antimicrobial Resistance and the next steps outlined in the report. Efforts must also be made to tackle the dangerous practice of self-medication and over-the-counter dispensing of antimicrobials, which was widespread in many developing countries. Lebanon supported and wished to sponsor the draft resolution.

Dr VALVERDE (Panama) said that her country also wished to sponsor the draft resolution, with the amendments read out by the member for Australia.

Ms MATSOSO (South Africa), speaking on behalf of the Member States of the African Region, welcomed the resolve of the international health community to tackle the issue of antimicrobial resistance, which constituted a challenge in most parts of the world. Noting the lack of relevant data in many countries of the Region, she called for the establishment of surveillance and monitoring systems for antimicrobial resistance with WHO support. Antimicrobial resistance placed a significant cost burden on health systems, and efforts should be made to foster innovation, research and development, and new tools. The countries of the African Region placed emphasis on strong laboratory infrastructure, early detection and treatment. South Africa wished to sponsor the draft resolution and suggested that the text might be further amended through the addition of the words “and, where appropriate, laboratory infrastructure” after “supply chain mechanisms” in subparagraph 1(5).

Ms DÁVILA CHÁVEZ (Mexico) said that antimicrobial resistance threatened global health security and must be the subject of an integrated approach that took into account the epidemiological specificities of each country and region. She agreed with the recommendation of the Strategic and Technical Advisory Group on Antimicrobial Resistance that WHO should lead the development and coordination of a global action plan on antimicrobial resistance. She would welcome coordinated action among Member States, strengthened intersectoral engagement, surveillance, medicines regulation, data collection and technology innovation. Mexico fully supported the draft resolution.

Dr USHIO (Japan) said that prevention of infectious diseases and improvement of basic sanitation were the most fundamental and important measures that could be taken against antimicrobial drug resistance. Other important elements included medicines regulation to ensure quality, management of available medicines, and establishment of a surveillance database concerning antimicrobial resistance at national and regional levels. He trusted that WHO would take initiatives in the area of research on antimicrobial resistance, since evidence needed to be strengthened. The Secretariat should also provide technical support to ensure that medical professionals prescribed medicines in the proper regimen, assessed the sensitivity of antimicrobials and managed medicines appropriately.

Dr REYNDERS (Belgium) said that his country, as a voluntary contributor to the flexible core voluntary contributions account, was concerned that funding for the implementation of the resolution was not covered by the Programme budget 2014–2015. Noting that the ongoing reform process would imply a change in attitude on the part of both Member States and the Secretariat, he urged the Secretariat to present the forthcoming Health Assembly with information on possible solutions, given that Member States held the Secretariat accountable for the full implementation of the approved

Programme budget. Member States were aware that the implications of their decisions remained their responsibility.

Mr PALOPOLI (Argentina) said that a national network for surveillance of antimicrobial resistance (WHONET-Argentina) had been established in his country in 1986. Argentina was involved in the network for surveillance of pathogens causing pneumonia and bacterial meningitis run by PAHO and was also taking action at the multisectoral level to combat antimicrobial drug resistance. His country recognized the need to step up international and national efforts to tackle the issue and welcomed the recommendation to establish a global action plan on antimicrobial resistance. He supported the draft resolution.

Dr PE THET KHIN (Myanmar) said that, given the danger that past achievements in the control of communicable diseases could be nullified by antimicrobial drug resistance, public health professionals should collaborate with other sectors, including the agriculture, livestock and fisheries sectors, to monitor the situation closely. Patients should be clearly informed about the causes and prevention of drug resistance by public health and medical professionals, and the issue should also be included in the curriculum of medical schools and teaching institutions in Member States. Myanmar welcomed the draft resolution and wished to be added to the list of sponsors.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that an antibiotic resistance surveillance network existed in Latin America, as did a laboratory network to monitor bacterial response to medicines. Cuba had established a network of microbiology laboratories in hospitals and municipal centres for hygiene and epidemiology, which was coordinated by the Pedro Kourí Institute of Tropical Medicine. It also had a policy on the use of antimicrobials, with each hospital monitoring susceptibility of microorganisms. A committee to control hospital infection and monitor behaviour and changes that could lead to antimicrobial resistance had been set up in every hospital. Efforts must be made to monitor viruses and fungi, which were also becoming resistant. Cuba supported the draft resolution.

Dr BEJTJA (Albania) commended WHO's leadership in tackling the issue of antimicrobial resistance and its productive collaboration with FAO and OIE on an issue that went beyond health. The Secretariat should provide guidance on intersectoral collaboration at country level. Albania supported the draft resolution, with the proposed amendments, which clearly reflected the need for research and development, regulation, rational and responsible use of antimicrobial agents, surveillance, and strengthening of laboratory capacity.

Dr BARBOSA DA SILVA (Brazil), noting that antimicrobial drug resistance was an issue of vital importance for global health, said that this country supported the draft resolution and wished to be added to the list of sponsors.

Dr ASADI-LARI (Islamic Republic of Iran) said that his country would welcome the development and coordination of a global action plan on antimicrobial resistance, as recommended in the report, but would appreciate further clarification and explanation in that regard. His country supported the draft resolution and wished to be added to the list of sponsors. In order to promote better coordination of a global action plan on antimicrobial resistance in different settings, he suggested the addition of a new paragraph in the operative part of the text, to read: "Member States are advised to develop Antimicrobial Resistance Surveillance System in three separate sectors (i) for inpatients in hospitals (ii) for outpatients in all other health care settings and the community (iii) for animals and non-human usage of antimicrobials;"

Dr AZODOH (Nigeria) said that antimicrobial resistance was a major public health challenge for her country. Commending the report, particularly paragraph 22 on medicines regulation, she said that Nigeria wished to be added to the list of sponsors of the draft resolution.

Mrs ANDRIENKO (Ukraine)¹ and Ms KOCHLEF (Tunisia)¹ said that their countries supported the draft resolution and wished to join the list of sponsors.

Dr RANJAN (India)¹ said that a coherent, comprehensive and integrated approach was needed at national, regional and global levels to deal with antimicrobial resistance, which placed a heavy and growing burden on countries of all income levels. Antimicrobial resistance in pathogens that caused important communicable diseases was a particular global public health concern and must be tackled in order to prevent untreatable illnesses becoming a reality. India was committed to promoting the rational use of medicines, and supported the draft resolution, with the proposed amendments.

Ms KIM Yu-na (Republic of Korea), welcoming the continued efforts of WHO in the prevention and control of antimicrobial resistance, said that her country fully supported the draft resolution and wished to be added to the list of sponsors.

Dr GULDVOG (Norway)¹ said that WHO should be given a clear mandate to counter the serious emerging threat of antimicrobial resistance. He emphasized the need for a “One Health” approach and for collaboration between WHO, FAO and OIE in order to ensure progress across all areas. Noting the uneven distribution of antimicrobial resistance across WHO regions, he called for an approach that provided for a continued focus on access to antimicrobial agents for some Member States, and a strengthened focus on the use of such products for others. Norway wished to sponsor the draft resolution.

Ms GABBASOVA (Russian Federation)¹ said that efforts to tackle antimicrobial resistance should be made in all sectors in which antimicrobial medicines were used and constituted a threat to the population. Antimicrobial resistance was a problem in terms of the pathogens causing infectious diseases, and especially tuberculosis, inasmuch as multidrug-resistant tuberculosis was a serious challenge for Brazil, Russian Federation, India and China. Efforts to combat antimicrobial drug resistance should focus on: increasing access to microbiological laboratory research; increasing the monitoring of antibiotic resistance of common pathogens; implementing a policy for the rational use of antimicrobial medicines; introducing new antimicrobial medicines; and quality control. The Russian Federation would be pleased to share its experience with regard to measures to prevent resistance in pathogens and monitor the use of antibiotics. She supported the draft resolution, drawing particular attention to the important amendments proposed by the members for Australia, South Africa and others, and said that her country wished to join the list of sponsors.

Ms JANELM (Sweden)¹ said that immediate action was required at global, regional and national levels to deal with the global and rapidly growing problem of antimicrobial resistance, which had unimaginable implications for health care systems and society as a whole. Sweden welcomed the efforts of the Secretariat in that connection, including the convening of the Strategic and Technical Advisory Group on Antimicrobial Resistance. Noting that the Group’s recommendations covered a broad spectrum of activities and merited an urgent response, she said that antibiotic resistance had been a high political priority for Sweden for a long time and her country looked forward to contributing to the development of the global action plan.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland)¹ welcomed the achievements outlined in the report. However, continued progress at the current rate would not be sufficient, since the world was rapidly approaching the point where everyday infections would become untreatable. WHO must do more and build a “One Health” approach with OIE, FAO and other partners. She paid tribute to her colleagues from Sweden for their tireless efforts on the draft

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

resolution and urged the Board to adopt the text in order to give renewed impetus and focus to that vital area of work.

Mr KOLKER (United States of America)¹ said that the United States of America looked forward to the development of a global action plan to define more clearly WHO's role and action. He recognized the leadership of the United Kingdom of Great Britain and Northern Ireland and Sweden in bringing the issue to the attention of the Board. In support of the "One Health" approach, the United States Food and Drug Administration had recently issued a new guideline to phase out medically important antimicrobials for growth promotion uses in livestock and poultry, and to phase in veterinary oversight of the use of medically important antimicrobials in animal feed.

Ms REITENBACH (Germany)¹ welcomed the increasing global recognition of antimicrobial resistance as an urgent public health problem requiring concerted and intersectoral action, and fully supported the development of a global action plan on antimicrobial resistance. In Germany, an antimicrobial resistance strategy, developed jointly by the ministries of health, agriculture and research, had been in place since 2008, and a second draft strategy was open for comment until the end of February 2014. Germany would be pleased to share its experience and offer its expertise in the development of the global action plan.

Ms AALDERS (Netherlands)¹ said that she fully supported the development of a global action plan. In recent years, her country had faced several challenges as a result of antibiotic resistance in both humans and animals. It recognized the need for cooperation with other countries and international organizations, such as WHO, FAO and OIE, and appreciated the leadership shown by WHO. She trusted that the Board would adopt the draft resolution and thanked those speakers who had expressed support for the text.

Dr JIAO Yahui (China)¹ said that, although some progress had been made by Member States in tackling antimicrobial drug resistance, joint and concerted global action was required to deal with the daunting challenges that remained. She was confident that the global plan of action would provide useful guidance for future efforts. Her Government attached great importance to the rational use of antimicrobial medicines, having issued guidance and management rules on that subject and implemented a joint campaign with the ministries of agriculture, health and industry. The data contained in paragraph 3 of the report on annual deaths from hospital-acquired infections with multiresistant bacteria in China were not well-founded and should be deleted.

Ms MUTIARANI (Indonesia)¹ said that her country had taken a number of steps to counter antimicrobial resistance, including the enforcement of rules and regulations on antibiotic production, distribution, sale and prescription; the development of guidelines on antibiotic use, including for some communicable diseases; and the establishment of standards for diagnostic laboratories to control the spread of multidrug-resistant tuberculosis. In order to raise awareness of the issue, antimicrobial resistance had been incorporated in the curriculum for health workers, and information was being disseminated to the general public. Indonesia had developed a national antimicrobial surveillance network and established a national multisectoral committee to coordinate national efforts on antimicrobial resistance. At the regional level, her country was playing an active role in the ASEAN Working Group on Pharmaceutical Development, where the control of antimicrobial resistance was one of the priorities under the 2010–2015 work plan, and gave priority to monitoring and evaluating the use of antibiotics. Indonesia supported the draft resolution and requested technical support from the Secretariat in developing the tools and mechanisms for data assessment to measure regulatory performance.

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

Mr KESKINKILIÇ (Turkey)¹ and Mr ALIMUZZAMAN (Bangladesh)¹ said that their countries wished to sponsor the draft resolution, as amended.

Dr ELOAKLEY (Libya)¹ encouraged countries to spread the message that antimicrobial resistance was a serious threat to life. If the situation continued without improvement, it would not be possible to treat infections or use antibiotic prophylaxis for life-saving operations.

Ms RUNDALL (Consumers International), speaking at the invitation of the CHAIRMAN, agreed that urgent, global action was needed in order to tackle the global threat of antimicrobial resistance. She welcomed the recommendation of the Strategic and Technical Advisory Group on Antimicrobial Resistance that WHO should lead the development and coordination of a global action plan, and that the prevention of antimicrobial resistance should be integrated into all health systems and practice. Food safety tests undertaken by consumer groups over the previous two years had revealed worrying levels of antibiotic-resistant bacteria in meat and poultry samples. Global and national action plans must include strong measures to regulate the use of antimicrobial medicines in animals and humans, as well as improved animal husbandry and good hygiene practices in agriculture and food production. The use of antibiotics in farming as growth promoters and as a means of disease prevention should be banned immediately and any financial incentives for veterinarians to prescribe antibiotics must be removed.

Dr DI GIROLAMO (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN and on behalf of the People's Health Movement, said that bold measures were necessary in order to counter antimicrobial resistance. To that end, the use of antibiotics as growth promoters in animal husbandry must be phased out, and the prophylactic and therapeutic use of such medicines in agriculture must be monitored and controlled effectively. A systematic approach must be taken to monitoring hot spots for horizontal gene transfer, such as waste water treatment facilities, and efforts must be made to ensure a clean water supply for all. An early warning system should be established to facilitate the rapid identification and reporting of antimicrobial resistance events, and to detect new mechanisms of resistance. New ways of funding research and development were required in order to promote work on new antibiotics and diagnostics, and she drew attention in that regard to the proposed antibiotics innovation funding mechanism. Lastly, she called for a substantive inquiry into how WHO's treaty-making powers could be used to develop standards to govern antibiotic uses and ensure appropriate surveillance systems.

Dr CHUA (MSF International), speaking at the invitation of the CHAIRMAN, welcomed the lead taken by WHO in developing and coordinating a global action plan on antimicrobial resistance, noting that her organization saw first-hand the emergence of high rates of resistant bacteria in a variety of settings but lacked access to tools to diagnose bacterial infections with sufficient accuracy. The draft resolution could be strengthened through the inclusion of: language supporting coordination of antimicrobial stewardship at all levels; defined targets and country-level indicators on reducing the burden of antimicrobial resistance; a call for mechanisms to decrease prices for key antimicrobials, including later-generation antibiotics; a focus on developing and improving diagnostic capacity; and clearer language on research and development, as well as a note on the failure of the intellectual property regime to stimulate the necessary private sector investment in antibiotic development, and the need for new models of innovation and new sources of research and development financing to overcome that barrier.

Dr FUKUDA (Assistant Director-General) said that concern about antimicrobial drug resistance had escalated enormously over the previous year. The world was entering a post-antibiotic era, which

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

would mean longer illnesses, more deaths, higher treatment costs and a rethinking of some modern medical practices. Although health was very much at the centre of concerns about antimicrobial drug resistance, the issue was genuinely multisectoral in nature and had to be tackled by a variety of stakeholders beyond the health sector. Moreover, the issue was a global one and there was no division between North and South or developed and developing countries. Although WHO had been working on various aspects of antimicrobial drug resistance for some time and had very strong programmes in some areas, it was clear that the existing efforts were not sufficient to deal with the problem, and the draft resolution, if adopted, would provide a mandate for WHO to accelerate its efforts significantly. The process of taking the resolution forward to the Health Assembly and developing a plan would entail a great deal of work. In the coming few months, WHO would publish a global report providing an overview of the issue and forging ahead on some aspects, such as surveillance.

Referring to the comment by the member for Belgium about the implications of the draft resolution for the Programme budget, he said that antimicrobial resistance provided a good example of WHO being called upon to respond to an issue that had escalated. The Secretariat would endeavour to accommodate the necessary funding within the Programme budget and would report on that matter at the forthcoming Health Assembly. He pointed out that the development of a global plan would require the involvement of all regional and country offices, and multiple programmes at headquarters. Lastly, turning to the comment from the representative of China, he said that it was clear that more data were required on the impact of antimicrobial resistance on individual countries. The figures cited in the report had come from scientific literature, but in future reports WHO would confirm such figures with the countries.

The DIRECTOR-GENERAL thanked speakers for their strong support. She assured Member States that the Secretariat would respond to their call for rapid action.

At the request of the CHAIRMAN, Ms ROSE-ODUYEMI (Governing Bodies and External Relations) read out the two amendments proposed during the discussion. In subparagraph 1(5), the words “and, where appropriate, laboratory infrastructure” should be added after “supply chain mechanisms.”. A new subparagraph should be added under paragraph 1, reading “Member States are advised to develop Antimicrobial Resistance Surveillance System in three separate sectors (i) for inpatients in hospitals (ii) for outpatients in all other health care settings and the community (iii) for animals and non-human usage of antimicrobials”.

The resolution, as amended, was adopted.¹

The meeting rose at 12:45.

¹ Resolution EB134.R13.

TWELFTH MEETING

Friday, 24 January 2014, at 14:40

Chairman: Professor J. HALTON (Australia)

1. MANAGEMENT, FINANCIAL AND LEGAL MATTERS: Item 11 of the Agenda (continued)

Follow-up of the report of the Working Group on the Election of the Director-General of the World Health Organization: Item 11.5 of the Agenda (Document EB134/43) (continued from the tenth meeting, section 2)

Professor LOUME (Senegal), speaking on behalf of the Member States of the African Region, welcomed the production of a single reference document on the nomination and election of the Director-General. The African Region afforded particular importance to the basic principles of the Code of Conduct for the Election of the Director-General of the World Health Organization, in particular that of equitable geographical representation. He requested clarification of the proposals for the web forum in paragraphs 17 and 18 of the report; the various openings and closings of the proposed forum were confusing.

Mr BURCI (Legal Counsel) explained that the web forum had been mandated in the Code of Conduct with a view to ensuring that the principles of transparency and emphasis on the personal qualities of the candidates were applied by providing a space for candidates to interact with Member States and present themselves, their vision and platform. A candidate forum would be held two months before the opening of the Executive Board session; the Secretariat's proposal was that the web forum should not overlap with the candidate forum. The Secretariat requested guidance from the Board on that suggestion as well as on the duration of the web forum. The first time a web forum had been held had been for the recent nomination of the Regional Director for the Western Pacific; during that nomination, the web forum had been open for two weeks, which had been sufficient but not so long as to reduce momentum. In addition, the Secretariat wished to know whether Member States wanted to hold a second web forum between the Board's session in January and the subsequent Health Assembly. In principle, the Board at that session would nominate three candidates and submit their names to the Health Assembly. As there would be no interviews at the Health Assembly, an extra web forum would enable Member States to ask more specific questions about the nominated candidates' platform, vision and programmes. A second web forum was not required, but it was permitted by the Code of Conduct.

The CHAIRMAN took it that the Executive Board wished to note the report.

The Board noted the report.

2. HEALTH SYSTEMS: Item 9 of the Agenda (continued)

Health intervention and technology assessment in support of universal health coverage: Item 9.6 of the Agenda (Document EB134/30) (continued from the ninth meeting, section 1)

The CHAIRMAN drew attention to a revised version of the draft resolution, reflecting earlier discussions and proposed by Bangladesh, Indonesia, Malaysia, Maldives, South Africa and Thailand. The amended text read as follows:

The Executive Board,
Having considered the report on health intervention and technology assessment in support of universal health coverage,¹

RECOMMENDS to the Sixty-seventh World Health Assembly the adoption of the following resolution:

The Sixty-seventh World Health Assembly,

PP1 Recalling World Health Assembly resolutions WHA52.19 on revised drug strategy, WHA58.33 on sustainable health financing, universal coverage and social health insurance, WHA60.16 on progress in the rational use of medicines, WHA60.29 on health technologies, WHA63.21 on WHO's role and responsibilities in health research, and WHA64.9 on sustainable health financing structures and universal coverage;

PP2 Recognizing the importance of evidence-based policy development and decision-making in health systems, including decisions on resource allocation, service system designs and translation of policies into practice, as well as reaffirming the roles and responsibilities of the World Health Organization in provision of support to strengthen information systems and health research capacity, and their utilization in Member States;

PP3 Noting that the efficient use of resources is a crucial factor in the sustainability of health systems' performance, especially when significant increases in access to essential medicines, including generic medicines, to medical devices and procedures, and to other healthcare interventions for **promotion**, prevention, diagnosis and treatment, rehabilitation and palliative care are pursued by Member States, as they move towards universal health coverage;

PP4 Noting that *The world health report 2010*² indicates that as high as 40% of spending on health is being wasted and that there is therefore, an urgent need for systematic, effective solutions to reduce such inefficiencies and enhance the rational use of health technology;

PP5 Acknowledging the critical role of independent health intervention and technology assessment, as multidisciplinary policy research, in generating evidence to inform prioritization, selection, introduction, distribution, and management of interventions for health promotion, disease prevention, diagnosis and treatment, and **rehabilitation and palliation**;

PP6 Emphasizing that with rigorous and structured research methodology and transparent and inclusive processes, assessment of medicines, vaccines, medical devices and equipment, and health procedures ~~and programmes~~, **including preventive intervention**, could help to address the demand for reliable information on the safety,

¹ Document EB134/30.

²*The world health report 2010. Health systems financing: the path to universal coverage.* Geneva, World Health Organization, 2010.

efficacy, quality, appropriateness, **cost-effectiveness** and efficiency dimensions of such technologies to determine if and when they are integrated into particular health interventions and systems;

PP7 Concerned that the capacity to assess, research and document the public health, economic, organizational, social, **legal** and ethical implications of health interventions and technologies is inadequate in most developing countries, resulting in inadequate information to guide rational policy and professional decisions and practices;

PP8 Recognizing the importance of strengthened national capacity, **and** regional and international networking, and collaboration on health intervention and technology assessment to promote evidence-based health policy,

OP1. URGES Member States¹:

(1) to encourage the systematic utilisation of independent health intervention and technology assessment **in support of universal health coverage** to inform policy decisions, including ~~the~~ priority-setting, selection, procurement supply system management and use of health interventions and/or technologies, as well as the formulation of sustainable financing benefit packages, medicines, benefits management including pharmaceutical formularies, clinical practice guidelines and protocols for public health programmes;

(2) to consider in addition to the use of established and widely agreed methods, developing as appropriate national methodological and process guidelines and monitoring systems for health intervention and technology assessment in order to ensure transparency, quality, and policy relevance of related assessments and research;

(3) to further consolidating and promoting health intervention and technology assessment into national frameworks, such as those for health system research, health professional education, health system strengthening and universal health coverage;

(3bis) to consider strengthening national capacity for regional and international networking, to develop national know-how, avoid duplication of efforts and achieve better use of resources;

(4) to consider collaborating with other Member States health organizations, academic institutions, professional associations and other key stakeholders in the country or region to collect and share information and lessons **learnt** in order to formulate and implement national strategic plans concerning capacity building for and introduction of health intervention and technology assessment, and to summarize best practices on transparent evidence-informed health policy and decision-making;

(5) to identify gaps with regard to promoting and implementing evidence-based health policy, as well as improving related information systems and research capacity, and consider seeking technical support and exchanging information and sharing of experiences with other Member States, regional networks and international entities, including WHO;

(5bis) to encourage member states to develop and improve the data collection system of health intervention and technology assessment and to train relevant professionals so as to improve the assessment capacity;

¹ And where applicable, regional economic integration organisations.

OP2. REQUESTS the Director-General:

- (1) to assess the status of health intervention and technology assessment in Member States in terms of methodology, human resources and institutional capacity, governance, linkage between health intervention and technology assessment units and/or networks with policy authorities, utilization of assessment results, and interests in and impediments to strengthening capacity;
- (2) to raise awareness and to foster knowledge and to encourage practice of health intervention and technology assessment and its uses in **evidence-based** decision-making among national policy-makers and other stakeholders, by drawing best practices from the operation, performance and contributions of competent research institutes and health intervention and technology assessment agencies and programmes, and sharing such experiences with Member States through appropriate channels and activities, including global and regional networks and academic institutions;
- (3) to integrate health intervention and technology assessment concepts and principles into the relevant strategies and areas of work of WHO, including, but not limited to, those on universal health coverage, including health financing, access to and rational use of quality-assured medicines, vaccines and other health technologies, the prevention and management of noncommunicable and communicable diseases, mother and child care, and the formulation of evidence-based health policy;
- (4) to provide technical support to Member States, **especially low-income countries**, relevant intergovernmental organizations and global health partners, in order to strengthen capacity for health intervention and technology assessment, including, when appropriate, the development and use of global guidance on methods and processes based on internationally agreed practices;
- (5) to ensure adequate capacity at all levels of WHO, and utilizing its networks of experts and collaborating centres other regional and international networks, in order to address the demand for support to facilitate evidence-based policy decisions in Member States;
- (6) to support exchange of information, sharing of experiences and capacity-building in health intervention and technology assessment through collaborative mechanisms and networks at global, regional and country levels, as well as to ensure these partnerships are active, effective and sustainable;
- (7) to report on progress in the implementation of this resolution, through the Executive Board, to the Sixty-ninth World Health Assembly.

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

1. Resolution: Health intervention and technology assessment in support of universal health coverage	
2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)	
Category: 4. Health systems	
Programme area: National health policies, strategies and plans	Outcome: 4.1 Output: 4.1.2
Programme area: Access to medicines and health technologies and strengthening regulatory capacity	Outcome: 4.3 Output: 4.3.1
Also contributes to Categories 1, 2, 3 and 5	

How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?

The resolution would directly contribute to the outcomes mentioned above as it would support increased capacity in countries to assess the cost-effectiveness of health interventions as well as of medicines and other health technologies, using an evidence-based and transparent approach. This would allow policy-makers to prioritize investment in health and support the progress towards sustainable universal health coverage.

Does the programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget**(a) Total cost**

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) Six years (covering the period 2014–2019)

(ii) Total: US\$ 28 million (staff: US\$ 12 million; activities: US\$ 16 million)

Current estimates are for a duration of six years (2014–2019) for a total cost of up to US\$ 28 million. Costs and staffing in relation to this strategy will be included in each of the biennial budgets during the lifespan of the strategy based on a realistic costing of outputs and deliverables related to the work planned for each of the respective programme budget periods starting with the programme budget for the biennium 2016–2017.

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 13.6 million (staff: US\$ 6.6 million; activities: US\$ 7.0 million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

Headquarters and all six regional offices.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

No.

If "no", indicate how much is not included.

US\$ 5 million would be required to implement the full scope of this resolution, taking into account the need to increase capacity across the relevant programmatic areas to apply health intervention and technology assessment, as well as the start up costs (for example, instruments and tools) for implementing the resolution.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No.

If "no" indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

A total of eight full-time equivalent staff would be required in the professional and higher categories (two at headquarters and one at each of the regional offices). These staff should have expertise in doing cost-effectiveness analysis or health intervention and technology assessment.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

No.

If "no", indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

The gap is currently estimated at US\$ 13.6 million. This funding gap will be tackled as part of the Organization-wide coordinated resource mobilization plan to deal with funding shortfalls in the Programme budget 2014–2015.

Dr AMMAR (Lebanon) reaffirmed his support for the draft resolution, as amended, which his country wished to sponsor.

Dr CAPAK (Croatia) said that the European Union and its Member States, on whose behalf he spoke, were prepared to support the adoption of the draft resolution by the Sixty-seventh World Health Assembly. They were, however, concerned about the programmatic and budgetary implications of adoption of resolutions not covered by the current Programme budget 2014–2015. He asked the Director-General to submit options for dealing with that situation to that Health Assembly for consideration.

The CHAIRMAN said that a summary of the implications of all resolutions adopted would be presented before the closure of the session.

Dr AZODOH (Nigeria) welcomed the draft resolution and requested that her country be added to the list of sponsors.

Ms MATSOSO (South Africa) expressed support for the draft resolution.

Mr COTTERELL (Australia) requested clarification of the wording of subparagraph 1(5)(*bis*).

Professor LOUME (Senegal) said that his country also wished to sponsor the draft resolution.

The CHAIRMAN suggested that subparagraph 1(5)(*bis*) be amended to read: “to develop and improve data collection on health intervention and technology assessment and to train relevant professionals, as appropriate, so as to improve assessment capacity;”. If she heard no objection, she would take it that the Board wished to adopt the draft resolution, as amended.

The resolution, as amended, was adopted.¹

Follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage: Item 9.8 of the Agenda (Documents EB134/1 Add.2, EB134/55 and EB134/55 Add.1)

The CHAIRMAN drew attention to an amended version of the draft resolution contained in document EB134/1 Add.2, noting that the financial and administrative implications of the draft resolution for the Secretariat were contained in document EB134/55 Add.1. The amended text read as follows:

The Executive Board,

Having considered the “**Secretariat report on the “Follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage”**”,

RECOMMENDS to the Sixty-seventh World Health Assembly the adoption of the following resolution:

¹ Resolution EB134.R14.

The Sixty-seventh World Health Assembly,

Having considered the outcome document of the III Global Forum on Human Resources for Health, held in Recife, Brazil, between the 10th and 13th of November 2013;

Recognizing the leadership role of the WHO on Human Resources for Health, and the mandate given in this regard by resolution WHA63.16;

Recalling the commitment to attain universal health coverage and the need for an improved health workforce to achieve it;

Reaffirming the importance of the Kampala Declaration and the Agenda for Global Action, as well as the WHO Global Code of Practice on the International Recruitment of Health Personnel, and recognizing the need to ~~reviser~~**renew** these commitments **and take them forward** in light of new developments with a view to progressing towards universal health coverage,

1. ENDORSES the call to action and **WELCOMES** the commitments made by Member States in the “Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage”;
2. URGES Member States¹: ~~(1) to implement~~**to implement, as appropriate, and in accordance with national and sub-national responsibilities**, the commitments made in the “Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage”;
3. REQUESTS the Director-General to take into consideration the “Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage” in the future work of the WHO.

Dr BARBOSA DA SILVA (Brazil) thanked the Board for including the item on its agenda and welcomed the proposed improvements to the text.

Dr USHIO (Japan) said that efforts to tackle the current health worker crisis must be intensified. As Chair of the Board of the Global Health Workforce Alliance, he was committed to ensuring that the Alliance facilitated stakeholder involvement in the process. Any strategic solution must be inclusive if it was to carry the necessary weight and garner political support across different constituencies; further, it should be realistic but ambitious and should outline global action for a medium timeframe. WHO had a central role to play, particularly in ensuring an approach that targeted all countries, not just developing ones. Although shortages of health workers were particularly acute in rural areas, the issue affected all countries; he therefore urged Member States to endorse the Recife Political Declaration on Human Resources for Health. He welcomed the Secretariat’s recent efforts to clarify the respective roles and responsibilities of WHO and the Alliance; those efforts had served to bring partners and stakeholders back to the table and demonstrated that, if managed properly, partnerships definitely provided added value to the global health community.

Ms DUSSEY-CAVASSINI (Switzerland) welcomed the report and draft resolution, particularly the latter’s reiteration of the importance of the WHO Global Code of Practice on the International Recruitment of Health Personnel. One of the strengths of the Code was its monitoring and institutional arrangements, which were designed to facilitate its implementation. Member States should renew their commitment and continue their efforts on the matter, at both national and international levels, and discussion of the issue should continue during the forthcoming Health Assembly.

¹ And, where applicable, regional economic integration organizations.

Mr PALOPOLI (Argentina) said that human resources were essential to the proper functioning of health systems. Although progress had been made, particularly with the adoption of the WHO Global Code of Practice, much remained to be done. It was vital to sustain ongoing actions and obtain adequate financing in order to meet the challenges. Implementation of the commitments contained in the Recife Political Declaration on Human Resources for Health would help to reinforce activities already under way, and he therefore supported the draft resolution. The Secretariat should continue working to strengthen human resources for health.

Dr GONZÁLEZ FERNÁNDEZ (Cuba), highlighting the importance that his country attached to the Recife Political Declaration, stressed that, without adequate human resources, universal health coverage could not be achieved. He therefore strongly supported the draft resolution.

Dr VALVERDE (Panama), noting that the issue affected all countries, agreed that insufficient health personnel could compromise the achievement of health and development goals and universal health coverage. In some regions of her country, there were no gynaecologists, paediatricians or other specialist physicians; legislation, including a training plan for health-related human resources, had been adopted to remedy the situation. Panama wished to sponsor the draft resolution.

Mr KOLKER (United States of America)¹ said that one of the main accomplishments of the Third Global Forum on Human Resources for Health had been the introduction of revised procedures to make the partnership between the Global Health Workforce Alliance and WHO more effective, avoid duplication of work and highlight the benefits of the collaboration in terms of civil society engagement and professional cooperation. He endorsed the remarks of the member for Japan and expressed the hope that any new structure would be lean, efficient and effective in its efforts to tackle the issue.

Dr KIENY (Assistant Director-General) said that the Global Health Workforce Alliance was working in synergy with the Secretariat; as requested by the member for Japan, the Secretariat intended to play a central role in the development of a new vision and strategy on human resources for health in the decade to come.

The CHAIRMAN took it that the Board wished to note the report and adopt the draft resolution, as amended.

The Board noted the report and adopted the resolution, as amended.²

Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination: Item 9.3 of the Agenda (Documents EB134/26 and EB134/27)

The CHAIRMAN drew attention to a draft decision on the follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination – health research and development demonstration projects, proposed by France, South Africa and Switzerland, which read as follows:

The Executive Board, having considered the report on the Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination –

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

² Resolution EB134.R15.

Health research and development demonstration projects,¹ taking into account the additional information requested by the Global Technical Consultative Meeting of Member States and provided by the proponents of the 7+1 demonstration projects which were shortlisted by the Global Technical Consultative Meeting of Experts;

DECIDED to request the Director-General:

- (1) to consider the demonstration projects in the order listed in EB134/27 and, taking into account the additional information received with the participation of the Chair and Vice-Chair of the CEWG, as appropriate start convening virtual or direct meetings with stakeholders interested in funding and/or implementing the projects. These meetings should aim to develop the project plan and mobilize the financial resources necessary for implementation of the projects;
- (2) to monitor the progress in implementation and, where appropriate, consider coordinating or combining projects that are closely interrelated or target the same disease or type of product to maximize their effectiveness;
- (3) to develop, with respect to the mandate of resolution WHA66.22, relevant indicators to measure success in this process and to submit them to the Sixty-seventh World Health Assembly.

The financial and administrative implications of the draft decision for the Secretariat were:

<p>1. Decision: Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination – Health research and development demonstration projects</p>		
<p>2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)</p> <p>Category: 4. Health systems</p> <table> <tr> <td>Programme area: Access to medicines and health technologies and strengthening regulatory capacity</td> <td>Outcome: 4.3 Output: 4.3.2</td> </tr> </table> <p>How would this decision contribute to the achievement of the outcome(s) of the above programme area(s)?</p> <p>The decision would support work on demonstrating the effectiveness of innovative approaches in financing and coordination for undertaking needs-based health research and development for health technologies where there is market failure. This would then inform the development of new models for research and development.</p> <p>Does the programme budget already include the outputs and deliverables requested in this decision? (Yes/no)</p> <p>Yes.</p>	Programme area: Access to medicines and health technologies and strengthening regulatory capacity	Outcome: 4.3 Output: 4.3.2
Programme area: Access to medicines and health technologies and strengthening regulatory capacity	Outcome: 4.3 Output: 4.3.2	
<p>3. Estimated cost and staffing implications in relation to the Programme budget</p> <p>(a) Total cost</p> <p>Indicate (i) the lifespan of the decision during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).</p> <p>(i) One year (covering the period 2014)</p> <p>(ii) Total: US\$ 700 000 (staff: US\$ 400 000; activities: US\$ 300 000)</p> <p>(b) Cost for the biennium 2014–2015</p> <p>Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).</p> <p>Total: US\$ 700 000 (staff: US\$ 400 000; activities: US\$ 300 000)</p>		

¹ Document EB134/27.

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

Headquarters and the regional offices from which identified demonstration projects originate.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

If “no”, indicate how much is not included.

(c) Staffing implications

Could the decision be implemented by existing staff? (Yes/no)

No, but the recruitment of two staff is provided for in the approved Programme budget.

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

Two additional full-time equivalent staff members: one in the professional and higher categories and one in the general service category.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

The gap is currently estimated at US\$ 700 000. This funding gap will be tackled as part of the Organization-wide coordinated resource mobilization plan to deal with funding shortfalls in the Programme budget 2014–2015.

Mr PALOPOLI (Argentina) expressed the hope that the Global Health Research and Development Observatory would prove to be effective in providing up-to-date information and improving coordination at the global level. A comprehensive strategy would be required to ensure that the Observatory received complete and representative information from all Member States and from a variety of sources. Highlighting the importance of developing norms and standards for the classification of health research and development, he stressed the crucial decision-making role of Member States in the establishment of research and development priorities, which should be defined on the basis of public health needs and within the framework of the global strategy and plan of action on public health, innovation and intellectual property. The mechanisms for monitoring, prioritization, coordination and financing should function as sub elements of a comprehensive global structure that was guided by the principles, leadership and governance of WHO. Such a structure would require progress to be made in developing a framework for engagement with non-State actors. The possible funding structure described in document EB134/26 was based on a managed coordination model; in order to avoid duplication of efforts, the two approaches should be presented as part of a single strategy. He supported the draft decision.

Mr AL-MARRI (Qatar), speaking on behalf of the Member States of the Eastern Mediterranean Region, acknowledged that the selection exercise had been a learning process fraught with difficulties, including limited advertisement and lack of consultation in some regions and a compromising selection process that had accepted an additional project but rejected others in a similar position. In order to avoid further difficulties, Member States should continue to play an active supervisory role until the process was complete. Therefore, in the draft decision, he proposed that “and one Member State from each region” should be inserted after “Chair and Vice-Chair of the CEWG” in paragraph 1.

Dr AMMAR (Lebanon) expressed support for the amendment proposed by the member for Qatar.

Ms RUÍZ VARGAS (Mexico) welcomed the establishment of the Global Health Research and Development Observatory and noted with satisfaction the effort made to identify demonstration projects on the basis of criteria that emphasized scientific and technological excellence, innovation and potential impact on public health. Mexico supported the projects selected and reaffirmed its commitment to continue working to promote research and development that would enhance health. The draft decision would facilitate urgently needed progress on neglected diseases. Member States should be kept informed of progress in financing and implementing the selected projects.

Mr CORRALES (Panama) said that resolution WHA66.22 should continue to form the basis for work on the matter under discussion and expressed the hope that concrete results would be seen by the next Health Assembly. He welcomed the excellent work performed by the Consultative Expert Working Group on Research and Development: Financing and Coordination, which had been carried out in a committed, transparent and evidence-based manner. The demonstration projects selected should be global in scope and their intellectual property-related benefits should be open to all. Member States should continue to be involved but did not need to micromanage. He supported the draft decision but suggested that the words “as observers” be inserted immediately after the amendment proposed by the member for Qatar.

Dr BARBOSA DA SILVA (Brazil) said that the Global Health Research and Development Observatory could become an important tool for supporting research and development on public health issues. PAHO had a platform that could be useful to the Secretariat in developing the Observatory. The information on existing coordination mechanisms in document EB134/26 indicated that, in principle, some would be suitable to host a new funding mechanism; their willingness to do so should be ascertained. Brazil welcomed the selected demonstration projects, which were important for public health and would contribute to implementation of the recommendations of the Consultative Expert Working Group and the global strategy and plan of action on public health, innovation and intellectual property.

Dr CAPAK (Croatia), speaking on behalf of the European Union and its Member States, expressed support for the draft decision.

Ms DUSSEY-CAVASSINI (Switzerland) said that the proposed draft decision would facilitate prompt implementation of the demonstration projects. Although she agreed that transparency was essential, it was important to respect the independence of the experts who had selected the projects; if Member States were to participate in the process, it should be only as observers, as suggested by the member for Panama.

Dr ASADI-LARI (Islamic Republic of Iran) expressed support for the amendments proposed by the members for Qatar and Panama.

Mr AL-MARRI (Qatar) expressed support for the amendment proposed by the member for Panama.

Dr BAYE LUKONG (Cameroon) said that the African Region wanted speedy progress. She agreed that micromanagement should be avoided and therefore supported the proposal that Member States should participate as observers.

Mr ROSALES LOZADA (Plurinational State of Bolivia)¹ recalled that his country had been actively involved in efforts to promote research and development on diseases that disproportionately

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

affected developing countries. Of the possible coordination mechanisms identified in document EB134/26, he believed that a managed coordination model would be most suitable. However, any such mechanism should be under the auspices of WHO in order to enable it to benefit from the Organization's structure and guiding principles and to ensure the involvement of Member States. The issue required further analysis before the forthcoming Health Assembly. He supported the draft decision, with the two amendments, and expressed the hope that the selected projects would receive adequate support to enable their implementation. Although he appreciated the complex and important nature of the work undertaken by the group of experts, it would have been preferable for projects to be selected on the basis of the principles enshrined in the global strategy and plan of action on public health, innovation and intellectual property. Such processes must be transparent and carried out in consultation with Member States and civil society organizations. The work accomplished thus far had not obviated the need to convene a meeting of Member States, as called for in subparagraph 4(7) of resolution WHA66.22, to seek sustainable solutions and assess progress in relation to monitoring, coordination and financing for research and development on medicines for neglected diseases.

Ms NAULEAU (France),¹ expressing support for the draft decision, observed that the demonstration projects, which should be implemented as soon as possible, would help to identify the most innovative approaches for fostering research and development on health issues of particular concern to developing countries. The establishment of the Global Health Research and Development Observatory would be a vital step towards enabling WHO to identify health research and development needs. France had provided funding for the Observatory and urged other countries to do the same. It would be useful to receive an update, during the Health Assembly in May, on the Secretariat's progress in identifying the organizations and partners best suited to host a funding mechanism, together with an analysis of feasibility and costs involved.

Dr DAULAIRE (United States of America)¹ said that it was important to ensure that the Secretariat was sufficiently empowered to implement the decisions taken by the technical consultative meeting of experts in December 2013. Although he supported the draft decision, he did not accept the proposed amendments as they would slow, complicate and unnecessarily politicize the process.

Ms LANTERI (Monaco)¹ welcomed the steps taken to establish the Global Health Research and Development Observatory and encouraged the Secretariat to continue its efforts so that the Observatory could become operational quickly. Noting the three coordination models described in document EB134/26, she urged a stepwise approach that optimized as far as possible existing structures and resources. Once the Observatory was operational, priorities could be established and needs, particularly with regard to coordination, could be discerned more clearly. With regard to the draft decision, she agreed that Member States should participate only as observers.

Dr ELOAKLEY (Libya)¹ said that opposing the participation of Member States in decision-making relating to funding for health research and development was anything but transparent.

Dr FABBRI (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN and on behalf of the People's Health Movement, said that the voluntary funding mechanism proposed in document EB134/26 was likely to be financially unstable and might be vulnerable to pressure from donors. She reiterated her organization's call for a global research and development treaty funded through mandatory contributions from countries and based on the principles of open sharing of knowledge and delinkage of research and development costs from product price. The proposal regarding the Global Health Research and Development Observatory did not explain how the Observatory would engage with

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

actors at the country level or how it would function in the context of similar initiatives of other organizations with different agendas. Her organization had concerns about conflicts of interest and the selection criteria applied by the group of experts. Consequently, it was unlikely that the demonstration projects chosen would contribute significantly to rectifying the current failure of global research and development. Bold and decisive measures were needed to develop systems of innovation that would value human life over patents and profits.

Mr LOVE (Stichting Health Action International), speaking at the invitation of the CHAIRMAN, said that, although the projects endorsed by the expert group would respond to important health needs and some also proposed good policies on management of intellectual property rights and access to products, they would not test the transformative reforms needed to scale up access to medicines. Several of the demonstration projects had proposed new incentive mechanisms, but none had been selected by the experts, who had favoured more traditional grant proposals. WHO needed to consider new incentive mechanisms, as the current approaches often led to high prices and access barriers. Real progress must be made to delink research and development costs from product prices. He encouraged the Executive Board to consider all the demonstration project proposals supported by the regional groups and to recommend that the Health Assembly endorsed at least one project that would test new incentive mechanisms.

Ms ATHERSUCH (MSF International), speaking at the invitation of the CHAIRMAN, expressed concern at the lack of bold action to respond to research and development needs. Discussion of the most transformative project proposals had been postponed until 2016, and the work to be undertaken in the meantime through the Global Health Research and Development Observatory and the selected demonstration projects would by no means be sufficient to meet those needs. Most of the selected projects would probably not provide evidence for long-term sustainable solutions, nor did they incorporate new incentive models. She encouraged Member States to ensure that only proposals that met those criteria were approved, and to work towards a sustainable framework to tackle the persistent research and development challenges associated with diseases that affected developing countries. She also emphasized that any funding mechanisms put in place must create new models for research and development based on open, collaborative approaches and innovation with access.

Dr KIENY (Assistant Director-General) welcomed the continued interest shown by Member States in the agenda item. As requested in the draft decision, the Secretariat would, in collaboration with the Chair and Vice-Chair of the Consultative Expert Working Group, evaluate the responses received from the proponents of the eight projects to a list of questions. Of course Member States were welcome to attend as observers, but given the potential for disagreement as to the relative merits of the projects and the attendant potential for implementation delays, it would be important that they did not intervene or attempt to change the opinions of the experts. She sought guidance from Member States on how the observers from each region would be selected.

The DIRECTOR-GENERAL, acknowledging the need for transparency and fairness, stressed that the selection of projects had been carried out by eminent experts selected from the six regions. The Secretariat was happy to follow the guidance of the Board, but she urged Member States to trust in the process and expertise of the members of the Consultative Expert Working Group. She suggested that, in the interests of expediency, the Member States that would attend the meetings of the Group as observers could be selected by the regional directors by drawing lots.

The CHAIRMAN took it that the Executive Board wished to note the reports contained in documents EB134/26 and EB134/27.

The Board noted the reports.

The CHAIRMAN further took it that the Board wished to accept the suggestion of the Director-General and to adopt the draft decision, as amended.

It was so agreed.

The decision, as amended, was adopted.¹

(For continuation of the discussion, see the summary record of the fourteenth meeting, section 3.)

3. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 10 of the Agenda (continued)

Poliomyelitis: intensification of the global eradication initiative: Item 10.4 of the Agenda (Document EB134/35)

Mr COTTERELL (Australia) commended the efforts of WHO and its global partners to eradicate poliomyelitis. Australia supported the objectives of the Polio Eradication and Endgame Strategic Plan 2013–2018 and welcomed the work being done to strengthen vaccination efforts, especially in countries in which the disease was endemic or where conflict had affected routine vaccination programmes. Good progress was being made towards eradication in Nigeria and Afghanistan, but he expressed concern at the situation in Pakistan and the recent outbreaks in the Horn of Africa and the Syrian Arab Republic, as well as the insecurity faced by, and the attacks on, health workers, which threatened eradication campaigns, undermined the right of children to good health and jeopardized the progress made to date. He condemned such attacks and called on the authorities to commit themselves to unhindered, safe access for vaccination workers.

Professor LOUME (Senegal), speaking on behalf of the Member States of the African Region, noted that the Regional Committee for Africa had discussed the Strategic Plan's implementation at its sixty-third session. The situation continued to improve in Nigeria, with 55% fewer confirmed cases in 2013 than in the same period in 2012, no wild poliovirus type 3 detected for 12 months and fewer genetic clusters in circulation. Vaccination coverage, however, remained low in Kano and Borno states. The countries in which transmission of wild poliovirus had resumed between 2009 and 2011 – Angola, Chad and Democratic Republic of the Congo – had had no further outbreaks for 18 to 24 months. The situation was under control in Cameroon, Ethiopia and Kenya, which had experienced outbreaks. The challenge in the Region was to stop transmission of wild and circulating vaccine-derived polioviruses. The African Regional Certification Commission had been reactivated and expanded in 2013.

Dr AZODOH (Nigeria) thanked the Secretariat for its support and paid tribute to those who had died while carrying out immunization activities. Polio eradication remained a top public health priority for her Government, which had invested unprecedented levels of domestic resources to that end; political commitment was maintained at the highest level. Intersectoral collaboration had been strengthened and other measures taken in order to support implementation of the national Polio Eradication Emergency Plan for 2014, which extended and consolidated existing strategies. Vaccination coverage was 80% in the states in which poliomyelitis remained endemic. Poliovirus type 3 had not been detected for more than a year, and the geographical spread of polioviruses was currently restricted to the three states in which security was a problem. Specific interventions,

¹ Decision EB134(5).

including firewalling, a “hit and run” vaccination strategy, the use of permanent health teams and health camps, were being applied in those states. Vaccines also continued to be administered at international border crossings. The pentavalent vaccine had been introduced in all states, and the conclusion of the introduction of vaccination against meningitis A was expected to result in broader acceptability of polio vaccination. Regular consultations were being held with all stakeholders, especially local government officials in the 34 states in which poliomyelitis remained endemic. The vaccine supply had been stabilized and availability guaranteed. In its current Polio Eradication Emergency Plan, Nigeria aimed to interrupt transmission in 2014; it asked the international community to continue to stand with it in global solidarity.

Mr AL-MARRI (Qatar), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that advances continued to be made towards eradication of poliomyelitis, which remained endemic in only two countries in the Region. Remarkable progress had been made in Afghanistan in 2013, but the increase in the number of cases in Pakistan and the international spread of poliovirus resulting in outbreaks in the Syrian Arab Republic, as well as the detection of poliovirus in environmental samples in the Middle East and outbreaks of disease in the Horn of Africa, were deeply worrying. In 2013, for the first time, nearly 80% of all cases of poliomyelitis worldwide had occurred in the Region. After reviewing the situation as a matter of urgency, the Regional Committee at its sixtieth session had adopted resolution EM/RC60/R.3, declaring the new international spread of wild poliovirus an emergency for all Member States of the Region and reiterating the continuing emergency situation of endemic poliomyelitis in Pakistan. It also requested Pakistan to intensify the necessary steps to ensure that all children were vaccinated as a matter of the utmost urgency and urged all Member States of the Region to extend all possible support to Pakistan, Somalia and the Syrian Arab Republic. He condemned, in the strongest terms, the attacks on health workers in Pakistan, and expressed deep concern about the current situation of uncontrolled transmission in parts of that country. Member States of the Region, with their partners, were providing substantial financial and material support for its polio programme. The Regional Director had convened an urgent high-level meeting to prepare a regional intercountry plan of support for eradication in Pakistan and a multicountry response to outbreaks in Somalia and the Syrian Arab Republic. The Member States of the Region renewed their request to the Government of Pakistan to ensure that all children were vaccinated and take additional steps to vaccinate travellers, thereby reducing the risk of international spread. With respect to the Polio Eradication and Endgame Strategic Plan 2013–2018, they renewed their commitment to strengthen routine immunization, introduce inactivated poliovirus vaccine and withdraw the trivalent oral polio vaccine.

Dr USHIO (Japan) applauded the significant reduction in the number of cases of poliomyelitis in Afghanistan and Nigeria; eradication there would generate knowledge, skills and financial and human resources that would be useful in reaching the global goal. His Government was deeply concerned about the surge in cases in Pakistan and the security issues that were hobbling immunization activities. It had provided Pakistan with a loan to support eradication efforts in 2011 and with other forms of support over the years, but recognized the need for further efforts, including high-level political commitment and greater awareness of the importance of immunization. In order to maintain high vaccination coverage rates, which were essential for eradication, routine immunization programmes had to be strengthened. Japan had been the first country worldwide to introduce the inactivated poliovirus vaccine into its routine immunization schedule, and it was willing to share its technology and skills with other countries.

Dr GRABAUSKAS (Lithuania), speaking on behalf of the Member States of the European Region, acclaimed the passage of three years since the last case of poliomyelitis had been recorded in India. He expressed deep concern, however, at the high number of cases of poliomyelitis in Pakistan. In the countries in which poliomyelitis remained endemic, the key to successful implementation remained local ownership, trust in implementers, and the engagement of local religious leaders and authorities. Outbreaks in the Horn of Africa and the Syrian Arab Republic were poignant reminders of

the need for Member States to remain vigilant and step up measures to interrupt transmission of wild poliovirus, for instance by strengthening health systems and improving delivery of routine immunization programmes. He applauded the renewed political commitment of the three Member States in which poliomyelitis remained endemic and the robust response of WHO and its partners in the Syrian Arab Republic and the subregion, but remained concerned about the serious risks posed by the high levels of insecurity and access bans faced by vaccination workers in vulnerable areas. He roundly condemned the attacks on health workers and called for more systematic action to tackle those threats. He asked for an update on the situation in the Syrian Arab Republic. He welcomed the Secretariat's decision to convene an expert group in 2014 to review the issue of vaccinating travellers to and from polio-affected countries. Adequate global capacity should be established to help Member States to plan and implement the transition from use of oral polio vaccine type 2 to the inactivated poliovirus vaccine, including cash-flow forecasts (as country-level variations in the availability of funds could hamper implementation of crucial time-bound activities). In that area, he welcomed the enhanced cooperation between the Global Polio Eradication Initiative and the GAVI Alliance. For legacy planning, the consultation process should be continued through the WHO regional committees in 2014. He requested more information on recent initiatives regarding transparent monitoring and accountability of the Global Polio Eradication Initiative, such as the systematic risk review and new decision-making process for oversight.

Sustained and flexible funding from the international community was crucial. Every country had a contribution to make towards the global public good of eradication, and the outbreak in the Syrian Arab Republic underscored the importance of regional and global cooperation. Previous achievements and operational priorities should not be undone or diminished by an insufficiency of resources.

Dr AMMAR (Lebanon) said that Lebanon's poliomyelitis-free status was jeopardized by the outbreak in the Syrian Arab Republic and circulation of poliovirus in the Middle East. The country was providing support for the vaccination of the large number of refugees from the Syrian Arab Republic currently living in Lebanon, and participating in the multicountry response to the outbreak, which involved the vaccination of 22 million children across the region. It had upgraded surveillance to facilitate rapid detection of poliovirus and was implementing a series of nationwide vaccination campaigns. He called on the international community to support regional efforts to control the outbreak in the Syrian Arab Republic so that the entire region might achieve the eradication goal.

Mr BAE Kyung-taek (Republic of Korea) acknowledged the excellent leadership of WHO and Member States' proactive implementation of key projects, which had limited the incidence of poliomyelitis to occasional outbreaks in certain parts of Africa and the Middle East. However, international travel meant that importation of poliovirus remained a risk. The Organization's role of conducting immunization programmes in countries where outbreaks were reported and monitoring information-sharing would therefore become even more important. In addition, practical measures had to be taken to protect health workers. The eradication of poliomyelitis, following that of smallpox in 1980, would send a powerful message to the world about the importance of vaccination.

Mr KLEIMAN (Brazil) identified poliomyelitis eradication as one of the most important public health objectives of the day. Valuable lessons could be learnt from India's achievement in attaining poliomyelitis-free status. All countries had a duty to work towards poliomyelitis eradication, by providing financial or other resources and maintaining high levels of immunization coverage. Brazil was firmly committed to eradication and willing to share its knowledge.

Mr PALOPOLI (Argentina) agreed that it was important to ensure that the knowledge and experience acquired through the Global Polio Eradication Initiative benefited other public health programmes, even after the goal was reached. He expressed concern at the difficulties encountered by the Initiative, chiefly the obstacles to vaccination campaigns in Africa, attacks on vaccination workers, inadequate epidemiological surveillance and the constant risk that wild poliovirus would spread to

vulnerable regions. Overcoming those difficulties required the commitment of Member States, which should, as requested by the Health Assembly, improve their surveillance systems, strengthen immunization coverage, undertake supplementary immunization activities, and plan for the introduction into their routine immunization programmes of at least one dose of inactivated poliovirus vaccine by the end of 2015. A further concern was that high vaccine demand could increase the price, which, combined with production shortfalls and global supply problems, would affect developing countries in particular. The Argentine Commission for Polio Eradication and Wild Poliovirus Laboratory Containment therefore proposed to assess the possibility of producing the inactivated poliovirus vaccine within the country, so as to promote prompt and equal access nationally and potentially throughout the Region. He asked the Secretariat to consider the matter of equitable access to vaccines and to promote production and availability so as to guarantee universal access.

Dr SAEEDI (Saudi Arabia) recalled that his country had been poliomyelitis-free for more than 15 years, and expressed concern about the current threat in the Eastern Mediterranean Region. It had joined other Member States of the Region in supporting efforts to control and eliminate the disease. It was coordinating with the Secretariat and the Government of Pakistan to send a delegation of religious scholars, headed by the Imam of the Holy Mosque in Mecca, to Pakistan, and would provide vaccines for the immunization of children there. It was facilitating the engagement of its religious scholars and support from key institutions, such as the Organization of Islamic Cooperation, the Islamic Development Bank and the Islamic Fiqh Academy, in the eradication programme.

As host to the hajj and the umrah pilgrimages, Saudi Arabia had gained substantial experience in limiting the international spread of poliomyelitis, with its decision to require vaccination before travel to the country and to vaccinate travellers on arrival proving effective in preventing the spread of the disease as a result of those events.

Dr REFFAET (Egypt) recalled that no case of poliomyelitis had been recorded in Egypt since 2004. Nevertheless, as a result of the discovery of imported poliovirus by the surveillance system in environmental samples the previous year and the reports of cases in neighbouring countries, the Government was taking the utmost care and implementing all preventive measures, including routine immunization coverage, which exceeded 96% nationally. In addition, the country was running extended national polio immunization campaigns. He thanked the Secretariat, in particular the Regional Office for the Eastern Mediterranean, for its continuing support.

Ms ALI (Maldives) commended the successful efforts of the Member States of the South-East Asia Region, especially India, to control poliomyelitis. The Member States concerned were currently implementing the Polio Eradication and Endgame Strategic Plan 2013–2018, making concerted efforts to maintain high-quality activities despite financial, operational and political impediments. The Region's large population made it difficult to implement regional plans, such as the introduction of the inactivated poliovirus vaccine into immunization schedules. She keenly awaited the development in 2014 of the framework to support legacy planning at national and international levels. Continued resource mobilization was essential for enhancing surveillance, immunization coverage and supplementary immunization activities. Attaining the 2014 eradication target of the Endgame Strategic Plan would require the full support of Member States.

Dr ASADI-LARI (Islamic Republic of Iran), recognizing the importance of poliomyelitis eradication in the Eastern Mediterranean Region, said that his Government remained willing to provide technical assistance and support for regional immunization campaigns, in close collaboration with the Regional Office.

Dr DAULAIRE (United States of America),¹ encouraged at the gains made in Nigeria, Afghanistan and India, expressed confidence that sustained high-level political commitment could interrupt the circulation of polioviruses in Nigeria and that ongoing outbreaks in the Middle East and the Horn of Africa could be stopped by the end of 2014. He extended heartfelt condolences to the families of health workers killed during their vaccination work and stressed the need for a safe environment for health programmes. The strong personal stand taken by the Prime Minister of Pakistan in support of poliomyelitis eradication and vaccination workers was praiseworthy. Pakistan's initiative to administer vaccinations at travel hubs was particularly admirable and a model for other countries. The reimportation of the poliovirus into polio-free countries presented a new obstacle in the final stretch towards eradication. Member States had done well to reach a consensus on the recommendation of the Independent Monitoring Board of the Global Polio Eradication Initiative to promote vaccination of travellers to and from countries in which poliomyelitis remained endemic. In the context of the International Health Regulations (2005), the Director-General should convene the Emergency Committee under the Regulations, so as to obtain input from affected countries and produce a recommendation on measures to reduce the risk of international spread of poliovirus, before the Health Assembly in May 2014. His Government was exploring options to promote vaccination of travellers and called on other Member States to do the same. Any such steps should emphasize the creation of opportunities for vaccination rather than obstacles to travel. In order to prevent fresh outbreaks, polio-free Member States should prevent cross-border transmission and reduce identified gaps in immunity by strengthening delivery of integrated immunization and conducting immunization campaigns as necessary. In support of those efforts, WHO should identify areas at high risk if poliovirus were introduced; countries at risk of reimportation should develop action plans to close their immunity gaps as soon as possible; WHO offices should coordinate with health ministries, UNICEF, nongovernmental organizations and other partners to promote low-cost action plans, for example by supporting routine immunization and including oral poliomyelitis vaccine in other vaccination campaigns; and the Secretariat should provide stronger guidance to polio-free countries to enable them to prioritize plans to prevent reimportation, and should help to plan the transfer of knowledge and assets from poliomyelitis eradication programmes to other public health activities.

Mr HU Xiaomeng (China)¹ said that eradication efforts continued to face huge obstacles in certain regions. Some countries and regions that had been declared polio-free had experienced the importation of wild poliovirus. The Secretariat should therefore coordinate the efforts of all parties to provide technical and financial support to priority countries, helping them to increase inactivated poliovirus vaccine coverage to stop transmission of wild poliovirus at an early stage. Neighbouring countries should be helped to strengthen border controls, conduct regular evaluations and prevent the spread of imported viruses. The Secretariat should also establish an information-sharing mechanism, strengthen international cooperation on data analysis and outbreak surveillance, and, in particular, adopt multicountry joint prevention and control strategies. It should also consider country-specific situations and adapt strategies accordingly, for example by arranging for a transition period for countries introducing inactivated poliovirus vaccine. It should also coordinate efforts to promote research and development, and the production of inactivated poliovirus and bivalent attenuated vaccines. Further, the Organization should fund efforts by developing countries to conduct risk evaluations for strategy readjustments, with such adjustments being made only once an adequate vaccine supply had been guaranteed and the risks of readjustment were fully recognized and controlled.

Ms LANTERI (Monaco)¹ said that poliomyelitis eradication was a priority for Monaco, which had been a partner of the Global Polio Eradication Initiative for many years. The re-emergence of the poliovirus in the Middle East and the Horn of Africa and the almost systematic attacks on health

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

workers prompted fears that the gains made to date would not be consolidated. The Eastern Mediterranean Region had made laudable efforts to put in place regional cooperation to limit poliovirus circulation, and she agreed with the member for Saudi Arabia that the measures taken during mass events in Mecca had stopped circulation. She expressed her condolences to the families of the workers killed in the performance of their duties, observing also that preventing poliomyelitis vaccinations would not only hamper eradication efforts but also hinder access to health services and acceptance of other vaccinations.

Ms PALMIER (Canada)¹ congratulated Nigeria, Afghanistan and India on the gains made and acknowledged ongoing efforts in Pakistan, where the very difficult environment made the accomplishments all the more noteworthy. She expressed concern about the recent rise in the number of confirmed cases and about the security of vaccination teams, urging the Government of Pakistan to find innovative ways of increasing access to high-risk communities as part of its national eradication plan, to prosecute those responsible for the attacks and to continue working on improved security arrangements for vaccination workers. She acknowledged the commitment made by non-State actors in Pakistan and Afghanistan not to target vaccination workers. The most fragile countries, those with weak health systems and difficult political contexts, were at greatest risk of importing the virus. It was therefore crucial to minimize the risk posed by travellers from countries in which poliomyelitis remained endemic. The Director-General should convene an appropriate committee to consider options for limiting the spread of poliovirus outside areas in which it remained endemic, for instance traveller certification. The oversight and accountability mechanisms of the Global Polio Eradication Initiative should continue to be strengthened, as they were crucial for effective vaccination campaigns and surveillance.

Ms MEL'NIKOVA (Russian Federation)¹ said that poliomyelitis-affected countries must take full ownership of their poliomyelitis eradication programmes and do their utmost to ensure good-quality epidemiological monitoring and expanded targeted vaccination campaigns, including in areas that were difficult to reach. All countries needed to establish plans for the introduction of at least one dose of the inactivated poliovirus vaccine into their routine immunization programmes. The international community should support countries of limited means in gaining access to the vaccine, and the Organization needed to continue its efforts to lower the cost of the vaccine. In gauging readiness to transition to the bivalent oral polio vaccine at the national and global levels, all five criteria presented in the Secretariat's report must be met. She asked the Secretariat to explain how verification of the global eradication of wild poliovirus type 2 would be conducted.

Dr RANJAN (India)¹ expressed support for the four main objectives of the Polio Eradication and Endgame Strategic Plan 2013–2018. It was a matter of great satisfaction that no new wild poliovirus case had been reported in India for three years, thanks to, inter alia, the support provided by WHO and other partners. In order to mitigate the risk of importation and to maintain high coverage, children were being vaccinated around the clock at or near international borders, and national and subnational immunization days were being carried out, as recommended by the India Expert Advisory Group. The period 2013–2014 had been declared the Year of Intensification of Routine Immunization in more than 411 000 high-risk areas identified by public health experts during campaigns at district and subdistrict levels. Active support of the National Certification Committee for Polio Eradication took the form of coordination with state governments, laboratories and other stakeholders, with a view to obtaining poliomyelitis-free certification in the South-East Asia Region by early 2014.

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

Ms WIDIYARTI (Indonesia)¹ expressed support for the Polio Eradication and Endgame Strategic Plan 2013–2018. Indonesia had been poliomyelitis-free since 2006 and continued to maintain a high level of immunization coverage and to strengthen routine immunization. The expected certification of the South-East Asia Region as poliomyelitis-free would be a significant achievement and provide added momentum for the goal of global eradication. Her Government would continue to implement acute flaccid paralysis surveillance and other activities as required.

Mr AKRAM (Pakistan)¹ said that his country attached the highest priority to poliomyelitis eradication. Its efforts to that end included a multipronged strategy comprising the National Emergency Action Plan and federal and provincial task forces overseen and coordinated by the Prime Minister's Polio Monitoring Cell, which was chaired by the Prime Minister himself. The unfortunate increase in the number of poliomyelitis cases in Pakistan in 2013 was not due to a lack of political will or awareness at the highest level, but had to be seen in the broader context. Some 90% of the country was poliomyelitis-free, and wild poliovirus type 3 had been successfully eradicated. Most cases of disease occurred in northern Pakistan, where counter-terrorism operations and the resulting conflict made accessibility difficult and dangerous and had sparked opposition to immunization campaigns, including attacks on vaccination workers. Despite those obstacles, the Government and people of Pakistan were committed to fighting poliomyelitis, as evidenced by the recent convening by the President of a grand *jirga* attended by more than 2000 tribal elders in the northern areas to garner support for the eradication programme. On the same day, a three-day campaign had been launched in the Khyber Agency to vaccinate an estimated 50 000 previously unvaccinated children. Some 400 trained security force members were administering polio vaccine drops to children in the most volatile areas, in addition to providing security for vaccination workers. Vaccination desks had been established at international airports, railway stations and highways. Routine meetings were held with Afghanistan in order to review and coordinate strategies to stop cross-border transmission by the high-risk migrant population in the border areas. Pakistan sought positive reinforcement from its partners and the support of the international community to augment those efforts. At the National Task Force meeting to be held at the end of January, the Prime Minister would be briefed on the National Emergency Action Plan 2014, which enhanced the focus on strategies for reservoir areas, mobile populations and security issues. There was consensus across the Pakistani political spectrum to condemn the targeting of vaccination workers; religious leaders, civil society and the media likewise actively opposed such actions. He expressed appreciation for Member States' expressions of sympathy and support and reaffirmed Pakistan's commitment to eradicating poliomyelitis in 2014.

Mr BOUZO (Syrian Arab Republic)¹ recalled that his country had eradicated poliomyelitis in 1995. The imported cases recorded in the Governorate of Deir Al-Zour at the end of September 2013 were a matter of grave concern. In cooperation with WHO and UNICEF, the national health ministry had immediately adopted a strict plan for developing a series of immunization campaigns. In the most recent campaign, concluded earlier that month, more than 2.4 million children under the age of five years had been immunized with bivalent poliovirus vaccine. However, all those efforts were put at risk by the illegal introduction into the country of, and immunization of children with, vaccines other than the bivalent poliovirus vaccine. He conveyed his thanks to the Secretariat – particularly the Director-General, the Regional Director for the Eastern Mediterranean and the WHO Representative in the Syrian Arab Republic – for the support provided to his country in eradicating the epidemic.

Dr SUCHADA JAISIRI (Thailand)¹ expressed concern about the affordability of inactivated poliovirus vaccine. Vaccine manufacturers in developing countries had an important role to play in the transition to that vaccine, and WHO should therefore expedite the transfer to them of the relevant

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

technology in order to ensure an adequate and affordable supply. It should also prepare practical guidelines for that transition.

Mr ALIMUZZAMAN (Bangladesh)¹ said that his Government maintained high-quality and sensitive surveillance of acute flaccid paralysis, provided all funding for routine poliomyelitis immunization and covered 95% of the cost of supplementary immunization activities. The last indigenous case of poliomyelitis due to wild poliovirus had occurred in August 2000, and the last imported case in November 2006. Bangladesh nevertheless continued to implement and monitor all strategies for eradication. With the Secretariat's report highlighting the importance of withdrawing the type 2 component of oral poliomyelitis vaccine and recommending the use of inactivated poliovirus vaccine, it was encouraging that the Global Polio Eradication Initiative had taken steps to make inactivated poliovirus vaccine available at affordable prices. Under the Director-General's leadership, WHO appeared willing to provide technical support to help vaccine manufacturers in developing countries to produce the bivalent oral and inactivated poliovirus vaccines and to help national regulatory authorities to monitor vaccine production. Poliomyelitis eradication efforts needed to be intensified, in which context India's high level of political commitment to remain poliomyelitis-free and the personal commitment of the Prime Minister of Pakistan were encouraging.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland)¹ said that recent outbreaks of poliomyelitis in the Syrian Arab Republic, the Horn of Africa and Pakistan threatened to reverse decades of progress. She therefore agreed with the proposal made by the representative of the United States of America that the Director-General should convene an Emergency Committee under the International Health Regulations (2005) before the Sixty-seventh World Health Assembly.

Ms KURAL (Turkey)¹ congratulated India on achieving poliomyelitis-free status, welcomed the decrease in the number of cases in Nigeria and Afghanistan, and expressed appreciation of the Government of Pakistan's eradication efforts. Turkey was an unstinting backer of initiatives and efforts for a poliomyelitis-free world and attached importance to WHO's work. The Endgame Strategic Plan provided a concrete timeline for efforts towards eradication.

Mr STENHAMMAR (Rotary International), speaking at the invitation of the CHAIRMAN, said that governments had to use all available tools to reach and vaccinate children in their territories. All parties should allow access to children for vaccinations and must stop the deadly attacks on innocent health workers. Without strong action in Pakistan and Nigeria, poliomyelitis would continue to spread globally. Of the US\$ 5500 million needed to implement the Strategic Plan through 2018, US\$ 560 million remained to be raised. Planned and emergency activities could not be conducted unless that gap was closed. Poliomyelitis-affected countries should also fund some of their own activities. Stronger oversight, greater accountability and tighter management of resources were needed in poliomyelitis-affected countries and among United Nations partners. All WHO regions should focus more closely on routine immunization and better acute flaccid paralysis surveillance. Rotarians would continue to raise funds and awareness, and to build the trust needed to reach every child, but governments in poliomyelitis-affected countries had to lead and take stronger action immediately.

Dr AYLWARD (Assistant Director-General) said that, one year into the Polio Eradication and Endgame Strategic Plan 2013-2018, the guidance provided by the Board was extremely helpful. The environment had clearly been different in the past year: for the first time ever, the world had been free of poliovirus type 3; great progress had been made in Nigeria, where all the northern states had more than 80% vaccination coverage rates; the relationship with the GAVI Alliance was extremely close and growing stronger, translating, inter alia, into better work on routine immunization and the

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

introduction of the inactivated poliovirus vaccine; and, as a result of the recent Global Vaccine Summit, the Endgame Strategic Plan had garnered financial support. The Board had provided clear guidance on its priorities for the coming year. With regard to the first – reducing and tracking the risk of international spread – the Director-General was convening a meeting of the Polio Working Group of the Strategic Advisory Group of Experts on immunization on 5 and 6 February 2014 to consider WHO's advice and recommendations on the vaccination of travellers, drawing on Saudi Arabia's guidance and experience. Risk assessments were being conducted quarterly, with plans adjusted accordingly, in close coordination with the Member States. The second priority related to the Organization's support to Pakistan and its work on reducing the risks of attacks on health workers in Pakistan and elsewhere. Although the Syrian Arab Republic remained a difficult and very dangerous environment in which to work, coverage was improving with each round and more children were being vaccinated. Despite the continued emergence of new cases, the prospects were good that the outbreak in the Syrian Arab Republic would be stopped. Thirdly, regarding the introduction of the inactivated poliovirus vaccine and the switch to bivalent vaccines, WHO had established the Immunization Management Group, which drew on expertise from a broad range of agencies to provide countries with support on best practice. Countries that needed such support should make themselves known. In terms of access to affordable inactivated poliovirus vaccine, technology transfers had started to six developing country manufacturers, which should be in a position to start production in the medium term. In the meantime, UNICEF had issued a major tender for the vaccine and certain WHO partners, such as the Bill & Melinda Gates Foundation, had provided help in negotiations. The outcome of the tender would be known in the coming months. WHO had also started to work with manufacturers of the bivalent vaccine in order to ensure that they could fast-track its development. The basic message from many countries on the introduction of inactivated poliovirus vaccine and the switch to bivalent vaccines was that they wanted to be properly prepared. He assured the Board that the Secretariat would be reporting on the timelines and that, once it appeared that the criteria were in place for global readiness, it would ensure that a period of 12 months or more was allowed before a firm date was set. Regarding certification of the eradication of wild poliovirus type 2, he said that the Global Certification Commission had set up a process whereby it would work through the regional certification commissions to request updates from all Member States on their surveillance quality, the time since they had last detected the virus and their progress on containment, so that it could decide by late 2014 or early 2015 whether to advise the Director-General that wild poliovirus type 2 had indeed been eradicated in 1999.

Two weeks earlier, the Polio Oversight Board had adopted new processes that would strengthen governance and oversight of the Global Polio Eradication Initiative, whereby all major stakeholders would be formally consulted about major decisions on issues such as timelines and financing. The new processes were also linked to the Initiative's new risk-management approach. He appreciated the condolences expressed by many Board members. It was an unfortunate fact that poliomyelitis eradication had become a deadly business; indeed, three more health workers had been shot dead since the Board had convened.

The DIRECTOR-GENERAL commended the reinforced commitment pledged by the Member States of the Eastern Mediterranean Region at the sixtieth session of the Regional Committee for the Eastern Mediterranean in October 2013. She also commended the efforts being made by Nigeria, Afghanistan and Pakistan to reduce the number of cases of poliomyelitis, and expressed particular interest in meeting the Prime Minister of Pakistan and reinforcing his support for eradication efforts. Notwithstanding the outbreaks in the Syrian Arab Republic and the Horn of Africa, there was great cause for optimism. The goal was in sight. The outbreak in the Syrian Arab Republic was likely to be brought under control, given the high coverage rates there and in the neighbouring countries. She thanked UNICEF for its cooperation with WHO in that regard. She thanked WHO's partners – UNICEF, the Centers for Disease Control and Prevention in the United States of America, Rotary International and the Bill & Melinda Gates Foundation – for their unfailing support, but said that countries must take ownership of the problem. As had been seen in the case of India, when a government was committed and contributed its own resources, it got the job done. The three countries

in which poliomyelitis remained endemic should look to India as an example. At the same time, attention should not be fixed only on the three countries in which poliomyelitis remained endemic. As had been seen, the countries from which poliomyelitis had been virtually eliminated could still produce unpleasant surprises. Constant vigilance must be the watchword. Regarding the proposal to convene an Emergency Committee, she first wanted an expert working group to indicate how WHO could provide guidance and a road map to governments on the recommendations produced by such a committee. She hoped to convene the Emergency Committee before the Sixty-seventh World Health Assembly in May 2014 and report back to the Executive Board.

The Board noted the report and expressed its solidarity with health workers engaged in vaccinating children. (*Applause*)

4. WHO REFORM: Item 5 of the Agenda (continued)

Options for improved decision-making by the governing bodies: Item 5.2 of the Agenda (Documents EB134/6, EB134/6 Add.1 and EB134/6 Add.2) (continued from the fifth meeting)

The CHAIRMAN drew attention to the draft decision contained in document EB134/6 Add.2, which reflected the discussions held during the fifth meeting. The key issues requiring discussion were those relating to the process for establishing the agenda of the Executive Board and the criteria for the inclusion of urgent items and late resolutions. She suggested that the Board focus on those issues, as there appeared to be consensus on the other elements of the text.

Dr CAPAK (Croatia), speaking on behalf of the European Union and its Member States, said that the discussions had shown how serious Member States were about governance reform. The draft decision would not introduce any mechanisms that did not already exist within the United Nations system; moreover, the measures proposed would not necessarily remain in effect forever. The Board was free to refine its working methods at any time. The draft decision presented a balanced approach that would keep the agendas of the governing bodies at a manageable level while allowing flexibility and not infringing the sovereign rights of Member States. It was important to build on existing mechanisms; the added value and the financial implications of establishing new structures were unclear and, therefore, he could not support the optional additional element proposed in paragraph 14 of the draft decision. If that element were deleted, he could support the draft decision without further amendment.

Dr AMMAR (Lebanon) said that the provisions of paragraphs 1 to 13 of the draft decision were acceptable. Subparagraphs 14(a) and (b) reflected the proposal he had made during the fifth meeting, and he encouraged all Board members to accept them. Regarding his proposal for a technical assessment of proposed agenda items, he understood that it was important not to add layers to the procedure. He also understood the reservations of some Board members with respect to the optional additional element put forward in paragraph 14 and welcomed their commitment to enhance the efficiency of the Board's meetings. In a spirit of compromise, he was therefore willing to withdraw his proposal. Nevertheless, it was important to note that an overcrowded agenda not only led to the need for evening meetings but also increased the work of the Secretariat and entailed extra cost.

The CHAIRMAN suggested subparagraph 14(c) should read "One week before the opening of a session of the Board..." rather than "One week before the opening of the January session of the Board...".

Ms POLACH (Argentina), supported by Mr KLEIMAN (Brazil) and Mr ROMERO PUENTES (Cuba), asked how and by what criteria the two limits of 36 and 48 items on the provisional agenda, referred to in subparagraph 14(a), had been chosen. She suggested that, instead of limiting the number of items, it would be preferable to limit the time frame in which proposals could be submitted. She could not support the proposal in subparagraph 14(b) to assign a score to each proposed agenda item, depending on how many of the three criteria set out in resolution EB121.R1 it met. That paragraph would make it obligatory for items to meet all three criteria, which did not reflect the consensus that she believed had been reached on the issue. In addition, the requirement described in paragraph 17 regarding the need for cosponsorship of resolutions would be difficult to achieve for smaller delegations or those Member States without permanent representation in Geneva. More analysis was needed to make that requirement more equitable.

Mr KLEIMAN (Brazil), referring to paragraph 14, said that the aim of the proposals made during the fifth meeting had been to enhance transparency and the participation of Member States in establishing the agendas of the governing bodies. He therefore believed that it would be beneficial for two members from each region, as proposed in the optional additional element, to be consulted electronically. Member States must have the necessary flexibility to table urgent items. He could therefore not support paragraph 17.

Ms DUSSEY-CAVASSINI (Switzerland), expressing gratitude to the member for Lebanon for his flexibility, welcomed the draft decision. A key aim of the reform process was to improve the efficiency and focus of the governing bodies. Member States should trust the Secretariat and the officers of the Executive Board to make informed and sensible decisions regarding the inclusion of items on the provisional agenda. She enquired what change would be needed in paragraph 14 in order to render it acceptable to the member for Argentina.

The CHAIRMAN observed that there appeared to be consensus on paragraphs 1 to 13 and asked whether the Board was ready to approve those paragraphs.

It was so agreed.

The CHAIRMAN asked the member for Argentina to indicate a maximum optimal number of items that would be acceptable for inclusion in subparagraph 14(a) and to clarify her objection to subparagraph 14(b).

Ms POLACH (Argentina) said that she was not convinced that a maximum number of items should be specified and reiterated her request for clarification of how the numbers 36 and 48 had been decided. With regard to subparagraph 14(b), Member States had agreed that agenda items should meet at least one of the three criteria established in resolution EB121.R1. If the scoring system proposed in subparagraph 14(b) were applied, only those items that met all three criteria would be considered top priorities.

The CHAIRMAN explained that items would receive one point for each criterion met. Hence, items that met all three criteria would receive a score of 3. However, items were not required to meet all three criteria in order to be included on the provisional agenda. As to the maximum optimal numbers, it was important to remember that they were not absolute ceilings, but rather targets that the Board officers were asked to endeavour not to exceed in the interests of ensuring that there would be adequate time for the discussion of all items during the time allotted for Board sessions.

Mr ROMERO PUENTES (Cuba) said that he, too, would like to know how the numbers 36 and 48 had been decided.

Dr TROEDSSON (Executive Director, Office of the Director-General) said that the numbers in subparagraph 14(a) were based on historical data from previous sessions of the Board. The Secretariat had determined that the number of items in non-budget years tended to average around 36 and the number in budget years had generally been about 10 more.

Dr AMMAR (Lebanon) pointed out that, if items that fulfilled only one of the agreed criteria could not be included on the provisional agenda of a session, they could be taken up in a future session.

Ms MATSOSO (South Africa) observed that if the provision in paragraph 10 of the draft decision – namely that progress reports would no longer be considered by the Board – had been in effect for the current session, the total number of items on the agenda would have been 51, which was close to the figure of 48 mentioned in subparagraph 14(a).

Mr KLEIMAN (Brazil) said that there was clear consensus on the need to keep agendas manageable. It was also clear that Board members wished to see greater transparency and participation by Member States in drawing up the provisional agendas. What was not clear, however, was the hierarchy of the criteria for the inclusion of items. Which criteria were most important? He shared the concerns of the member for Argentina regarding the limits proposed in subparagraph 14(a).

The CHAIRMAN said that the three criteria had the same weight.

The DIRECTOR-GENERAL, welcoming the consensus on the need to manage the governing body agendas in a reasonable manner, said that, if progress reports were removed from the Board's agenda, as provided in paragraph 10 of the draft decision which the Board had already approved, then the target numbers for items on the provisional agenda proposed in subparagraph 14(a) would appear feasible. She suggested that the Board apply the proposed changes on a trial basis. The Secretariat would keep a tally of the numbers of items actually placed on the provisional agenda during the trial period, and then the Board could reassess the situation.

Ms DÁVILA CHÁVEZ (Mexico) said that the Secretariat's explanations had made it clear that the numbers in paragraph 14(a) were not arbitrary but based on historical criteria. She shared the view of the member for Argentina on the need for further analysis of the implications of subparagraph 14(b). With regard to paragraph 17, it would be useful to have one criterion for urgent items and another for resolutions submitted after the deadline had passed.

Mr ROMERO PUENTES (Cuba) said that he continued to have reservations about the content of paragraph 14, particularly the limits on numbers of items on the provisional agenda and the prioritization of items. He therefore suggested that paragraph 14 should be deleted. Further analysis of paragraph 17 was needed in order to ensure that it took into account the different priorities of different regions.

The DIRECTOR-GENERAL suggested that the Board delete paragraphs 14 and 17 and proceed to implement the rest of the decision. She appealed to Member States to make every effort to adhere to the Rules of Procedure of the Executive Board and avoid late submission of proposals for supplementary agenda items.

Mr CASALS ALIS (Andorra) welcomed the suggestion made by the Director-General and said that paragraphs 15 and 16 should remain in the draft decision to enable more work to be done on the issue in future.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland),¹ welcoming the Director-General's suggestion, noted that, even without the progress reports, there would still have been 51 items on the agenda of the current session: dealing with that number of items adequately would still have been a challenge.

Mr KLEIMAN (Brazil) expressed support for the suggestion by the Director-General; he was confident that enhanced capacity-building and training for Board members would help to familiarize them with the Board's methods of work and thereby reinforce efforts to reduce the number of agenda items.

Dr BAYE LUKONG (Cameroon), endorsing the views expressed by the member for Andorra, said that it was particularly important to retain paragraph 15, which provided for a review of the results of implementing the decision.

The CHAIRMAN took it that the Executive Board wished to delete paragraphs 14, 16 and 17 and adopt the draft decision, as amended.

The decision, as amended, was adopted.²

Strategic resource allocation: Item 5.6 of the Agenda (Documents EB134/10 and EB134/10 Add.1) (continued from the sixth meeting)

The CHAIRMAN drew attention to the draft decision contained in document EB134/10 Add.1 and asked whether the Board was ready to adopt it.

The decision was adopted.³

The meeting rose at 18:20.

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

² Decision EB134(3).

³ Decision EB134(4).

THIRTEENTH MEETING

Saturday, 25 January 2014, at 09:45

Chairman: Professor J. HALTON (Australia)

1. HEALTH SYSTEMS: Item 9 of the Agenda (continued)

Access to essential medicines: Item 9.7 of the Agenda (Document EB134/31) (continued from the ninth meeting, section 1)

The CHAIRMAN drew attention to a draft resolution on access to essential medicines proposed by China, Libya, Republic of Korea and South Africa, with amendments proposed as a result of informal drafting meetings. The text read as follows:

The Executive Board,
Having considered the report on access to essential medicines,¹

RECOMMENDS to the Sixty-seventh World Health Assembly the adoption of the following resolution:

The Sixty-seventh World Health Assembly,

PP1 Noting that WHO's definition of an essential medicine² contains the following elements: "Essential medicines are those that satisfy the priority health care needs of the population"; "Essential medicines are selected with due regard to their public health relevance, evidence of efficacy and safety, and comparative cost-effectiveness";

PP2 Recalling World Health Assembly resolution WHA28.66 on prophylactic and therapeutic substances that relates to the formulation and implementation of medicines policies and pharmaceutical strategies; the Declaration of Alma-Ata in 1978 that recognized the provision of essential medicines as one of the pillars of primary health care, and subsequent World Health Assembly resolutions in relation to essential medicines such as resolution WHA54.11 on the WHO medicines strategy, WHA58.27 on improving the containment of antimicrobial resistance, WHA60.16 on the rational use of medicines, WHA60.20 on better medicines for children, WHA60.29 on health technologies, WHA61.21 on the global strategy and plan of action on public health, innovation and intellectual property, and WHA64.9 on sustainable health financing structures and universal coverage, as well as WHA66.10 on the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020, which, includes Target 9 on the availability of essential medicines required to treat noncommunicable diseases;

PP3 Bearing in mind that the WHO medicines strategy as captured in the Global Program of Work 2014–2019 is based on the principles of evidence-based selection of a limited range of medicines, efficient procurement and distribution systems, affordable prices, and the rational use of medicines in order to promote better management and

¹ Document EB134/31.

² TRS 985, report of the Expert Committee on Selection and Use of Essential Medicines, April 2013.

greater availability of medicines, more cost-effective use of health resources, and higher quality health care;

PP4 Considering that the effective implementation of the above principles is of critical importance to improving people's health, progressing towards universal health coverage and achieving the health-related Millennium Development Goals;

PP5 Welcoming WHO regional actions in support of greater access to and availability, affordability and rational use of safe, effective and quality-assured essential medicines, including the WHO Regional Office for the Western Pacific Regional Framework for Action on Access to Essential Medicines (2011–2016);

PP6 Acknowledging the complexity of the medicines supply chain **and the challenges that countries encounter in this regard**, the importance of good governance **for medicines programmes**¹, and the consequences of the high costs of medicines **which are the among the factors** that make accessing care and treatment unaffordable;

PP7 Aware that shortages of essential medicines are a global problem that has an impact on the care of patients, the causes and implications of which vary from one country to another and that there is insufficient information to determine the magnitude and specific characteristics of the problem;

PP8 Realizing the role of evidence-based clinical treatment guidelines to guide cost-effective treatment practices, the need for reliable and unbiased information to support rational prescribing, and the importance of increased health literacy to support patients and consumers to use medicines wisely;

PP9 Noting with concern that despite sustained efforts over a number of decades by Member States, the WHO Secretariat and partners, most low-income countries are still facing a multitude of challenges in improving the availability, affordability and rational use of essential medicines;

PP10 Noting that the goal of Member States is to increase access to affordable, safe, effective and quality-assured essential medicines, including as appropriate, through the full use of TRIPS flexibilities **as stated in in accordance with** the Global Strategy and Plan of Action on Public Health Innovation and Intellectual Property;

PP11 Noting that support for research and development is important for the sustainable supply of future essential medicines, to address public health needs,

(OP) 1. URGES Member States;²

(1) to recognize the need and provide adequate resources, as required, for the development of comprehensive national medicine policies, strengthened pharmaceutical regulatory, procurement and distribution systems and coordinated responses to address the complex and interrelated activities that affect access to essential medicines, in order to improve their availability, affordability, quality and rational use;

(2) to improve national essential medicine selection policies, particularly by using transparent, rigorous, evidence-based processes based on the methods of health technology assessment in selecting medicines for inclusion in the national essential medicines lists **according to each country's health needs and priorities**;

¹ In WHO Assessment Instrument for measuring transparency in the public pharmaceutical sector, **Good Governance** refers to the formulation and implementation of appropriate policies and procedures that ensure the effective, efficient and ethical management of pharmaceutical systems, in particular medicines regulatory systems and medicines supply systems, in a manner that is transparent, accountable, follows the rule of law and minimizes corruption.

² And, where applicable, regional economic integration organizations.

- (3) to encourage and support research on health systems regarding the procurement, supply and rational use of essential medicines;
- (4) to promote collaboration and strengthen the exchange of information on best practices in the development, implementation and evaluation of medicine policies and strategies, that enhance access to affordable, safe, effective and quality-assured essential medicines;
- (5) to place greater emphasis on medicines for children and to promote the availability, affordability, quality and safety of essential medicines for children through the development and manufacture of appropriate pediatric formulations and to facilitate market access to these medicines;
- (6) to improve the education and training of health care professionals in order to support the implementation of national policies and strategies in relation to essential medicines, and to develop and implement evidence-based clinical practice guidelines and other interventions for the rational use of essential medicines;
- (7) to strengthen the engagement with the general public and civil society to increase awareness and knowledge of essential medicines and public involvement in enhancing access to and the rational use of these medicines;
- (8) to identify key barriers to access to essential medicines and to develop strategies to address these barriers, making use of WHO tools¹ and guidance as appropriate;
- (9) to establish or strengthen, as appropriate, systems to monitor the availability, affordability and utilization of safe, effective and quality-assured essential medicines in public and private health facilities;
- (10) to systematize information collection and strengthen monitoring mechanisms, in order to better detect and understand the causes of essential medicines shortages, and to develop strategies to prevent and mitigate the associated problems and risk caused by shortages;
- (11) to consider, as appropriate, adapting national legislation in order to make full use of the provisions contained in the TRIPS agreement, including the flexibilities recognized by the Doha Ministerial Declaration on the TRIPS agreement and Public Health and other WTO instruments related to TRIPS agreement, in order to promote access to essential medicines, **as stated in ~~in accordance with~~ the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property;**

(OP) 2. REQUESTS the Director-General:

- (1) to urge Member States to recognize the importance of effective national medicines policies, and their implementation under good governance, in order to ensure equity of access to affordable, safe, effective and quality-assured essential medicines and their rational use in practice;
- (2) to facilitate and support the exchange of information and collaboration among Member States on best practices in the development and implementation of medicines policies;
- (3) to support Member States in sharing best practices in the selection of essential medicines and to facilitate collaboration between WHO and Member States in developing processes for the selection of medicines for national essential medicines lists consistent with the evidence-based methods used for updating the WHO Model List of Essential Medicines;

¹ Including but not limited to : WHO Pharmaceutical Sector Country Profile, WHO assessment Instrument for measuring transparency in the public pharmaceutical sector, WHO-HAI tool for measuring medicines prices, availability, affordability and price components, How to investigate drug use in health facilities.

- (4) to support Member States in building capacity for the evidence-based selection of essential medicines, the development and dissemination of and adherence to clinical practice guidelines and the promotion of other strategies for the rational use of affordable, safe, effective and quality-assured essential medicines by health care professionals and the public;
- (5) to support Member States in developing and implementing their national medicines policies and supply systems especially with regard to regulation, financing, selection, procurement, distribution, pricing, reimbursement and use, in order to increase their efficiency and ensure the access to safe, effective and quality-assured essential medicines, including high price essential medicines;
- (6) to support Member States in systematizing information collection and strengthening monitoring mechanisms, in order to better detect and understand the causes of essential medicines shortages, and in developing strategies to prevent and mitigate the associated problems and risk caused by shortages;
- (7) to urge Member States to expedite progress towards the achievement of the Millennium Development Goals and universal health coverage by, inter alia, implementing national medicines policies for improving access to affordable, safe, effective, and quality-assured essential medicines;
- (8) to provide, as appropriate, upon request, in collaboration with other competent international organizations, technical support, including, where appropriate, to policy processes, to Member States that intend to make use of the provisions contained in the TRIPS agreement, including the flexibilities recognized by the Doha Ministerial Declaration on the TRIPS agreement and Public Health and other WTO instruments related to TRIPS agreement, in order to promote access to essential medicines, in accordance with the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property;
- (9) to report to the Sixty-ninth World Health Assembly, through the Executive Board, on the implementation of the resolution.

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

<p>1. Resolution: Access to essential medicines</p>		
<p>2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)</p> <p>Category: 4. Health systems</p> <table> <tr> <td>Programme area: Access to medicines and health technologies and strengthening regulatory capacity</td> <td>Outcome: 4.3 Output: 4.3.3</td> </tr> </table> <p>Additional links to Categories 1, 2, 3 and 5</p> <p>How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?</p> <p>It would support achievement of improved access to and rational use of safe, efficacious and quality medicines and health technologies through: the development and implementation of national policies and best practices; regional approaches for sharing of information and experience; and provision by the Secretariat of support and guidance to countries for increasing and monitoring access to essential medicines.</p> <p>Does the programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)</p> <p>Yes.</p>	Programme area: Access to medicines and health technologies and strengthening regulatory capacity	Outcome: 4.3 Output: 4.3.3
Programme area: Access to medicines and health technologies and strengthening regulatory capacity	Outcome: 4.3 Output: 4.3.3	

3. Estimated cost and staffing implications in relation to the Programme budget**(a) Total cost**

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) Six years (covering the period 2014–2019)

(ii) Total: US\$ 18 million (staff: US\$ 8 million; activities: US\$ 10 million)

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 8.6 million (staff: US\$ 3.6 million; activities: US\$ 5.0 million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

Headquarters and all regional offices.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

If “no”, indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No, but recruitment will take place against approved positions that are included in the approved Programme budget.

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

Eight full-time equivalent staff would be required in the professional and higher categories (two at headquarters and six in the regional offices). The staff members concerned would have expertise in pricing, procurement and supply and rational use of medicines and health products.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

The gap is estimated at US\$ 5.6 million. This funding gap will be tackled as part of the Organization-wide coordinated resource mobilization plan to deal with funding shortfalls in the Programme budget 2014–2015.

Mr MAMACOS (United States of America)¹ said that he could not agree to the replacement in the tenth preambular paragraph and in subparagraph 1(11) of “in accordance with” by “as stated in”, as proposed during the third meeting of the informal drafting group, about which meeting his delegation had not been informed. Although he recognized that access to essential medicines was a key part of public health, he said that “in accordance with” better explained the context of the draft resolution with regard to the global strategy and plan of action on public health, innovation and intellectual property. If that was not possible, he proposed adding the words “, also recognizing that the protection of intellectual property is important for the development of new medicines ...” before “as stated in” in both the aforementioned paragraphs. As a direct quotation from the global strategy and plan of action, the language should be acceptable.

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

Dr WARIDA (Egypt) said that, as drafting meetings for various draft resolutions had been held in parallel, he had been unable to participate fully in discussions on the draft resolution. The concept of flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property (TRIPS) referred to in the two paragraphs under discussion recalled resolution WHA61.21 on the global strategy and plan of action on public health, innovation and intellectual property, and the phrase “as stated in” or similar phrases was intended to reflect the letter and spirit of the resolution. The use of “in accordance with” would limit Member States’ ability to interpret the flexibilities in the TRIPS agreement. The importance of intellectual property in promoting and encouraging new inventions, as contained in that agreement, was not in doubt, but it was important to consider the best use of those flexibilities in order to promote access to essential medicines.

Mrs ESCOREL DE MORAES (Brazil) said that it was extremely disappointing that similar discussions arose each time flexibilities in the TRIPS agreement were referred to in a draft resolution, as that agreement and its related resolutions had been approved by all Member States. The statement made by the member for South Africa during the ninth meeting had emphasized the difficulties facing Member States and the importance of the draft resolution. Agreement on the paragraphs in question had been reached after extensive negotiations, and she asked the representative of the United States of America to be flexible. In a spirit of compromise, she proposed replacing “as stated in” with “in line with”.

Ms DUSSEY-CAVASSINI (Switzerland) supported the comments made by the representative of the United States of America. Concerning the proposal made by the member for Brazil, she understood that “in line with” and “in accordance with” had similar meanings, and she expressed a preference for the latter.

Ms MATSOSO (South Africa) thanked the member for Brazil for her helpful proposal, which would accommodate various points of view, take into account the provisions of resolution WHA61.21 and benefit countries like South Africa in their current situation.

Mr ROMERO PUENTES (Cuba) asked that Cuba be added to the list of sponsors of the draft resolution. He recalled that the use of “as stated in” had been accepted by the Board on previous occasions and should therefore be acceptable. However, he would also accept the proposal made by the member for Brazil.

Mr COTTERELL (Australia), expressing sympathy with the situation in South Africa, said that Australia had no objections to the inclusion of a reference to the flexibilities in the TRIPS agreement, which also related to the situation in his country. Although he would prefer the words “in accordance with”, and he had been unaware of the third drafting meeting, he was prepared to accept the compromise proposed by the member for Brazil.

Dr NCHABI KAMWI (Namibia), recognizing the continuing situation in South Africa, supported the draft resolution and said that Namibia wished to be added to the list of sponsors.

Dr SHAKEELA (Maldives) supported the adoption of the draft resolution without further amendment. Access to essential medicines was of great importance in her country, and it would be disastrous if the draft resolution were not adopted because of one word. Expressing deep sympathy for the situation of South Africa, she wished to add her country to the list of sponsors. She was prepared to accept the compromise proposed by the member for Brazil.

Dr AMMAR (Lebanon) asked that Lebanon be added to the list of sponsors, and supported the compromise proposed by the member for Brazil.

Dr BAYE LUKONG (Cameroon) expressed disappointment at the state of the discussion. Currently, South Africa and Australia were facing difficult situations, as might any other country in the future. She supported the compromise proposed by the member for Brazil and said that Cameroon wished to be added to the list of sponsors.

Mr PIPPO BRIANT (Argentina) was dismayed by the repeated discussion of the flexibilities in the TRIPS agreement. Acknowledging the statement made by the member for South Africa in the ninth meeting, he firmly supported the proposal made by the member for Brazil.

Dr VALVERDE (Panama), recalling the statement made previously by the member for South Africa, stressed the importance globally of the effective management of medicines and resources and provision of higher-quality health care services. She noted the concerns expressed by the representative of the United States of America, but nevertheless supported the proposal made by the member for Brazil and wished her country to be added to the list of sponsors.

Mr MAMACOS (United States of America)¹ said that, having listened to the discussion and noting that, in his understanding, “in line with” did reflect the full context of the global strategy and plan of action, he accepted the proposal made by the member for Brazil.

Ms DUSSEY-CAVASSINI (Switzerland) accepted the compromise proposed by the member for Brazil.

Dr REN Minghui (China)¹ expressed appreciation of the discussions, given the importance of access to essential medicines. The three phrases under discussion: “as stated in”, “in line with”, and “in accordance with” had almost the same meaning in Chinese, and as such all three would be acceptable.

Mrs ESCOREL DE MORAES (Brazil) said that Brazil would also like to be a sponsor of the draft resolution, given that an acceptable compromise had been reached.

Mr ALIMUZZAMAN (Bangladesh)¹ strongly supported the draft resolution and asked that Bangladesh be added to the list of sponsors.

Mr COTTERELL (Australia) thanked the representative of China for leading discussions on the draft resolution and said that Australia would like to be added to the list of sponsors.

Ms MATSOSO (South Africa) thanked all the Member States that had supported the draft resolution.

Dr WARIDA (Egypt) asked the Secretariat to correct the language in the sixth preambular paragraph.

The CHAIRMAN took it that the Board wished to adopt the draft resolution on access to essential medicines, as amended.

The resolution, as amended, was adopted.²

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

² Resolution EB134.R16.

Regulatory system strengthening: Item 9.5 of the Agenda (Document EB134/29) (continued from the ninth meeting, section 1)

The CHAIRMAN drew attention to the first of two draft resolutions under the agenda item, the second of which would be discussed later.¹ The first, on regulatory system strengthening for medical products, revised in the light of comments made by members, was proposed by Australia, Mexico, Nigeria, South Africa, Switzerland and the United States of America and read:

The Executive Board,
Having considered the report on regulatory system strengthening,²

RECOMMENDS to the Sixty-seventh World Health Assembly the adoption of the following resolution:

The Sixty-seventh World Health Assembly,

(PP1) Welcoming the efforts of the Director-General, and recognizing the pivotal role that WHO plays in supporting countries in strengthening their regulatory systems of medical products for human use³ **and in promoting equitable access to quality, safe, efficacious, and affordable medical products;**

(PP2) Recalling the WHO Constitution, which affirms that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

(PP3) Recalling also United Nations General Assembly Resolution 67/81 on global health and foreign policy, which recognized the importance of universal coverage in national health systems, especially through primary health care and social protection mechanisms, to provide access to health services for all, in particular for the poorest segments of the population;

(PP4) Recalling further resolutions WHA45.17, WHA47.17, WHA52.19, WHA54.11, WHA59.24, WHA63.12, and WHA65.19, all of which encompass aspects of the need to promote the quality, safety, efficaciousness and affordability of medicines, including blood products;

[(PP4bis) Reaffirming WHA65.19 which establishes a new Member States mechanism for international collaboration from a public health prospective to prevent and control substandard/spurious/false-labelled/falsified/counterfeit medical products and to promote access to affordable safe and quality medical products;]

(PP5) Recognizing that effective regulatory systems are an essential component of ~~strong~~ health systems **strengthening** and contribute to better public health outcomes, that regulators are an essential part of the health workforce, and that inefficient regulatory systems themselves can be a barrier to access to safe, effective and quality medical products;

(PP6) Recognizing also that effective regulatory systems are necessary for implementing universal health coverage, responding to the dual burden of infectious and noncommunicable diseases, and achieving Millennium Development Goals 4, 5 and 6;

(PP7) Aware that health systems need to **promote** ~~avoid the lack of~~ access to essential ~~medicines~~ **medical products** and ~~the proliferation of substandard, spurious,~~

¹ See the summary record of the fourteenth meeting, section 1.

² Document EB134/29.

³ For the purpose of this resolution, medical products include medicines, vaccines, diagnostics, and medical devices.

~~falsely labelled, falsified, and counterfeit (SSFFC) medical products~~ in order to ensure universal access to health care, rational use of medicines and the sustainability of health systems, ~~and aware that~~ urgent action is needed by the international community, Member States and relevant actors in health systems;

(PP8) Very concerned by the impact on patients of ~~unsafe, poor quality~~ medical products of **compromised quality, safety and efficacy**, in terms of poisoning, inadequate or no treatment, contributions to drug resistance, the related economic burden, and erosion of public trust in the health system;

(PP9) Aware of the **regulatory challenges presented by** ever-increasing complexities of medical product global supply chains;

(PP10) Emphasizing WHO's role in strengthening regulatory systems for medical products from a public health perspective **and in supporting national drug regulatory authorities and relevant regional bodies in this area, and in particular developing countries**;

(PP11) Recalling the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property, in particular element three, which calls for establishing and strengthening regulatory capacity in developing countries as one effective policy for building and improving innovative capacity, and element six, which promotes establishing and strengthening mechanisms to improve ethical review and regulate the quality, safety and efficacy of health products and medical devices;

(PP12) ~~Welcoming~~ **Noting with appreciation** the many national and regional efforts to strengthen regulatory capacity (including through a variety of models), improve regulatory coherence and convergence among regulatory authorities, and enhance good governance, including transparency in decision-making, leading to improved availability of quality, safe, efficacious and affordable medical products, such as the European Union regulatory framework for medical products, work under way in PAHO following its 2010 resolution CD50.R9, the African Medicines Regulatory Harmonization Initiative, and the regulatory harmonization and cooperation work in the Association of Southeast Asian Nations (ASEAN);

(PP13) Also ~~welcoming~~ **noting with appreciation** the ~~intensive and~~ ongoing collaboration between ~~some~~ national regulatory authorities **including at the global level** in setting standards including the International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH) among others, and encouraging a continued emphasis of effort in ~~developing better~~ **strengthening** regulatory systems **in accordance with WHO principles and guidelines**;

(PP14) Recognizing the significant investments made in the procurement of medicines through global health initiatives, national health budgets, and in particular the essential role of WHO's prequalification programme and national regulatory systems in assuring the safety, quality, and efficacy of these medical products;

(PP15) Recalling the WHO ~~and ICH~~ good clinical practices that focus on the protection of human research subjects;

(PP16) Recalling WHO's ongoing reform agenda and welcoming in this regard the establishment in November 2012 of the Health Systems and Innovation cluster,

(OP) 1. URGES Member States:¹

- (1) to strengthen national regulatory systems by, as appropriate:
 - (a) undergoing self-evaluations, including ~~with through~~ **WHO support - coordinated evaluations**, to identify the strengths and opportunities for improvement in regulatory system functions, as a first step towards

¹ And, where applicable, regional economic integration organizations.

- formulating plans for regulatory systems strengthening, including through WHO-coordinated institutional development plans;
- (b) collecting data on regulatory systems performance to enable analysis and benchmarking for improved systems in the future;
 - (c) developing strong legal foundations and political leadership to underpin a regulatory system with a clear focus on patient safety and transparency in decision-making;
 - (d) identifying and developing a core set of regulatory functions, ~~including with reference to WHO identified functions~~, to meet country and/or regional needs (e.g. market control, postmarket surveillance);
 - (e) developing needed competencies as an integral part **of, although not limited to,** of the health workforce, and encouraging the development of the regulatory field as a profession;
 - (f) implementing relevant guidance and science-based outputs of international regulatory harmonization and convergence efforts **such as, where applicable,** ~~including~~ the *Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH)*;
 - (g) implementing strategies to address the increasing complexities of global supply chains;
- (2) to engage in global, regional and subregional networks of national regulatory authorities, as appropriate, recognizing the importance of ~~networking approaches~~ **collaboration** to pool regulatory capacities to promote greater access to quality, safe, efficacious and affordable medical products;
 - (3) to **promote** ~~strengthen~~ international cooperation, **as appropriate, for** convergence and information sharing, including through electronic platforms, ~~to achieve the common goal of securing supply chains for and access to quality, safe, efficacious and affordable medical products;~~
 - (4) to support regulatory systems for medical products with appropriate funding as an essential component of the health system;
 - (5) to support regulatory systems strengthening as an essential prerequisite to the development or expansion of local or regional production of **quality, safe and efficacious** medical products ~~meeting international standards for quality, safety and efficacy;~~
 - (6) to achieve access to and rational use of quality, **safe, efficacious and affordable** essential medicines, noting the growing emergence of resistance, and as a foundation for achieving broader access to quality, safe, efficacious and affordable medical products;
 - (7) to support WHO's institutional capacity relating to promoting access to and rational use of quality, safe, efficacious and affordable medical products in the context of universal health coverage;
 - (8) [to support WHO in its efforts to strengthen its prequalification programmes, including exploring modalities in consultation with Member States¹ for improved sustainability of this critical programme, [while also focusing on supporting national and regional initiatives to improve regulatory capacity for medical products][**Focusing on achieving longer term objectives of developing national regulatory authority capacity among Member States**];]
 - (9) to identify the need to strengthen regulatory systems capacity, collaboration and convergence in the technically complex areas where substantial gaps may still exist such as regulation of biotherapeutic products ~~that are similar in terms of~~

¹ And, where applicable, regional economic integration organizations.

~~quality, safety and efficacy to a licensed reference biotherapeutic products,~~
blood products, and in vitro diagnostics;

~~(10) to engage in international networks of national regulators to monitor development of new medicines for human use based on gene therapy, somatic cell therapy and tissue engineering in order to identify at an early stage the need to develop or adapt regulatory environments;~~

(OP) 2. REQUESTS the Director-General:

(1) to continue to support countries in the area of regulatory systems strengthening ~~through~~ **including by** developing **appropriate and promoting relevant global** norms and standards [taking account the standards created by existing regional and international initiatives]; continue evaluating national regulatory systems; continue applying and improving WHO evaluation tools; continue generating and analysing evidence of regulatory systems performance; continue facilitating the formulation and implementation of institutional development plans; and continue providing technical support to national regulatory authorities and governments;

(2) to ensure that all relevant parts of the organization at all levels are actively engaged and coordinated in the carrying out of WHO's mandate pertaining to regulatory systems strengthening as an integrated part of health systems development, recognizing that WHO's support on this critical area, particularly for developing countries, may be required, as appropriate, well into the future;

(3) to prioritize support to establishing and strengthening regional and subregional networks of regulatory authorities as appropriate, including strengthening areas of regulation of health products which are the least developed such as regulation of medical devices including diagnostics;

(4) [to promote the greater participation of Member States in existing international and regional initiatives for collaboration, harmonization and convergence **in accordance with WHO principles and guidelines**];

(5) [to strengthen the integration and coherence among WHO's prequalification programmes as an aid to ~~securing~~ **assuring** safe supply of quality medical products, engaging with Member States in the further refinement and improvement of the global prequalification model, while in parallel supporting the development of functional national and regional regulatory bodies and networks, leading to more global participation in the global prequalification programme];

(6) to increase support for and recognition of the significant role of the International Conference of Drug Regulatory Authorities (ICDRAs) in promoting the exchange of information and collaborative approaches among drug regulatory authorities, and as a resource to guide and facilitate further development of and regulatory harmonization and convergence among these authorities;

~~(7) [to engage the relevant global donor community and global health programmes on~~ **to raise awareness of** the importance of **strong effective** regulatory systems within the health systems context];

~~(8) to assess the role that regulatory systems have played in implementation of the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property when following up on instructions from the 133rd Executive Board in reviewing and evaluating the success of the GSPOA;~~

(9) to increase support and guidance for strengthening the capacity to regulate increasingly complex biological products with the focus on biotherapeutic products ~~that are similar in terms of quality, safety and efficacy to a licensed reference biotherapeutic products~~, blood products and associated in vitro diagnostics, and where appropriate on new medicines for human use based on gene therapy, somatic-cell therapy and tissue engineering;

(10) to report to the Seventieth and Seventy-second World Health Assemblies, through the Executive Board, on progress on the implementation of this resolution.

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

<p>1. Resolution: Regulatory system strengthening</p>		
<p>2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)</p> <p>Category: 4. Health systems</p> <table> <tr> <td>Programme area(s): Access to medicines and health technologies and strengthening regulatory capacity</td> <td>Outcome: 4.3 Output: 4.3.3</td> </tr> </table> <p>Additional links with Categories 1, 2, 3 and 5</p> <p>How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?</p> <p>This resolution would enhance strengthening of regulatory capacity worldwide to ensure the quality, safety and efficacy of medicines and other health technologies, through: improving assessment tools and their implementation; providing technical support and training to regulatory bodies; providing guidance on evaluation of new product classes; supporting and fostering regional and subregional networks and convergence of regulatory requirements; and strengthening of pharmacovigilance systems. It would also strengthen the WHO prequalification programme and allow prequalification of new classes of medicines.</p> <p>Safe, effective and affordable medicines and health products are an essential element of universal health coverage, attainment of the Millennium Development Goals, dealing with the growing burden of noncommunicable diseases, and fighting epidemics and pandemics.</p> <p>Does the programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)</p> <p>Yes.</p>	Programme area(s): Access to medicines and health technologies and strengthening regulatory capacity	Outcome: 4.3 Output: 4.3.3
Programme area(s): Access to medicines and health technologies and strengthening regulatory capacity	Outcome: 4.3 Output: 4.3.3	
<p>3. Estimated cost and staffing implications in relation to the Programme budget</p> <p>(a) Total cost</p> <p>Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).</p> <p>Current estimates are for a duration of 10 years (2014–2024) for a total cost of up to US\$ 250 million. Costs and staffing in relation to this strategy will be included in each of the biennial budgets during the lifespan of the strategy, based on a realistic costing of outputs and deliverables related to the work planned for each of the respective programme budget periods starting with the programme budget for the biennium 2016–2017.</p> <p>(b) Cost for the biennium 2014–2015</p> <p>Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).</p> <p>Total: US\$ 30 million (staff: US\$11.5 million; activities: US\$ 18.5 million)</p> <p>Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.</p> <p>Costs will be incurred at headquarters, all WHO regional offices and certain country offices.</p> <p>Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)</p> <p>No.</p> <p>If “no”, indicate how much is not included.</p> <p>US\$ 25 million would be required to implement the full scope of this resolution, taking into account, for example, the increased breadth and depth of support to be provided to regional regulatory networks and for global collaboration and information exchange, prequalification of essential new classes of medicines and strengthening of pharmacovigilance.</p>		

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No.

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

A total of 18 additional full-time equivalent staff members in the professional and higher categories would be needed (headquarters: three full-time equivalents; regional and subregional offices: two full-time equivalents; regional offices: two full-time equivalents per office; and in the three Intercountry Teams in the African Region: one per team.). These staff should have a background in regulatory expertise, experience working in developing countries and some experience in working in an international environment.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

The gap currently is estimated at US\$ 25 million.

This funding gap will be tackled as part of the Organization-wide coordinated resource mobilization plan to deal with funding shortfalls in the Programme budget 2014–2015.

Mr McIFF (United States of America),¹ as a sponsor of the draft resolution, said that the list of sponsors should include Japan. The revised text reflected the lively discussions in the drafting group. The draft resolution contained text in square brackets, some of which required further discussion before the Sixty-seventh World Health Assembly and some of which should be forwarded to the Health Assembly still in brackets for its consideration. The latter group comprised preambular paragraph 4bis and subparagraphs 1(8) and 2(5). In addition, he asked that square brackets be placed around the ninth preambular paragraph and subparagraph 1(1)(g), and removed from subparagraphs 2(1), 2(4) and 2(7). The paragraphs that required discussion primarily related to the Member State mechanism on substandard/spurious/falsely-labelled/falsified/counterfeit medical products, concerning the impact of the draft resolution on supply chains and strengthening prequalification programmes. The English version of preambular paragraph 4bis needed editing, including the replacement of “prospective” by “perspective”. The rest of the amendments, indicated by the use of bold type or strikethrough, had been agreed and should be accepted as written.

The CHAIRMAN said that, owing to the need for further discussion as indicated by the presence of square brackets, the recommendation to the Health Assembly in the third line of the draft resolution should be amended by adding “the consideration and” before “adoption”.

Mrs ESCOREL DE MORAES (Brazil) asked to retain the square brackets in subparagraph 2(1) as she had a major concern with the concept contained therein.

Dr ASADI-LARI (Islamic Republic of Iran), noting the essential role of national regulatory authorities in ensuring access to quality-assured medical products, urged the Secretariat to continue its efforts to assess and strengthen regulatory capacity in low- and middle-income countries, as well as regional and subregional networks of regulatory authorities. In collaboration with Member States, the Secretariat should identify a sustainable funding mechanism to continue that long-term work. Therefore, the draft resolution should be adopted as it stood.

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

Mr ROMERO PUENTES (Cuba) shared the concerns expressed by some Member States, and agreed to the retention of square brackets around those paragraphs mentioned by the representative of the United States of America, but asked for retention also of the square brackets in subparagraph 2(1). He further requested the inclusion of the thirteenth preambular paragraph in square brackets.

Mr KOTALWAR (India),¹ acknowledging the work done by the United States of America in leading the discussions in the drafting group, expressed appreciation that his delegation's concerns were reflected in the revised text. He asked that square brackets be also placed around subparagraph 1(1)(f). He looked forward to further discussions to finalize the draft resolution before the Health Assembly in May.

Ms MATSOSO (South Africa) agreed with the square brackets that had been requested by the members for Brazil and Cuba and the representative of the United States of America. With regard to subparagraph 1(1)(f), she said that the International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use was a partnership among regulatory authorities and experts from the European Union, the United States of America and Japan. Reference solely to that specific grouping could restrict smaller harmonization initiatives, especially in Africa. Further discussion should be held to find a less restrictive textual formulation, and she therefore supported the proposal made by the representative of India.

Dr REYNDERS (Belgium) recognized the importance of strengthening regulatory systems to improve equitable access to quality, safe and affordable medical products. Although he supported recommending the draft resolution to the Sixty-seventh World Health Assembly for consideration, he expressed concerns about the associated financial and administrative implications, which were not covered by the Programme budget 2014–2015. He asked the Director-General to submit options to the Health Assembly for filling the funding gap.

Dr HE Li (China)¹ said that strengthening national regulatory systems was an important step towards universal health coverage, both for medical products and food safety. In March 2013, China had reorganized its regulatory system administration, establishing a China Food and Drug Administration, bringing together several former national health agencies and committees. Collaboration with the Secretariat was important in many areas; for example, in China, the regulatory systems had been evaluated by the Secretariat. She hoped that that collaboration would continue. Although she supported the draft resolution, she reserved the right to make amendments in the future, and looked forward to discussions during the Sixty-seventh World Health Assembly.

Mr ALIMUZZAMAN (Bangladesh)¹ welcomed the report, and acknowledged the leadership of the United States of America in the drafting group. He looked forward to working with other Member States to reach consensus in the future.

Dr KIENY (Assistant Director-General), responding to the request made by the member for Belgium for updated cost implications for the draft resolution, said that, as the draft resolution was still being amended, its financial and administrative implications would be revised accordingly before the Sixty-seventh World Health Assembly.

The CHAIRMAN asked if the Board was ready to submit the draft resolution, as amended, to the Sixty-seventh World Health Assembly for its consideration, noting the need for further work before the Health Assembly, including the financial and administrative implications.

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

It was so agreed, and the resolution, as amended, was adopted.¹

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

2. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 10 of the Agenda (continued)

Hepatitis: Item 10.5 of the Agenda (Document EB134/36) (continued from the fourth meeting, section 3)

The CHAIRMAN drew attention to a revised draft resolution on hepatitis proposed by Brazil, Colombia, Costa Rica, Egypt, Iran (Islamic Republic of), Kuwait, Lebanon, Libya, Oman, Qatar, Republic of Moldova, Saudi Arabia, South Africa and Tunisia, which read:

The Executive Board,
Having considered the report on hepatitis,²

RECOMMENDS to the Sixty-seventh World Health Assembly the adoption of the following resolution:

The Sixty-seventh World Health Assembly,

(PP01) Reaffirming resolution WHA63.18, adopted in 2010 by the World Health Assembly, which recognised viral hepatitis as a global public health problem and the need for governments and populations to take action to prevent, diagnose and treat viral hepatitis and that called upon WHO to develop and implement a comprehensive global strategy to support these efforts, and expressing concern at the slow pace of implementation;

(PP02) Recalling also resolution WHA45.17 on immunization and vaccine quality, which urged Member States to include hepatitis B vaccines in national immunization programmes, and concerned that currently the global hepatitis B vaccine coverage for infants is estimated at 75% and is therefore below the 90% global target;

(PP03) Recalling further resolution WHA61.21, which adopted the Global Strategy and Plan of Action on Public Health Innovation and Intellectual Property;

(PP04) Noting with deep concern that viral hepatitis is now responsible for 1.4 million deaths every year (compared to 1.5 million deaths from HIV/AIDS and 1.2 million deaths from each of malaria and TB), that around 500 million people are currently living with viral hepatitis and some 2 billion have been infected with hepatitis B virus (HBV), and considering that most people with chronic hepatitis B or C are unaware of their infection and are at serious risk of developing cirrhosis or liver cancer, contributing to global increases in both of these chronic diseases;

(PP05) Also noting that millions of acute infections with hepatitis A virus (HAV) and hepatitis E virus (HEV) occur annually and result in tens of thousands of deaths almost exclusively in lower and middle income countries;

(PP06) Considering that while hepatitis C is not preventable by vaccination, current treatment regimens offer high cure rates which are expected to further improve with upcoming new treatments; and that while hepatitis B is preventable with a safe and

¹ Resolution EB134.R17.

² Document EB134/36.

effective vaccine, there are 240 million people living with HBV infection and available effective therapies could prevent cirrhosis and liver cancer among many of those infected;

(PP07) Expressing concern that preventive measures are not universally implemented and that equitable access to and availability of quality, effective, affordable and safe diagnostics and treatment regimens for both hepatitis B and C is lacking in many parts of the world, particularly in developing countries;

(PP08) Recognizing the role of health promotion and prevention in the fight against viral hepatitis, and emphasizing the importance of strengthening vaccination strategies as high impact and cost effective actions for public health;

(PP09) Noting with concern that globally, the birth dose coverage rate with hepatitis B vaccine remains unacceptably low;

(PP10) Acknowledging also that in Asia and Africa hepatitis A and E continue to cause major outbreaks while a safe effective hepatitis A vaccine has been available for nearly two decades and that hepatitis E vaccine candidates have been developed but not yet certified by the WHO, and that lack of basic hygiene and sanitation promotes the risks of HAV and HEV transmission and most vulnerable populations do not have that access to these vaccines;

(PP11) Taking into account that injection overuse and unsafe practices account for a substantial burden of death and disability worldwide, with an estimated 2 million HBV and 500 000 hepatitis C virus (HCV) infections in 2010;

(PP12) Recognising the need for safe blood to be available to blood recipients, as established by resolution WHA28.72 on utilization and supply of human blood and blood products, which recommended the development of national public services for blood donation, and in resolution WHA58.13, which agreed to the establishment of an annual World Blood Donor Day, and considering that one of the main routes of transmission of HBV and HCV is parenteral;

(PP13) Further recognising the need to strengthen health systems and integrate collaborative approaches and synergies between prevention and control measures for viral hepatitis and those for infectious diseases such as HIV and other related sexually transmitted and bloodborne infections, other mother-to-child transmitted diseases, as well as for cancer and noncommunicable disease programmes;

(PP14) Recalling UNGA resolution 65/277 (paragraph 59(h)) and that the nine core interventions¹ mentioned in the “WHO/UNODC/UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users” are important components for both HBV and HCV prevention, diagnosis and treatment, and that access to these remain limited or absent in many countries of high HBV and HCV burden;

(PP15) Cognizant of the fact that 4–5 million people living with HIV are coinfecting with HCV and over 3 million are coinfecting with HBV, which has become a major cause of disability and mortality amongst those taking antiretroviral therapy;

(PP16) Taking into account that viral hepatitis is a major problem within indigenous communities in some countries;

(PP17) Welcoming the development by WHO of a global strategy, within a health systems approach, on prevention and control of viral hepatitis infection;²

¹ Needle and syringe programmes; opioid substitution therapy and other drug dependence treatment; HIV testing and counselling; antiretroviral therapy; prevention and treatment of sexually transmitted infections; condom programmes for injecting drug users (IDUs) and their sexual partners; targeted information, education and communication for IDUs and their sexual partners; vaccination, diagnosis and treatment of viral hepatitis; prevention, diagnosis and treatment of tuberculosis.

² “Prevention and control of viral hepatitis infection: framework for global action”.

(PP18) Considering that most Member States lack adequate surveillance systems for viral hepatitis to enable them to take evidence-based policy decisions;

(PP19) Taking into account that a periodic evaluation of implementation of the WHO strategy is crucial to monitor the global response to viral hepatitis and that the process was initiated with the 2013 publication of the *Global policy report on the prevention and control of viral hepatitis in WHO Member States*;

(PP20) Acknowledging the need to reduce liver cancer mortality rates and that viral hepatitis are responsible for 78% of cases of primary liver cancer and welcoming the inclusion of an indicator on hepatitis B vaccination in the comprehensive global monitoring framework adopted in resolution WHA 66.10 on noncommunicable diseases;

(PP21) Acknowledging the need to fight and to eliminate stigma and discrimination against people living with or affected by viral hepatitis and determined to protect and safeguard their human rights,

(OP) 1. URGES Member States:¹

- (1) to develop and implement coordinated multisectoral national strategies for preventing, diagnosing, and treating viral hepatitis based on local epidemiological context;
- (2) to enhance actions related to health promotion and prevention of viral hepatitis, while stimulating and strengthening immunization strategies, including for hepatitis A, based on local epidemiological context;
- (3) to promote the involvement of civil society in all aspects of preventing, diagnosing and treating viral hepatitis;
- (4) to put in place an adequate surveillance system for viral hepatitis to support decision-making on evidence-based policy;
- (5) to strengthen the system for collection of blood from low-risk, voluntary, non-remunerated donors, for quality-assured screening of all donated blood for HIV, hepatitis B, hepatitis C and syphilis, and for good transfusion practices to ensure patient safety;
- (6) to strengthen the system for quality-assured screening for HIV, hepatitis B, hepatitis C and syphilis of all donors of tissues and organs;
- (7) to reduce the prevalence of chronic hepatitis B infection as proposed by WHO Regional Committees, in particular by enhancing efforts to prevent perinatal transmission through the delivery of hepatitis B vaccine birth dose;
- (8) to strengthen measures for the prevention of hepatitis A and E, in particular food and drinking-water safety and hygiene promotion;
- (9) to strengthen infection control in health care settings through all necessary measures to prevent the re-use of equipment designed only for single use, and cleaning and either high-level disinfection or sterilization, as appropriate, of multi-use equipment;
- (10) to include, where appropriate, in national immunization programmes hepatitis B vaccine for infants, working towards full coverage;
- (11) to make special provision in policies for the equitable access to prevention, diagnosis and treatment for populations affected by viral hepatitis particularly indigenous people, migrants and vulnerable groups, where applicable;
- (12) to consider, as necessary, national legislative mechanisms for the use of the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual

¹ And, where applicable, regional economic integration organizations.

Property Rights (IPR) in order to promote access to specific pharmaceutical products;¹

(13) to consider, whenever necessary, the use of administrative and legal means in order to promote access to preventive, diagnostic and treatment technologies against viral hepatitis;

(14) **[to establish as appropriate, national harm reduction policies based on national legislation, policies and procedures, while using WHO standards,;]²**

(14) **[ALT OP8: to implement, in line with the UNGA resolution 65/277 (paragraph 59(h)), [harm reduction programmes] taking into account the nine core interventions” included in the “WHO /UNODC/UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users” when establishing policies for the prevention, control and treatment of viral hepatitis, taking into account the domestic context and jurisdictional responsibility.]**

(15) to aim to transition by 2017 to the exclusive use, where appropriate, of WHO prequalified or equivalent safety engineered injection devices including Reuse Prevention (RUP) syringes and Sharp Injury Prevention (SIP) devices for therapeutic injections and develop related national policies;

(16) to review, as appropriate, policies, procedures and practices associated with stigma and discrimination, including the denial of employment, training, education, as well as travel restrictions, against people living with and affected by viral hepatitis, or impairing them from the full enjoyment of the highest attainable standard of health;

(OP) 2. REQUESTS the WHO’s Director-General:

(1) to provide the necessary technical support to enable countries to develop robust national viral hepatitis prevention, diagnosis and treatment strategies with time-bound goals;

(2) to develop specific guidelines on adequate, effective, affordable algorithms for diagnosis in developing countries;

(3) in consultation with Member States, to develop a system for regular monitoring and reporting on the progress in viral hepatitis prevention, diagnosis and treatment;

(4) to provide technical guidance on cost-effective ways to integrate the prevention, testing, care and treatment of viral hepatitis into existing health care systems and make best use of existing infrastructure and strategies;

(5) to work with national authorities upon their request, to promote comprehensive, equitable access to prevention, diagnosis and treatment for viral hepatitis, with particular attention to needle and syringe programmes and OST or other evidence-based drug treatments for people who inject drugs, in national plans, taking into consideration national policy context and procedures and to assist countries, upon request, to implement these measures;

¹ The WTO General Council in its Decision of 30 August 2003 (i.e. on Implementation of paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health) decided that “‘pharmaceutical product’ means any patented product, or product manufactured through a patented process, of the pharmaceutical sector needed to address the public health problems as recognized in paragraph 1 of the Declaration. It is understood that active ingredients necessary for its manufacture and diagnostic kits needed for its use would be included.”.

² Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva: World Health Organization, United Nations Office on Drugs and Crime, Joint United Nations Programme on HIV/AIDS 2009.

- (6) to provide technical guidance on prevention of transfusion-transmitted hepatitis B and C through safe donation from low-risk voluntary non-remunerated donors, counselling, referral and treatment of infected donors, and effective blood screening;
- (7) to examine the feasibility of and strategies needed for the elimination of hepatitis B and hepatitis C with a view to potentially setting global targets;
- (8) to estimate global, regional and domestic economic impact and burden of viral hepatitis in collaboration with Member States and relevant organizations taking into due account potential and perceived conflicts of interest;
- (9) to support Member States with technical assistance in the use of TRIPS flexibilities when needed, in accordance with the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property;
- (10) to lead a discussion and work with key stakeholders to facilitate equitable access to quality, effective, affordable and safe hepatitis B and C treatments and diagnostics;
- (11) to assist Member States to ensure equitable access to quality, effective, affordable and safe hepatitis B and C treatments and diagnostics, in particular in developing countries;
- (12) to maximize synergies between viral hepatitis prevention, diagnosis and treatment programmes and ongoing work to implement the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020;
- (13) to report to the Sixty-ninth World Health Assembly, or earlier if needed, through the Executive Board, on the implementation of this resolution;

(OP) 3. CALLS upon all relevant United Nations funds, programmes, specialized agencies and other stakeholders:

- (1) to include prevention, diagnosis and treatment of viral hepatitis in their respective work programmes and work in close collaboration;
- (2) to identify and disseminate mechanisms to assist countries in the provision of sustainable funding for prevention, diagnosis and treatment of viral hepatitis.

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

1. Resolution: Hepatitis	
2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)	
Category: 1. Communicable diseases	
Programme area: HIV/AIDS	Outcome: 1.1 Output: 1.1.2
Programme area: Vaccine-preventable diseases	Outcome: 1.5 Output: 1.5.2
Category: 4. Health systems	
Programme area: Integrated, people-centred health services	Outcome: 4.2 Output: 4.2.3
Programme area: Access to medicines and health technologies and strengthening regulatory capacity	Outcome: 4.3 Output: 4.3.1
Category: 5. Preparedness, surveillance and response	
Programme area: Alert and response capacities	Outcome: 5.1 Output: 5.1.1
Programme area: Epidemic-prone and pandemic-prone diseases	Outcome: 5.2 Output: 5.2.1

How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?

The key actions called for in the resolution directly support attainment of outputs formulated in the above programme areas, in particular by way of increasing commitment and capacities for an appropriate hepatitis prevention and treatment response.

Does the programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) The resolution is not time-bound and it is anticipated that many activities outlined in the resolution will be ongoing.

(ii) An overall costing for the full implementation of the resolution across the Organisation will be completed in the process of preparation of the programme budget for 2016–2017.

(iii) The resolution includes elements that go beyond the previously-agreed framework for action on hepatitis, particularly with regard to accelerating access to hepatitis treatment and the assessment of the economic impact and burden of the disease at global and regional levels.

(iv) An indicative costing for the biennium 2016–2017 currently estimates the work to be performed by the secretariat of the Global Hepatitis Programme at headquarters at US\$ 7.4 million (staff: US\$ 5.8 million; activities: US\$ 1.6 million). It does not include yet costs incurred at regional and national levels.

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 3.3 million (staff: US\$ 2.1 million; activities: US\$ 1.2 million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

In support of the initial implementation of the resolution, priority is given to covering core activities at headquarters, including the elaboration of diagnostic and treatment guidelines, reporting, support to national strategy development, and the initiation of an access initiative.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

If “no”, indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No.

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

For the biennium 2014–2015, existing staff within the Global Hepatitis Programme, other departments and in the regional offices will initiate implementation of the resolution. However, this will not be sufficient and, in the medium term, additional staff needs will be determined in collaboration with regional offices.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

No.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

Funding gap: US\$ 1.7 million.

This funding gap will be tackled as part of the Organization-wide coordinated resource mobilization plan for making good funding shortfalls in the Programme budget 2014–2015.

Mrs ESCOREL DE MORAES (Brazil) said that the discussions on the draft resolution, which she had chaired, had been attended by Member States from the six WHO regions, had been extremely constructive and had resulted in a text that included references to all hepatitis viruses. A paragraph had been inadvertently omitted from the final revision; as the fourteenth preambular paragraph it would read: “Noting that hepatitis B virus and particularly hepatitis C virus disproportionately impact upon people who inject drugs and that of the 16 million people who inject drugs around the world, an estimated 10 million are living with hepatitis C virus and 1.2 million are living with hepatitis B virus;”.

The CHAIRMAN said that, owing to the need for further discussion as indicated by the presence of square brackets, the third paragraph of the draft Board resolution containing the draft Health Assembly resolution would need to be amended by adding “the consideration and” before “adoption”.

Dr NCHABI KAMWI (Namibia) said that Namibia wished to be added as a sponsor of the draft resolution, as amended.

Dr REFFAET (Egypt) said that the draft resolution was extremely important for his country in view of the immense disease burden imposed by viral hepatitis; its adoption was vital for implementing preventive measures and assisting intervention by other entities in order to control hepatitis C, in particular. Excluding minor details, the only outstanding matter to be agreed in the text related to subparagraph 1(14). He appealed to the Chairman to use her good offices to find a straightforward technical solution in order to produce a clean draft and thus avoid deferral of the issue until the Sixty-seventh World Health Assembly.

Dr CAPAK (Croatia), speaking on behalf of the European Union and its Member States, thanked the sponsors of the draft resolution for its presentation and for leading informal discussions. Taking into account the fact that subparagraph 1(14) was already in square brackets, he requested that the corresponding fourteenth preambular paragraph, which would become the fifteenth preambular paragraph if the amendment just read out by the member for Brazil were to be accepted, also be placed in square brackets for consideration at the Sixty-seventh World Health Assembly.

Ms LANTERI (Monaco),¹ supported by Dr REYNDERS (Belgium), noted that subparagraph 3(a)(iii) of the text on the financial and administrative implications stated that the draft resolution introduced elements that went beyond the previously-agreed framework for action on hepatitis. The severity of the impact of hepatitis was not being called into question, but it would be important to discuss the programmatic and budgetary implications of the draft resolution during the Sixty-seventh World Health Assembly, before its adoption.

Mr ALSAATI (Saudi Arabia) agreed with the call by the member for Egypt for further discussions in order to remove the square brackets from subparagraph 1(14) of the draft resolution, enabling it to be adopted by the Board.

Mr ROMERO PUENTES (Cuba) welcomed the draft resolution and asked that Cuba be added to the list of sponsors.

Mr CASALS ALIS (Andorra) also supported the statement made by the representative of Monaco, reiterating that any financial and administrative implications of the draft resolution should be discussed before its adoption.

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

Mr AL-ABDULLA (Qatar) said that, as he understood it, the only remaining issue to be agreed related to harm reduction measures, concerning which he urged that a technical solution be found immediately. So many issues were being deferred to the Sixty-seventh World Health Assembly as to call into question the point of the present session, namely the finalization of all draft resolutions for transmission to the Health Assembly. The practice of deferring issues and convening extraordinary meetings to discuss them further must stop, especially in the light of the budget constraints that prevented the implementation of projects without external support. Budget increases were being requested while exorbitant amounts were wasted on producing meeting documentation that would ultimately be discarded.

The CHAIRMAN expressed the view that no swift solution was likely to emerge from the immediate convening of any informal consultations and that the only realistic option was to leave the issue pending until the Sixty-seventh World Health Assembly.

Dr REFFAET (Egypt) said that he respected that view, but the Board was sufficiently robust to be capable of allowing for flexibility in reaching agreement and facilitating solutions. He appealed for a demonstration of such flexibility so that the draft resolution could be adopted without qualifications.

The CHAIRMAN reiterated that a solution would not be forthcoming as the issue relating to subparagraph 1(14) was political and not technical, despite the importance of the subject matter. Member States could, however, hold further consultations if they wished.

Mrs ESCOREL DE MORAES (Brazil) said that Brazil shared the frustrations expressed by others and would have liked to see the draft resolution adopted without having to wait until the next Health Assembly. The many hours of informal discussions had not produced agreement on the content of the paragraph under discussion, despite the strong engagement of Member States. Expressing concern that the situation could be made worse by continuing discussions during the present session, she conceded that it might be better to allow more time for members and representatives to speak to their capitals and to request them to show some flexibility. Such flexibility would have to be shown on both sides of the argument in order to reach a compromise. Brazil would do all it could to help to resolve the matter in the intersessional period before the Sixty-seventh World Health Assembly.

The CHAIRMAN thanked the member for Brazil for her efforts in chairing the informal consultations on the draft resolution.

Mr AL-ABDULLA (Qatar) insisted that an immediate solution must be found in order to finalize the draft resolution without further delay. At the present late stage of the Board's session, it would not be wise to go on discussing the issue until late at night, because delegations would gradually leave, and those that remained would carry the day.

The CHAIRMAN said that, given the political nature of the issue, it could be discussed until midnight without being resolved.

Dr REFFAET (Egypt) maintained that the problem was technical rather than political and asked for clarification and support from the Secretariat.

The CHAIRMAN respectfully underscored the political nature of the issue and said that, as such, the Secretariat was unable to respond to comments unless they referred to the financial and administrative implications of the draft resolution. She urged Member States to heed the statement made by the member for Brazil.

Dr NAKATANI (Assistant Director-General), responding to the comments made by the representative of Monaco, supported by the members for Belgium and Andorra, said that the draft

resolution would give WHO a mandate for work in four areas that were not included in the Programme budget 2014–2015, namely: access, economic impact and evaluation, a monitoring system, and guidelines relating to treatment. Those four areas were not currently budgeted, and each of them would require further careful examination by the Secretariat.

Responding to the frustration that had been expressed by the members for Egypt and Qatar, he assured the Board that the essential work on hepatitis would continue, and informal meetings would be held in order to ensure that more information would be available to form the basis of discussions during the Health Assembly.

Dr REFFAET (Egypt), taking into account the comments made by the Chairman and the Secretariat, requested that the scope of any informal consultations be restricted to the one outstanding issue, with no further discussion on the rest of the text. He reiterated that any such consultations had to be concluded before the Health Assembly, at which time a finalized text could then be presented.

The CHAIRMAN considered that the wish expressed by the member for Egypt was in fact the aspiration of the Board as a whole. She asked if the Board was ready to submit the draft resolution, as amended, to the Health Assembly for its consideration, noting the need for further work before the Sixty-seventh World Health Assembly.

It was so agreed and the resolution, as amended, was adopted.¹

3. PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 8 of the Agenda (continued)

Addressing the global challenge of violence, in particular against women and girls: Item 8.4 of the Agenda (Document EB134/21)

The CHAIRMAN drew attention to the report and a draft resolution on the role of the health system in addressing violence, in particular against women and girls, which was proposed by Albania, Australia, Belgium, Costa Rica, Guatemala, India, Italy, Latvia, Mexico, Namibia, Netherlands, Norway, Paraguay, Portugal, Republic of Moldova, Switzerland, Ukraine, United States of America, Uruguay and Zambia. Informal discussions had already taken place, resulting in proposed amendments to the text (marked in bold typeface), which read:

The Executive Board,
Having considered the report on addressing the global challenge of violence, in particular against women and girls,²

RECOMMENDS to the Sixty-seventh World Health Assembly consideration of the following resolution:

The Sixty-seventh World Health Assembly,
PP1 Concerned that in 2011, 1.37 million people died as a result of violence and that non-fatal violence affects large proportions of women, children, and men;
PP2 Deeply concerned that globally, one in three women experience either physical and/or sexual intimate partner violence or non-partner sexual violence at least

¹ Resolution EB134.R18.

² Document EB134/21.

once in their lives,¹ and that violence may be exacerbated in situations of humanitarian emergencies, including as a result of armed conflicts;

PP3 Affirming the unique and important leadership role that health systems must play in documenting, prevention and providing health and referral services, for those affected by violence, including as advocates within governments and among all multisectoral stakeholders at local, national, regional and global levels;

PP4 Noting that violence is defined by WHO as the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation;²

PP5 Reaffirming the definition of violence against women provided by the United Nations in 1993 in the Declaration on the Elimination of Violence against Women:³ “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life”; **[and further that violence against women includes, but is not limited to, the following: physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution; and physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs;]**

PP6 Aware that violence, which causes both long-term physical and mental health problems, often affects the least empowered members of a society, between a fifth and a quarter of adults were physically abused as children, 4–6% of the elderly report maltreatment and persons with disabilities are disproportionately affected by violence, and other vulnerable groups who in addition to experiencing greater incidences of violence are less likely to have access to services, including state protection from violence;

PP7 Recognizing that violence is preventable, and that a substantial body of high-quality, science-based technical and normative guidance already exists that demonstrates which programmes to scale up in order to achieve both short- and long-term reductions in violence;

PP8 Deeply concerned about the pervasiveness of violence, including against women and against children, in all its different forms and manifestations, and reiterating the need to intensify efforts to prevent and eliminate all forms of violence and to re-emphasize that violence, including against women and against children, is unacceptable and constitutes a violation or an abuse of human rights, as well as can amount to crimes prohibited by international humanitarian law and international criminal law;

PP9 Recognizing that all forms of violence against women and girls seriously violate and impair or nullify the full enjoyment by women and girls of their human rights and fundamental freedoms;

¹ Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. World Health Organization; 2013.

² *World report on violence and health*. Geneva: World Health Organization; 2002.

³ United Nations General Assembly resolution 48/104.

PP10 Recognizing also that violence against women and girls is rooted in historical and structural inequality in power relations between men and women and in social and cultural norms that condone violence, and that these discriminatory social norms can also operate within the health systems;

PP11 Recognizing further that violence, in particular against women and girls, touches every country and every part of society, constitutes a major global challenge to public health, and impairs the objective of sustainable development;

PP12 Recognizing also that preventing violence, particularly violence against women and girls, requires the active participation of men and boys;

PP13 Recalling resolution WHA49.25, which declared violence a leading worldwide public health problem, and resolution WHA56.24 on implementing the recommendations of the *World report on violence and health*, as well as the recommendations from the *WHO Multi-country Study on Women's Health and Domestic Violence against Women* (2005) calling on Member States to improve activities to prevent violence, and to provide medical, psychological, social and legal assistance and rehabilitation for persons suffering because of violence;

PP14 Conscious of the many efforts across the United Nations system to address the challenge of violence, in particular against women and girls, including the International Conference on Population and Development A/CONF.171/13/Rev.1, 1994; the Beijing Declaration and Platform for Action (A/CONF.177/20/Rev.1, 1995); and all relevant United Nations General Assembly and Human Rights Council resolutions;¹

PP15 Acknowledging the commitment by Member States in the Agreed conclusions of the 57th session of the Commission on the Status of Women that focused on the elimination and prevention of all forms of violence against women and girls,² including through addressing the physical and mental health dimensions of violence against women, and encouraging the continued collaboration of United Nations agencies to address violence against women and against children;

PP16 Aware that the effort under way for the post-2015 development agenda can contribute to addressing the comprehensive and multisectoral nature of violence, in particular violence against women and violence against children, including as it relates to gender equality and empowerment of women, and to building critical mass in setting the envisaged transformative actions in motion;

PP17 Acknowledging the many regional and subregional efforts aimed at coordinating prevention and response to violence, in particular against women and children;

PP18 Noting with appreciation the leading role WHO has played in establishing the evidence base on the magnitude, risk factors and consequences of violence, including violence against women and violence against children, and recognizing that tackling violence is a component of WHO's work to address the social, economic and environmental determinants of health, which is a leadership priority within the Twelfth General Programme of Work, 2014–2019;

¹ These include United Nations General Assembly resolution 55/68 on the elimination of all forms of violence, including crimes against women; United Nations General Assembly resolution 67/144 on the intensification of efforts to eliminate all forms of violence against women; United Nations General Assembly resolution 58/147 on the elimination of domestic violence against women; United Nations General Assembly resolution 63/23 promoting development through the reduction and prevention of armed violence; the Draft Asian and Pacific declaration on population and development of 18 September 2013; and the Declaration of Commitment to End Sexual Violence in Conflict 2013.

² Document E/2013/27-E/CN.6/2013/11.

PP19 Commending ongoing work by the WHO Secretariat in a broad array of areas that relate to preventing violence;¹

PP20 Emphasizing the catalytic and leadership role that Member States, in collaboration with the Secretariat of WHO, can play in the following areas: promoting societal transformation through the development of strategies to address violence; strengthening the health system's response to violence, in particular against women and girls; and supporting global, regional and national efforts to strengthen public health policies, programmes, and laws on violence prevention and response,

OP.1 URGES Member States:

- (1) to address violence, by strengthening their health system's response to violence, in particular women and children, and to support WHO work related to this resolution;
- (2) to develop and strengthen health plans and strategies integrated into national action plans on violence prevention and response, including violence against women and against children, in order to provide a framework for health system engagement and to highlight the role of key non-health sectors, such as education, law enforcement and women and child development, in preventing violence and providing services for victims;
- (3) to strengthen the legal framework and resource allocation aimed at preventing and eliminating all forms of violence against women and girls, including by achieving gender equality and the empowerment of women, and by increasing the focus on prevention, protection and accountability in laws, policies and programmes and their implementation, monitoring and evaluation;
- (4) to ensure access to health services, including in the area of sexual and reproductive health and raise public awareness of women's and girls' rights, including their reproductive rights;²
- (5) to ensure that all victims and those affected by violence, including violence against women and violence against children, have timely and effective access to essential services that meet both physical health needs, including sexual and reproductive health, and mental health and psychosocial needs, recognizing the important role played by the health system in providing care and referrals to such support services;
- (6) to develop or strengthen appropriate national policies or programmes within the health system to engage men and boys in families and communities, as agents of change in promoting gender equality, the empowerment of women, and preventing and condemning violence against women and violence against children, including through advocacy, counselling, and data collection;
- (7) to collect data documenting the magnitude, risk factors and consequences of violence, in particular against women and girls, as well as information on promising/best practices, including the quality of care received by those affected by violence, in order to contribute to the extent possible to ongoing WHO data collection measures, including the global status report proposed in subparagraph 2(2) below and updates of the global and regional estimates of prevalence and health burden of violence against women;

¹ In particular the work to follow up on the publication of the 2002 *World Report on Violence and Health*, the work to combat violence against children and the elderly, and the contribution of the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training on Human Reproduction to addressing violence against women and girls, and WHO's work on *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*.

² As defined in paragraph 95 of the Beijing Declaration and Platform for Action.

(8) to prioritize partnerships and multisectoral collaboration between health ministries and other relevant authorities, such as social services, women's affairs ministries, child protection services and criminal justice systems, recognizing the importance of working with local authorities to support; **[the legal rights of victims] [a victims-oriented approach in addressing the consequences of violence;]**

(9) to ensure that due consideration is given to the importance of preventing and responding to violence, in particular violence against women and violence against children, in the elaboration of the post-2015 development agenda;

OP2 REQUESTS the Director-General:

(1) to produce a global plan of action to develop the role of the health system in a multisectoral response to address all forms of interpersonal violence, in particular violence against women and violence against children, building on and complementing efforts by other organizations of the United Nations system, relevant international organizations and other stakeholders;

(2) to develop in 2014, and continue to produce every four years, a global status report on violence that will provide a baseline measurement for countries and a tool to monitor activities relevant to the implementation of the global plan of action at country level, including data collection, the legal environment, and prevention programmes as well as victim assistance programmes;

(3) to support Member States in developing, testing and implementing large-scale strategies to prevent and respond to violence, in particular violence against women and girls, and in providing other relevant health services, including by engaging other relevant sectors;

(4) to continue to support Member States, upon their request, in strengthening health system responses to violence, in particular against women and girls, including by supporting the development of curricula and training opportunities for health personnel and other health sector professionals to identify cases of violence and assist the victims;

(5) to continue to strengthen WHO's efforts to develop the evidence base on the magnitude and consequences of violence, as well as on effective interventions to prevent and respond to it, in particular violence against women and violence against children including developing a research agenda on health system response towards violence against women and children in humanitarian settings, including on barriers to access and use of services, building on the existing research agenda for sexual violence;

(6) to report further to the Board at its 138th session on progress in implementing this resolution, including presentation of the draft global action plan, for consideration by the Sixty-ninth World Health Assembly.

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

1. Resolution: The role of the health system in addressing violence, in particular against women and girls		
2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)		
Category: 2. Noncommunicable diseases		
Programme area: Violence and injuries		Outcome: 2.3 Output: 2.3.3
Programme area: Mental health and substance abuse		Outcome: 2.2 Output: 2.2.2

Category: 3. Promoting health through the life-course

Programme area: Reproductive, maternal, newborn,
child and adolescent health Outcome: 3.1
Output: 3.1.4

Category: 5. Preparedness, surveillance and response

Programme area: Emergency risk and crisis management Outcome: 5.3
Output: 5.3.1

How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?

The resolution would contribute to bringing increased attention to bear on violence, in particular against women and girls, as a public health issue, on its severe health impacts and its preventability, and on the role the health sector plays in combating violence. It would further strengthen the health sector's role within a multisectoral response and provide committed policy-makers in the health sector with a stronger mandate for dealing with the topic.

The resolution would help to create awareness of: violence and violence prevention, in particular, against women and girls and the interrelation of different types of violence; the links between violence and noncommunicable diseases; and the need to address violence taking a broader perspective. It could contribute to increase commitment of donors to further invest in violence prevention.

The resolution will help to increase collaboration both between WHO and its external partners and within the Organization.

Does the programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)

Yes.

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) Five years (covering the period 2014–2018)

(ii) Total: US\$ 34.65 million (staff: US\$ 18.81 million; activities: US\$ 15.84 million)

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 13.54 million (staff: US\$ 7.39 million; activities: US\$ 6.15 million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

All levels of the Organization.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

Yes.

If "no", indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

Yes, for the biennium 2014–2015.

For the biennium 2016–2017 and beyond additional staff might be needed, in particular at regional and country levels.

If "no" indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

The need for additional staff will depend on the development of the global plan of action requested in the resolution.

4. Funding**Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)**

No: approximately US\$ 5 million of the US\$ 13.54 million for the biennium have currently been secured.

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

For the biennium 2014–2015, the funding gap is approximately US\$ 8.54 million. It is envisaged that the gap will be closed through the financial dialogue process and coordinated resource mobilization efforts.

Ms DÁVILA CHÁVEZ (Mexico) said that violence, especially against women and girls, was a serious public health issue that must be approached from different angles and had various social consequences. It was time for health systems to lead efforts to develop new public policies and programmes to tackle the problem. A health sector-led multisectoral response would improve the quality of life for families that frequently suffered such violence and would reduce the costs of the resultant medical and psychological care. She added that Thailand wished to join the list of sponsors.

Dr MAKASA (Zambia)¹ welcomed the work on the issue since the Sixty-sixth World Health Assembly, when many Member States had committed themselves to focusing their attention on the unique role of health systems in combating violence against women and girls. The issue was a high priority for Zambia, whose First Lady was the current WHO Goodwill Ambassador against Gender-based Violence.

Although the burden of morbidity and mortality resulting from such violence had habitually been the responsibility of national health systems in their traditional medical role, it was time to recognize the unique additional role of such systems in documenting statistics and data that must be integrated with information from other sectors. Good data were vital in formulating appropriate policies and response programmes. Health workers also needed to be reminded of their special roles and responsibilities in that area.

Mr COTTERELL (Australia) said that the sponsors had been meeting during the week for informal consultations, but that those consultations had not concluded and the draft resolution was not in a proper state to be considered by the Board. The group therefore proposed that the work be continued before the Sixty-seventh World Health Assembly, whereby regional coordinators in Geneva would collect all further comments on the draft resolution and compile them into a revised draft that would form the basis for further informal consultations, being provided to all Member States a week before the first of those consultations. He proposed that the Board consider adopting a draft decision that reflected that process and would read, “The Board decided to take note of the ongoing discussions on the draft resolution under agenda item 8.4 and encouraged Member States to finalize this work, to be duly considered by the Sixty-seventh World Health Assembly.”.

Mr ROMERO PUENTES (Cuba) supported the process proposed by the member for Australia, and affirmed that the discussion should not focus on the draft resolution.

The CHAIRMAN proposed that Member States follow the process that had been suggested and keep the proposed draft decision in mind during their present discussions. She affirmed that it would not be helpful for Member States to comment on the draft resolution, but speakers did not need to refrain from expressing their views more broadly on the issue of violence towards women and girls.

It was so agreed.

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

Dr CAPAK (Croatia), speaking on behalf of the European Union and its Member States and adding that the former Yugoslav Republic of Macedonia, Montenegro, Iceland, Serbia, Albania, Bosnia and Herzegovina, Ukraine, Republic of Moldova and Georgia aligned themselves with his statement, said that violence pervaded every part of society in every country, affecting women and girls in particular. Violence against women and girls was a major challenge for global public health, gender equality and human rights, and he reaffirmed the European Union's commitment to full implementation of relevant international agreements and plans of action. Gender equality could not be achieved without also guaranteeing women's sexual and reproductive health and rights. Expanding access to information and services in that area was essential to achieving the Millennium Development Goals and other international agreements. The goal of gender equality and empowerment of women should feature prominently in discussions on the post-2015 development agenda; preventing violence against women was a precondition for equitable and inclusive sustainable development. All women would benefit from a new framework for development based on human rights, the elimination of inequalities and corruption, robust health systems and transparency. He strongly condemned all forms of violence against women as a violation of the full enjoyment of their human rights; customs, tradition, culture, religion or so-called honour must not be invoked to justify such violence or permit States to avoid their obligation to prevent and eliminate violence and prosecute the perpetrators. All European Union Member States had implemented strategies against female genital mutilation, combining legislative and non-legislative measures. The European Union supported a systematic and holistic approach to combating violence and welcomed the draft resolution, which its Member States were considering sponsoring.

Ms DUSSEY-CAVASSINI (Switzerland) said that her country attached great importance to the issue of violence against women and girls and had for that reason sponsored the draft resolution. She expressed support for the process proposed by the member for Australia.

Dr NCHABI KAMWI (Namibia), speaking on behalf of the Member States of the African Region, expressed their concern that the Region had one of the highest rates of interpersonal violence in the world. Violence against women restricted their enjoyment of their human rights and fundamental freedoms, as well as their ability to live a fulfilled, balanced and healthy life. There was a great need to instil a culture of defending such rights, especially for women in Africa, through increased public awareness of cultural gender-based violence, prevention of all forms of such violence, and education to help to free victims from fear and stigmatization and to make them aware of their own rights. He expressed further concern that the implementation of recommendations in the *World report on violence and health* and other WHO reports had not been sufficiently prioritized by some Member States. He urged the Secretariat to continue supporting those Member States, including by enhancing human and financial resources.

Dr ASADI-LARI (Islamic Republic of Iran) welcomed the report and recalled that the United Nations General Assembly had recently adopted resolution 68/127 on a world against violence and violent extremism, which had been introduced by his country. Violence was a significant social determinant of health; it was incumbent on the health sector to call for increased attention to be paid to the issue, provide appropriate services to victims, collect and disseminate data, and identify effective prevention and response strategies, in particular against women and girls. Particular attention should be paid to developing agreed operational definitions taking into account cultural and contextual diversities; providing consistent, accurate and disaggregated data on domestic and other types of violence; prioritizing actions, including protection of vulnerable groups, especially women and girls, in emergency situations and conflicts; establishing evidence-based guidelines for all sectors; and sharing data and best practices regionally and globally. Those aspects should be considered in the consultations proposed by the member for Australia, which he supported.

Dr BAYE LUKONG (Cameroon) commended WHO's lead in establishing an evidence base on the magnitude and consequences of violence, in particular against women and girls, and underscored the need for individual countries to do the same, by collecting local evidence. She strongly supported, and wished to be a sponsor of, the draft resolution; she also supported the process proposed by the member for Australia.

Dr AMMAR (Lebanon) urged WHO to take the lead within the health sector in tackling violence, providing support to countries to develop policies that dealt with the health and social aspects of the issue. Such policies should focus on women and children, as they were particularly affected by different forms of violence and abuse, and should include measures to tackle risk factors, promoting prevention and providing the necessary medical, psychological and social support. Civil society organizations were valuable allies. The social and security dimensions of the issue needed multisectoral collaboration, with exchanges of information between different agencies and ministries. An effective social network should facilitate the necessary referral and follow-up, and mental health services should be strengthened in order to deal with the acute and chronic consequences of violence, including post-traumatic stress disorders. Due attention should also be paid to situations of armed conflict, where violence and sexual abuse against women and children were often exacerbated.

Ms OKAMOTO (Japan) said that her Government had adopted several multisectoral approaches, based on relevant legislation, to ensure the protection of human rights and to realize gender equality. The issue would not be resolved by the health sector alone, particularly as there were various social and cultural barriers, but all Member States should take appropriate measures to combat violence, under the leadership of WHO.

Mr ROMERO PUENTES (Cuba), expressing support for the proposed draft decision, said that the draft resolution should focus on not only health system responses to violence but also measures for prevention. The mandate of both WHO and health systems should be clearly defined, as the issue involved many stakeholders at both national and international levels, and should respect that of other intergovernmental processes regarding the post-2015 development agenda.

Ms MATSOSO (South Africa) expressed support for the process proposed by the member for Australia and said that South Africa wished to sponsor the draft resolution. The health sector had a crucial role to play in documenting and preventing violence and in providing services to victims. The rights espoused in WHO's Constitution would not be fully realized without tackling the problem of violence; that would need a multisectoral response.

Dr REYNDERS (Belgium), likewise expressing support for the proposed process, wanted to reach agreement by consensus on the draft resolution before the next Health Assembly. He commended the Secretariat's efforts in having provided to the sponsors the technical background and information on the financial implications, which would allow Member States to table a draft resolution that would not endanger the implementation of the Programme budget 2014–2015.

Dr WARIDA (Egypt) said that Egypt's commitment to the elimination of all forms of violence against women and children was evident in the country's new Constitution. Texts such as the draft resolution, with profound social dimensions, entailed major difficulties owing to the need for in-depth studies to determine the health sector's approach and to ensure that WHO's decisions did not impinge on the mandates of other sectors or duplicate discussions in other United Nations forums, but rather added value to the overall debate. There should be more specific consideration in the current discussion about the role of doctors, nurses, hospitals and awareness-raising activities in dealing with violence against women and children. Member States must adopt a multisectoral approach geared to their respective cultural and social contexts. Other aspects for consideration included capacity, cost, training, assistance and ensuring that the health sector was not diverted from its main tasks of delivering public health services and combating disease and epidemics. He welcomed the proposal to

pursue consultations before the Health Assembly on the basis of input from Member States in the light of their national circumstances and international obligations.

Dr BEJTJA (Albania) welcomed the report and the evidence of the need for increased collective action in tackling violence against women and girls. The topic should be given higher priority by WHO. Although some progress had been made, much more still had to be done, with intensified and multisectoral action at all levels to tackle the underlying risk factors and social determinants of violence and the consequences for public health. Raising public awareness should be a vital component of any strategy, as gender-based violence often had its roots in social and cultural gender inequalities. Efforts should also focus on producing gender-disaggregated data in order to measure accurately the consequences of gender-based violence and to formulate programmes that better served the victims. His Government had identified the matter as a high priority, and was implementing recently adopted legislation against gender inequality. He called for support for the draft resolution.

Mrs ESCOREL DE MORAES (Brazil) said that her Government's Ministry of Health was working extensively to deal with violence and its consequences for health, including collection of data on violence (which were valuable to other sectors as well). She looked forward to continued constructive engagement in the issue.

Mr CASALS ALIS (Andorra) commended the work done on the draft resolution and said that he looked forward to its submission to the Sixty-seventh World Health Assembly. His country wished to join the list of sponsors. He also supported the draft decision on the consultative process proposed by the member for Australia.

Mr ALSAATI (Saudi Arabia), endorsing the proposal to pursue consultations in the interval preceding the Health Assembly, said that internationally recognized and agreed terminology should be used throughout the draft resolution, which must also elaborate further on violence reduction and the important role of the health sector in that domain. He supported the draft decision.

Dr SHAKEELA (Maldives) welcomed the discussion of a subject that was still taboo in many countries. In the patriarchal cultures of her region, violence against women was not something that was spoken about. Women often believed that it was something that they deserved and thus became their own worst enemies by not raising the issue. Studies in Maldives had shown that a significant proportion of women between the ages of 15 and 45 years were victims of violence, with many suffering at the hands of people close to them. The psychological trauma of violence against women had a high global cost, and many countries and regions did not have appropriate capacity or mechanisms to deal with the issue. A male-dominated culture was often perpetuated through education systems in which teaching materials were prepared by or based on men, and ideas about power were inextricably linked with supposedly male characteristics. There needed to be an end to the idea that women should always have a lower position in society and be submissive to men.

The CHAIRMAN, responding to the comments made by the previous speaker, recalled the powerful words of a senior Aboriginal woman: violence against women was never culturally appropriate.

Mr McIFF (United States of America)¹ expressed support for strengthening WHO's capacity to tackle violence against women and girls. The repercussions of violence were not limited to physical injuries; they could also lead to a variety of short- and long-term health issues, including behavioural and psychosocial difficulties. Protection of sexual and reproductive health and reproductive rights was

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

also central to the prevention and mitigation of violence. In the United States of America, despite efforts by the Government to mitigate the problem, three women a day were killed by intimate partners, one in three women had experienced some form of abuse by their partners, and one in five women was a victim of rape in her lifetime. Strong WHO leadership had been central in promoting a broader public health approach to violence prevention, and he therefore called for continued and strengthened international collaboration on the issue.

Mr RUSH (United Kingdom of Great Britain and Northern Ireland)¹ welcomed WHO's commitment to countering violence against women and girls, including sexual violence in conflict and emergency situation, and thanked the Organization for its engagement in a high-level event hosted by his Government (London, 13 November 2013), which had focused on protecting women and girls in emergencies. Ending all forms of violence against women and girls was a national priority. He fully supported the statement made by the member for Lebanon. His Government's Preventing Sexual Violence Initiative sought to tackle the culture of impunity for crimes of sexual violence committed in conflict and to ensure that those responsible were held to account. In 2013, in both the G8 Declaration and the Declaration of Commitment to End Sexual Violence in Conflict, signatory Member States had committed themselves to taking coordinated action. His Government would be launching an international protocol on the documentation and investigation of crimes of sexual violence in conflict; an area that would require WHO's support and expertise. He welcomed WHO's leadership in developing a research agenda on violence against women and girls in settings of humanitarian need and noted that his Government was establishing a Violence against Women and Girls Research and Innovation Fund in order to design and expand effective preventive measures. He welcomed the proposal for intersessional consultations in order to strengthen the draft resolution for consideration by the Health Assembly in May.

Dr GRECH (Malta)¹ said that, although the statement made by the member for Croatia reflected Malta's stance on the elimination of violence against women and girls, he wished to clarify his country's position on sexual and reproductive health and rights. His Government was firmly committed to the full implementation of the various relevant international agreements, including the Convention on the Elimination of All Forms of Discrimination against Women, but believed that any discussion or reference to services or commodities relating to reproductive health and rights could not happen outside the framework of the fundamental right to life. Abortion was illegal in Malta, and recommendations implying practices that resulted in termination of pregnancy were unacceptable.

Dr RANJAN (India)¹ expressed strong support for the global efforts to deal with violence against women and girls and acknowledged the important dual role played by the health care system in providing victims of sexual violence with not only the required medical treatment but also medico-legal assistance through collecting evidence and ensuring high-quality documentation. He called for all health care systems to establish a comprehensive response mechanism for victims of sexual violence. As India was a sponsor of the draft resolution, he urged Member States to give their full support to it and submit it to the Sixty-seventh World Health Assembly for consideration.

Ms ST LAWRENCE (Canada)¹ commended the report. She agreed with positioning violence against women and girls as a gender-based issue, but her Government recognized that boys, too, experienced high rates of violence with significant health impacts, and that violence against boys contributed to intergenerational cycles of violence. It would be advantageous to engage men and boys in primary and secondary prevention efforts. She supported an enhanced leadership role for WHO in tackling violence, in particular against women and children, from the standpoint that violence in all its

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

forms was a public health issue and that the health system had a leading responsibility in preventing and responding to it. She therefore fully supported the draft decision.

Mr ALIMUZZAMAN (Bangladesh)¹ welcomed the report and recognized the role played by the health sector both in prevention and in care for the victims. The WHO Country Office for Bangladesh had supported the national health sector in its efforts to promote greater public awareness of violence against women and girls and build a stronger public health response. He welcomed all the support provided by the Secretariat and other development partners for ongoing training, advocacy and capacity-building to further strengthen his Government's efforts in that area.

Mr AASLAND (Norway)¹ expressed support for the draft decision and acknowledged the work of the delegation of the United States of America in chairing the drafting group on the draft resolution. Its text presented an opportunity to focus the work already started to tackle violence, especially against women and girls. WHO's expertise on violence prevention was insufficiently recognized, and its accumulated knowledge would provide an excellent basis for cooperation with national governments. The health sector had a central role to play in combating interpersonal violence but a broad, integrated and multisectoral approach must be adopted at the national level. An action plan against violence, particularly that directed towards women and girls, should acknowledge the relative strengths of the health and other sectors concerned, should be broad and comprehensive, and should include adequate responses to gender-specific aspects.

Ms LANTERI (Monaco)¹ commented that violence against women and girls occurred in every socioeconomic situation and, unfortunately, behind many families' closed doors. Monaco had adopted legislation to protect the victims of domestic violence, recognizing that the health sector, and WHO in particular, had a central role, in effect protecting human rights. Progress meant victims having access to a place where they could report what had happened and to care. In that area, the Secretariat should provide support to countries, through for instance the training of health workers.

Mr CANDIA IBARRA (Paraguay)¹ said that Paraguay, as one of its sponsors, accepted the proposal for refining the draft resolution before its submission to the Sixty-seventh World Health Assembly. He looked forward to continued collaboration with the Secretariat.

Mrs PEAN MEVS (Haiti)¹ said that talking about violence against women and girls meant assessing its effect on physical and mental health. She welcomed the Secretariat's guidance to Member States in developing national plans to prevent and respond to such violence. She supported the draft resolution and asked for Haiti to be added as a sponsor.

The DIRECTOR-GENERAL thanked all Member States for their commitment to such an important topic – one that, as had been said, was often not talked about. Ending violence was a matter of decent humanity, as no culture should find violence acceptable. She agreed that interpersonal violence was a multisectoral issue and that the health sector had an important role to play in tackling it, but she stressed that little progress would be made if women's equality was not fully recognized and their rights to equal educational, political and economic opportunities were not adequately safeguarded. She reaffirmed that the Secretariat would do its utmost to work effectively with partners in order to ensure that efforts to tackle such an important subject remained a priority.

The Board noted the report.

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

The CHAIRMAN took it that the Board wished to adopt the draft decision on addressing the global challenge of violence, in particular against women and girls, which read: “The Board decided to take note of the ongoing discussions on the draft resolution under agenda item 8.4 and encouraged Member States to finalize this work, to be duly considered by the Sixty-seventh World Health Assembly.”.

The decision was adopted.¹

The meeting rose at 12:45.

¹ Decision EB134(6).

FOURTEENTH MEETING

Saturday, 25 January 2014, at 14:15

Chairman: Professor J. HALTON (Australia)

1. **HEALTH SYSTEMS:** Item 9 of the Agenda (continued)

Regulatory system strengthening: Item 9.5 of the Agenda (Document EB134/29) (continued from the thirteenth meeting, section 1)

The CHAIRMAN drew attention to the revised draft resolution on access to biotherapeutic products and ensuring quality, safety and efficacy, which was based on the draft resolution that had been considered at the ninth meeting¹ and which read as follows:

~~Biological medicines: access to medicines and ensuring safety, quality and efficacy~~

Access to biotherapeutic products and ensuring quality, safety and efficacy

The Executive Board,
Having considered the report on Regulatory system strengthening,

RECOMMENDS to the Sixty-seventh World Health Assembly the adoption of the following resolution:

The Sixty-seventh World Health Assembly,

~~PP1 Considering that health is a fundamental human right recognized in various international human rights treaties;~~

PP1 Recalling the WHO Constitution, which affirms that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition,

~~PP2 Recalling United Nations Human Rights Council resolution A/HRC/RES/23/14, which stressed “the responsibility of States to ensure the highest attainable level of health for all, including through access, without discrimination, to medicines, in particular essential medicines, that are affordable, safe, efficacious and of quality”;~~

PP2 Noting with particular concern that for millions of people, the right to the enjoyment of the highest attainable standard of physical and mental health, including access to medicines, remains a distant goal, that especially for children and those living in poverty, the likelihood of achieving this goal is becoming increasingly remote, that millions of people are driven below the poverty line each year because of catastrophic out-of-pocket payments for health care, and that excessive out-of-pocket payments can discourage the impoverished from seeking or continuing care;

¹ See the summary record of the ninth meeting, section 1.

PP3 Recalling resolution WHA55.14 on ensuring accessibility of essential medicines, which recognizes “the responsibility of Member States to support solid scientific evidence, excluding any biased information or external pressures that may be detrimental to public health”;

PP4 Further recalling that resolution WHA55.14 urged Member States, inter alia, “to reaffirm their commitment to increasing access to medicines, and to translate such commitment into specific regulation within countries, especially enactment of national drug policies and **establishment of lists of essential medicines based on evidence and with reference to WHO’s model list** into actions designed to promote policy for, access to, and quality and rational use of, medicines within national health systems”;

~~PP5 Considering that resolution WHA66.7 on implementation of the recommendations of the United Nations Commission on Life-Saving Commodities for Women and Children recognized that millions of women and children die needlessly every year from conditions that are easily prevented by the use of existing inexpensive medical commodities, and further recognized the need to overcome the barriers that prevent women and children from accessing and using appropriate commodities;~~

PP6 Considering that one of the objectives of pharmaceutical regulation is the assurance of the quality, safety and efficacy of pharmaceutical products through the regulatory processes of authorization, vigilance and monitoring;

PP7 Considering also that national pharmaceutical regulation should contribute to the **performance and** sustainability of health systems and the general welfare of society;

PP8 Considering that an update of the norms and standards applicable to medicines is required in the light of advances made in biotechnology, and the new generation of medicines introduced as a result, in order to ensure the entry into the market of medicines that are affordable, safe, efficacious, of good quality and accessible in a timely and adequate fashion;

~~PP9 Recognizing that, although the use of such medicines has a positive impact on morbidity and mortality rates, their high cost could affect access to them and the sustainability of health systems;~~

PP9 Recognizing that the use of such medicines has a positive impact on morbidity and mortality rates and that, while there are multiple barriers to access, their high cost affects the sustainability of health systems and could in many cases affect access to them;

[PP9(bis) Noting that WHO Expert Committee on Biological Standardization guidelines of 2009 on evaluation of similar biotherapeutic products and that the placing on the market of these types of products is expected to significantly increase;]

~~PP10 Conscious that biological medicines proposed as being similar to medicines taken as comparators~~ **similar biotherapeutic products** could be more affordable and offer better access to new treatments of biological origin, while ~~maintaining~~ **ensuring** quality, safety and efficacy,

1. URGES Member States:¹

~~(1) to provide appropriate national regulatory frameworks for the health regulation of medicines of biological origin, with a view to meeting the needs of public health, in particular of medicines of biotechnological origin developed to be similar to medicines taken as comparator in terms of quality, safety and efficacy;~~

¹ And, where applicable, regional economic integration organizations.

(1) to develop or strengthen, as appropriate, national regulatory assessment and authorization frameworks, with a view to meeting the public health needs for biotherapeutic products, and in particular similar biotherapeutic products.

~~[(1)bis to ensure that a solid, scientifically-based regulatory review process for reviewing, approving, and monitoring reference biotherapeutic products has been conducted before embarking on the review and approval of similar biotherapeutic products;]~~

~~(2) to ensure that the introduction of new national regulations applicable to the medicines referred to in the paragraph above does not constitute a barrier to access to medicines that are affordable, safe, efficacious and of quality;~~

(2) to work to ensure that the introduction of new national regulations, where appropriate, does not constitute a barrier to access to quality, safe, efficacious and affordable similar biotherapeutic products;

2. REQUESTS the Director-General:

(1) to support Member States in strengthening their capacity in the area of the health regulation of **biotherapeutic products and in particular similar biotherapeutic products** ~~medicines of biological origin, and in particular of biotechnology medicines developed to be similar to medicines taken as comparator in terms of quality, safety and efficacy;~~

~~(2) to encourage and support the development of health regulation frameworks consistent with access to medicines that are affordable, safe, efficacious and of quality.~~

(2) to support, as appropriate, the development of national regulatory frameworks that promote access to quality, safe, efficacious and affordable similar biotherapeutic products;

(3) to encourage and promote cooperation and exchange of information, as appropriate, among Member States in relation to biotherapeutic products, in particular similar biotherapeutic products.

Mr PIPPO BRIANT (Argentina), speaking on behalf of the Member States of the Union of South American Nations, said that access to high-quality, safe and efficacious medical products should be equitable and based on health requirements rather than ability to pay. The regulatory procedures for registering and licensing medical products must be based on sound scientific evidence, as had been emphasized in a recent report by the Pan American Network for Drug Regulatory Harmonization. The process of authorizing regulatory norms and standards, and updates thereto, in response to the emergence of new health technology should not be subject to external pressures, hence the importance of the revised draft resolution above, which had been discussed in three meetings of an informal drafting group. Two subparagraphs with specific technical points remained between square brackets, but it was hoped that a consensus on them could be reached before the Sixty-seventh World Health Assembly. He commended the draft resolution to the Board for adoption and submission to the Health Assembly.

Dr VALVERDE (Panama) urged adoption of the draft resolution. It was important for WHO to initiate discussion of the implications of biotherapeutic products for public health. Efforts must be made to devise additional regulatory frameworks and norms in order to ensure effective monitoring of such products and equitable access to high-quality, safe and efficacious medicines.

The CHAIRMAN noted the need for further work before the Health Assembly in order to reach agreement on the text in square brackets and to report the financial and administrative implications for the Secretariat of its adoption. The recommendation in the third line of the text of the draft resolution would therefore need to be amended by adding “the consideration and” before “adoption”. She asked

if the Board was ready to adopt the text, thereby submitting the draft resolution to the Health Assembly for its consideration.

It was so agreed and the resolution, as amended, was adopted.¹

2. DRAFT RESOLUTIONS: COMPILATION OF FINANCIAL AND ADMINISTRATIVE IMPLICATIONS

The CHAIRMAN said that, in response to the concerns raised by some Member States,² the Secretariat had prepared a summary compilation (see Table below) of the financial and administrative implications of all the draft resolutions considered at the current session, so as to facilitate a dialogue about how each proposed resolution fitted into the overall financial context governed by the Programme budget 2014–2015. The possible contradictions between the programme budget and the funding requested under resolutions posed a major challenge for the Organization. She had asked the Secretariat to prepare, whenever possible, such a document in advance for future governing body meetings.

EB134 resolutions/decisions/CONF. papers and their costings (FIGURES BELOW REFER TO BUDGET SPACE)

Resolution	Title	Costing	Estimated total cost (US\$'000)	Estimated total duration	Cost for the biennium 2014–2015 (US\$'000)	Costed within approved PB 2014–2015 (US\$ '000)	Costs <u>not</u> included in PB 2014–2015 (US\$ '000)
EB134.R1	Appointment of the Regional Director for South-East Asia	N/A					
EB134.R2	Appreciation of the outgoing Regional Director for South-East Asia	N/A					
EB134.R3	Appointment of the Regional Director for the Western Pacific	N/A					
EB134.R4 (EB134/CONF./4 Rev.1)	Global strategy and targets for tuberculosis prevention, care and control after 2015	EB134/CONF./4 Rev.1 Add.1	TBD	20 years (2016–2035)	98 500	98 500	–
EB134.R5	Public health impacts of exposure to mercury and mercury compounds: the role of WHO and ministries of public health in the implementation of the Minamata Convention	EB134/CONF./7 Add.1	9 030	min. 7 years (2014–2020)	2 470	2 470	–
EB134.R6	Traditional medicine	EB134/CONF./2 Add.1	26 110	10 years (2014–2023)	5 200	5 200	–
EB134.R7	Strengthening of palliative care as a component of integrated treatment throughout the life course	EB134/CONF./6 Add.1	20 000	min.7 years (2014–2020)	1 000	1 000	–
EB134.R8	Contributing to social and economic development: sustainable action across sectors to improve health and health equity (follow up of the 8th Global Conference on Health Promotion)	EB134/CONF./8 Rev.1 Add.1	1 450	3 years (2014–2016)	980	980	–

¹ Resolution EB134.R19.

² For the earlier discussion of this matter, see the summary record of the eleventh meeting, section 1.

Resolution	Title	Costing	Estimated total cost (US\$'000)	Estimated total duration	Cost for the biennium 2014–2015 (US\$'000)	Costed within approved PB 2014–2015 (US\$ '000)	Costs not included in PB 2014–2015 (US\$ '000)
EB134.R9	Confirmation of amendments to the Financial Rules	N/A				–	
EB134.R13	Antimicrobial drug resistance	EB134/CONF./1 Add.1	9 600	2 years (2014–2015)	9 600	1 800	7 800
EB134/CONF./5	Hepatitis	EB134/CONF./5 Add.1	TBD	"not time bound"	3 300	3 300	–
EB134/CONF./3	Biological medicines: access to medicines and ensuring safety, quality and efficacy	EB134/CONF./3 Add.1	25 000	10 years (2014–2023)	3 000	3 000	–
EB134/CONF./9	Health intervention and technology assessment in support of universal health coverage	EB134/CONF./9 Add.1	28 000	6 years (2014–2019)	13 600	8 600	5 000
EB134/CONF./10	Addressing the global challenge of violence, in particular against women and girls	EB134/CONF./10 Add.1	34 650	5 years (2014–2018)	13 540	13 540	–
EB134/CONF./12	Regulatory system strengthening	EB134/CONF./12 Add.1	250 000	10 years (2014–2023)	30 000	5 000	25 000
EB134/CONF./13	CEWG demonstration projects	EB134/CONF./13 Add.1	700	1 year (2014)	700	700	–
EB134/CONF./14	Access to essential medicines	EB134/CONF./14 Add.1	18 000	6 years (2014–2019)	8 600	8 600	–
EB134/1 Add.2	Follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage	EB134/55 Add.1	18 800	4 years (2014–2017)	9 400	9 400	–
EB134/32	Implementation of the International Health Regulations (2005)	EB134/32 Add.1	–	n/a	–	–	–
EB134/51	Amendments to the Staff Regulations and Staff Rules	EB134/51 Add1	20	2 years (2014–2015)	20	20	–
EB134.R12	Salaries of staff in ungraded posts and of the Director-General	N/A					
Subtotal			441 360		199 910	162 110	37 800

Decision	Title	Costing	Estimated total cost (US\$'000)	Estimated total duration	Cost for the biennium 2014–2015 (US\$'000)	Costs within PB 2014–2015 (US\$'000)	Costs not included in PB 2014–2015 (US\$'000)
EB134(xx)	Follow-up to the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases	EB134/14 Add.3	300	1 year (2014)	300	300	–
EB134(xx)	Maternal, infant and young child nutrition	EB134/CONF./11 Add.1	1 870	2 years (2014–2015)	1 870	1 870	–
EB134/6 Add.2	Methods of work of the governing bodies	N/A					
EB134/10 Add.1	Strategic resource allocation	N/A					
Subtotal			2 170		2 170	2 170	–
Grand total			443 530		202 080	164 280	37 800

She invited members to review the document and provide feedback to the Secretariat, for example on how its content could be clarified or otherwise improved to assist in governing body discussions and decision-making.

It was so agreed.

3. HEALTH SYSTEMS: Item 9 of the Agenda (resumed)

Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination: Item 9.3 of the Agenda (Documents EB134/26 and EB134/27) (continued from the twelfth meeting, section 2)

The CHAIRMAN announced that the Director-General was putting decision EB134(5) into effect immediately. The following procedure would be used for the selection of a country to represent each region as an observer at the meeting of the Consultative Expert Working Group on Research and Development: Financing and Coordination that would be held to assess whether the seven plus one projects shortlisted by the Group at its meeting in December 2013 met the criteria set by the experts for the demonstration of new financing and coordination mechanisms. Six baskets, one per WHO region, would be prepared on 25 January 2014 by the Secretariat. Each basket would contain the names of all countries of the respective WHO region. The same day, the Regional Director, or in his or her absence, the Director-General, would pick one ballot corresponding to his or her region. The Secretariat would subsequently contact the health ministry of the selected country to explain the responsibilities of the role and the likely time involved. In the event of a country declining to participate in a meeting in Geneva on a fixed date within the coming few months as an observer, the Regional Director, or the Director-General, would draw the name of another country from the region for the role of observer. When all the observers had been selected, their names would be announced on the WHO website. The Secretariat would assist with logistical arrangements to enable the observers to participate either virtually or in person. The role of the regional observers would be to guarantee a fair and transparent selection process. The result of the assessment of the seven plus one projects would be announced on the same day on the WHO website. If a designated observer country was unable to attend at very short notice, the meeting would proceed as planned and the meeting report would state that the region concerned had not been represented owing to the unexpected absence of the observer country.

4. MANAGEMENT, FINANCIAL AND LEGAL MATTERS: Item 11 of the Agenda (continued)

Reports of committees of the Executive Board: Item 11.6 of the Agenda

- **Standing Committee on Nongovernmental Organizations** (Document EB134/44)

The CHAIRMAN invited the Board to consider the draft resolution and draft decision contained in the report.

The resolution and decision were adopted.¹

¹ Resolution EB134.R20 and decision EB134(7), respectively.

- **Foundations and awards** (Document EB134/45)

Dr A.T. Shousha Foundation Prize

Decision: The Executive Board, having considered the report of the Dr A.T. Shousha Foundation Prize Committee, awarded the Dr A.T. Shousha Foundation Prize for 2014 to Professor Abla Mehio Sibai from Lebanon for her significant contribution to public health in Lebanon, in particular in the areas of ageing and noncommunicable diseases. The laureate will receive the equivalent of 2500 Swiss francs in United States dollars.¹

Jacques Parisot Foundation Fellowship

Decision: The Executive Board, having considered the report of the Jacques Parisot Selection Panel, awarded the Jacques Parisot Foundation Fellowship for 2014 to Dr Htin Zaw Soe (Myanmar). The laureate will receive US\$ 5000.²

Ihsan Dođramacı Family Health Foundation Prize

Decision: The Executive Board, having considered the report of the Ihsan Dođramacı Family Health Foundation Selection Panel, awarded the Ihsan Dođramacı Family Health Foundation Prize for 2014 to Professor Zulfiqar Bhutta from Pakistan for his long-standing career in global work on child and newborn survival and health, and in improving maternal and child health in his own country. The laureate will receive US\$ 20 000.³

Sasakawa Health Prize

Decision: The Executive Board, having considered the report of the Sasakawa Health Prize Selection Panel, awarded the Sasakawa Health Prize for 2014 to the Leprosy Control Foundation, Inc./Dominican Institute of Dermatology and Skin Surgery “Dr Hubert Bogaert Diaz” of the Dominican Republic which has greatly contributed to the reduction of the rates of incidence of leprosy in the Dominican Republic. The laureate, as an organization, will receive US\$ 40 000.⁴

United Arab Emirates Health Foundation Prize

Decision: The Executive Board, having considered the report of the United Arab Emirates Health Foundation Selection Panel, awarded the United Arab Emirates Health Foundation Prize for 2014 to the National Institute for Health Research of Costa Rica, which is being honoured for the contribution made to scientific research in the fields of individual and collective ageing, genetic and infectious diseases, early detection and diagnosis of gastric cancer, which has a high prevalence in Costa Rica, and genotoxic damage from occupational exposure to pesticides. The laureate will receive US\$ 20 000.⁵

¹ Decision EB134(8).

² Decision EB134(9).

³ Decision EB134(10).

⁴ Decision EB134(11).

⁵ Decision EB134(12).

Dr LEE Jong-wook Memorial Prize for Public Health

Decision: The Executive Board, having considered the report of the Dr LEE Jong-wook Memorial Prize Selection Panel, awarded the Dr LEE Jong-wook Memorial Prize for Public Health for 2014 jointly to Professor Sinata Koulla-Shiro from Cameroon for her dedication and outstanding contribution to the research and management of communicable diseases, and clinical microbiology in bacterial infections, and to the Czech Society of Cardiology of the Czech Republic for its success in improving standards of prevention, diagnosis and treatment of cardiovascular diseases. The laureates will each receive US\$ 50 000.¹

Provisional agenda of the Sixty-seventh World Health Assembly and date and place of the 135th session of the Executive Board: Item 11.7 of the Agenda (Document EB134/46)

The CHAIRMAN invited the Secretariat to outline changes in the provisional agenda and drew attention to the draft decision contained in document EB134/46.

Ms ROSE-ODUYEMI (Governing Bodies and External Relations) read out amendments to the provisional agenda of the Sixty-seventh World Health Assembly. Two additional subitems, entitled “Contributing to social and economic development: sustainable action across sectors to improve health and health equity” and “Follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage”, should be inserted under item 14 (Promoting health through the life course) and item 15 (Health systems), respectively. Following the request of the member for Cameroon, the draft action plan on newborn health would be included as a separate subitem under item 14. Under item 11 on WHO reform, subitem 11.3 on streamlining national reporting and communication with Member States should be deleted following the Board’s agreement that a report be prepared on the subject for consideration by the Board at its 136th session in January 2015.

Mr MAMACOS (United States of America)² recalled that a proposal had been made during the discussion of strengthening of palliative care to insert a subitem on access to safe surgery and anaesthesia into the provisional agenda of the Sixty-seventh World Health Assembly;³ he endorsed the submission of a draft resolution on the subject.

The CHAIRMAN said that the Secretariat had been unable to include a subitem on that subject in the provisional agenda of the Sixty-seventh World Health Assembly as it had received no formal request to that effect; the Board member had flagged the subject as needing consideration in the future. In the absence of any objections, she took it that the Board wished to adopt the draft decision contained in paragraph 4 of document EB134/46, as amended.

It was so decided.⁴

The CHAIRMAN proposed that the 135th session of the Executive Board be held on 26 and 27 May 2014, in Geneva.

It was so decided.⁵

¹ Decision EB134(13).

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

³ See summary record of the eighth meeting, section 3.

⁴ Decision EB134(14).

⁵ Decision EB134(15).

The CHAIRMAN said that, in compliance with Rule 8 of the Rules of Procedure of the Executive Board, the provisional agenda for the 135th session of the Board would be drawn up by the Director-General and circulated to Member States and Associate Members within four weeks of the closure of the current session.

5. MATTERS FOR INFORMATION: Item 13 of the Agenda

Reports of advisory bodies: Item 13.1 of the Agenda

- **Expert committees and study groups** (Documents EB134/52 and EB134/52 Add.1)

The Board noted the reports.

Progress reports: Item 13.2 of the Agenda (Document EB134/53)

Communicable diseases

- A. Global health sector strategy on HIV/AIDS, 2011–2015 (resolution WHA64.14)**
- B. Eradication of dracunculiasis (resolution WHA64.16)**

Mr GALLINAL CUENCA (Brazil) noted the numerous new developments in the global HIV/AIDS epidemic and response and in the broader public health agenda since the endorsement of the global health sector strategy on HIV/AIDS in resolution WHA64.14 in 2011. WHO should consider their implications for its post-2015 strategy on HIV/AIDS, and interested Member States should work together on new strategy proposals. Any new strategy would need to take into consideration, *inter alia*, the advances in prevention, diagnosis and treatment; the increasing importance of HIV comorbidities; the focus on improving service delivery; increasing emphasis on health equity; maximizing the potential of new resources; and ensuring coherence with new global policies and initiatives, including the goals of both universal health coverage and post-2015 sustainable development.

Mr KOLKER (United States of America)¹ endorsed the need for work on a new strategy. He strongly urged WHO to continue its targeted support at country level for antiretroviral treatment and voluntary medical male circumcision, including helping countries to interpret and implement the new circumcision guidelines effectively, and to maintain the focus on populations and settings with an increased risk of transmission, morbidity and mortality.

Turning to the outcome of the meeting of the International Commission for the Certification of Dracunculiasis Eradication on 6 December 2013, he welcomed the fact that 197 countries, territories and areas had been declared free of dracunculiasis transmission, and he expressed support for the continued leadership of WHO in the eradication of the disease.

Ms GEBREMARIAM (Ethiopia)¹ congratulated those countries certified free of dracunculiasis transmission and those entering the prequalification phase. The Minister of Health of her country had expressed his commitment to eradicating dracunculiasis at the Sixty-sixth World Health Assembly, and activities to combat the disease had been included in the National Master Plan for the control and elimination of neglected tropical diseases launched in June 2013. She welcomed the work of the Secretariat to link dracunculiasis surveillance with ongoing large-scale interventions, such as the

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

mapping of neglected tropical diseases and community-based distribution of medicines, and called for further technical support from the Secretariat and partners to strengthen surveillance, raise awareness of the reward scheme and support the implementation of the Ethiopian National Master Plan.

Noncommunicable diseases

C. Child injury prevention (resolution WHA64.27)

Promoting health through the life course

D. Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets (resolution WHA57.12)

E. Female genital mutilation (resolution WHA61.16)

F. Youth and health risks (resolution WHA64.28)

G. Implementation of the recommendations of the United Nations Commission on Life-Saving Commodities for Women and Children (resolution WHA66.7)

H. Climate change and health (resolution EB124.R5)

Mr NAVARRO BRIN (Panama) said that climate change had an impact on every basic health requirement, including clean air and drinking water; scientific evidence suggested that it enhanced the spread of many diseases. Developing countries with insufficient health systems faced the greatest difficulties in preparing for and responding to the effects of climate change and would need increased international support. The international community had yet to tackle the causes of climate change and its effects adequately and he urged the Secretariat to revise, improve and strengthen its work plan on climate change and health, which had expired in 2013. The new work plan must include provisions for greater awareness-raising, strengthened coordination with other United Nations bodies and an improved evidence base, in order to support Member States to adapt appropriately their national health systems. Because of the impact of air pollution on health, climate change and health should be included in the post-2015 development agenda. He fully supported WHO's planned global conference on climate change and health and sustainable development.

Dr SHAKEELA (Maldives) said that the global public health challenge of climate change could not be ignored. Many of the related hazards called for a greater emphasis on disease prevention and a better balance with regard to the current focus on curative and reactive measures. Despite the attention paid to climate change issues, a comprehensive strategy to combat the effects of climate change on environmental health determinants, such as water and sanitation services, and an appropriate public health response were conspicuously lacking in regional health systems. As a global problem, climate change needed a comprehensive international strategy that could be translated into regional and national actions. Coordinated preventive measures would therefore be essential in reducing the risk of health emergencies. She urged WHO to consider climate change not only in scientific and economic terms, but as a matter of human rights.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland)¹ said that female genital mutilation was one of the most extreme manifestations of gender inequality and violence against women and girls. WHO should continue to provide support and information to health workers so that they could recognize and prevent the practice. Her Government had recently made its largest-ever donor commitment to ending female genital mutilation, at around £35 million over five years, and she urged WHO to increase its support to the growing African movement against female genital mutilation.

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

On climate change and health, her Government continued to support WHO's involvement in the United Nations Framework Convention on Climate Change but called for health to be more fully integrated into the process. She therefore fully supported proposals for a WHO global conference on climate change and health and an international advisory committee of scientific health experts, and suggested that Member States' representatives be asked to participate. She stressed the importance of revising and updating the WHO work plan on climate change and health for 2014–2019 and requested further information on the progress of the process.

Dr BEJTJA (Albania) welcomed the progress report on climate change and health and commended the technical guidance provided by the Secretariat on developing the health components of national adaptation plans in a number of countries in the European Region, thus shaping a regional framework of action. He thanked partner countries for technical support and called for the Secretariat, in coordination with other organizations in the United Nations system, to continue to provide support.

Mr GALINDO (Bolivarian Republic of Venezuela)¹ urged WHO to maintain its focus on climate change and health. The success of the Secretariat's work would depend on enhanced cooperation and collaboration with other organizations in the United Nations system. His country attached great importance to the effects of climate change on health, and it was organizing a meeting in October 2014 to prepare for the Conference of the Parties to the United Nations Framework Convention on Climate Change. It had also undertaken numerous activities at national level to ensure that a social and health dimension was incorporated in its own climate change strategies. WHO must continue its participation in climate change negotiations, and he asked for further clarification on the future status of the report on climate change and health once it had been considered by the Sixty-seventh World Health Assembly.

Mr SCIAMA (France)¹ congratulated the Secretariat on its work on the work plan on climate change and health, and looked forward to a successful outcome from the Conference of the Parties to the United Nations Framework Convention on Climate Change due to be held in Paris in December 2015. He invited the international community to join his country in making climate change and health a public health priority. The increase in extreme climate events would have a serious impact on global health, and WHO should continue to support initiatives to counter the effects of climate change. He agreed with the member for Panama that the WHO work plan on climate change and health should be updated and called for a strengthening of international and national coordination and collaboration.

Ms MARTHOLM-FRIED (Sweden),¹ speaking on behalf of Australia, Belgium, Brazil, Denmark, Estonia, Finland, France, Germany, Iceland, Luxembourg, Malaysia, Netherlands, New Zealand, Norway, Sweden, Switzerland, Thailand, United Kingdom of Great Britain and Northern Ireland, and Uruguay, and referring to the progress report on reproductive health, recalled that 2014 marked the 20th anniversary of the adoption of the Cairo Programme of Action at the International Conference on Population and Development. Yet 10 years after the Health Assembly had first endorsed the reproductive health strategy to accelerate progress towards the attainment of international development goals on reproductive health, great challenges remained in meeting Millennium Development Goal 5 (Improve maternal health). The goal would only be met if sexual and reproductive health and rights were fully addressed at global, regional and national levels as part of the reproductive health strategy and its human rights-based approach. Promoting, investing in and fulfilling the sexual and reproductive health and rights of all would be essential in the eradication of poverty and the achievement of sustainable development, as well as forming a key component in the attainment of universal health coverage. Every person must be able to make informed choices about all aspects of health and well-being, and effective health care systems that respected such choices must be

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

established. WHO had played a pivotal role in realizing the Cairo Programme of Action through its reproductive health strategy and must remain committed to making sexual and reproductive health and rights a global, regional and national priority in the future development agenda.

Mr KOLKER (United States of America)¹ encouraged WHO to continue to participate actively in the work of the Climate and Clean Air Coalition to Reduce Short-Lived Climate Pollutants. He highlighted the continuing need for contributions from the global health community to health-related aspects of adaptation to climate impacts at country level, and multilaterally through activities on health in the Nairobi work programme of the United Nations Framework Convention on Climate Change.

Mr AASLAND (Norway),¹ referring to the report on female genital mutilation, said that WHO should focus on research, developing guidelines and monitoring their implementation, and scaling up treatment and reparative surgery for girls and women who had undergone female genital mutilation. He urged the Secretariat to provide advice and support to Member States in strengthening their health-sector response to female genital mutilation at national level, and to work with other relevant actors and initiatives in the field, such as the joint UNFPA–UNICEF programme on female genital mutilation.

On climate change and health, he commended WHO's work and endorsed the points made by the member for Panama and the representatives of the United Kingdom of Great Britain and Northern Ireland and the United States of America on the status of the WHO work plan. Evidence indicated that air pollution was a major avoidable cause of morbidity and mortality, leading to an estimated 6.5 million premature deaths annually. Policies to improve air quality could limit climate change and widen access to sustainable energy. The magnitude of the growing global health problem merited more attention from WHO as a whole, and the health sector must articulate its intended coordinated contribution and engage with other sectors in developing a robust preventive response. Meanwhile, air quality was deteriorating and exacerbating ill health in many parts of the world, including emerging economies. WHO should strengthen its efforts to deal with the public health impacts of air pollution in response to emerging new evidence, by inter alia promoting research, monitoring and evaluation, intensifying the response of national health systems, and building cross-sectoral cooperation with other relevant actors, such as the Climate and Clean Air Coalition to Reduce Short-Lived Climate Pollutants.

Ms ORTEGA CRESPO (Spain)¹ said that, in response to the effects of climate change, her Government had implemented a national adaptation plan and was in the process of developing a third programme of work covering the period until 2020. The implications of climate change for the health sector were serious and measures were being introduced to mitigate them, such as engaging in multisectoral coordination with the Ministry of Agriculture on the national Health and Climate Change Observatory, conducting research, increasing the resilience of health systems, carrying out monitoring and surveillance, and building response capacity. She urged the Secretariat to continue its vital work, in the light of future commitments such as the United Nations Climate Summit.

Mr LUCIO (World Meteorological Organization) underscored the magnitude of the global threat posed by climate change. As predicted by the Intergovernmental Panel on Climate Change, extreme weather, climate variability and long-term climate change posed key challenges to the performance and management of the health sector. "Climate-informed" health systems and services could save lives and optimize the use of resources by identifying and targeting the populations most at risk, and building capacity to manage such health risks. Recognizing the importance of the links between climate and health, the Global Framework for Climate Services placed emphasis on providing

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

services to health and the need to support the health sector. The *Atlas of health and climate*¹ provided scientific information on the spread and impacts of health problems induced by climate. In October 2013, the Global Framework for Climate Services had launched its Adaptation Programme in Africa in collaboration with WFP, WHO and the International Federation of Red Cross and Red Crescent Societies, and a joint WHO/WMO office was being established to support implementation of the health component of that framework. He urged the health and meteorological communities to collaborate at regional and national levels on designing WHO's next work plan on climate change and health for 2014–2019.

Ms WANJAU (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, welcomed the progress report on youth and health risks. With 43% of the world's population under 25 years of age and 2.6 million preventable deaths occurring annually among young people, there was a strong need for a structured mechanism to tackle youth-related health issues. Such a mechanism could be used to monitor youth networks and trends in order to ensure that current behaviours and conditions did not compromise the health of young people. It would also enable them to contribute to policies and strategies that affected them. Young people faced barriers to accessing health care services and were vulnerable to a unique set of health risks. One theme of the World Conference on Youth 2014 (Colombo, May 2014) would be promoting healthy lives and access to health. She called on WHO to ensure that its reform process would lead to a greater willingness on its part to engage with young people.

Dr DOEBBLER (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN, welcomed the progress report on climate change and health. He had noted WHO's participation in recent conferences on climate change and health and encouraged the Organization to be more active in future meetings. Member States were also beginning to take more interest in climate change and the Secretariat's work on the subject. He welcomed the Secretariat's increased efforts to train and sponsor health representatives to attend such meetings. WHO's continued engagement, in the context of the 20th Conference of the Parties to the Framework Convention (Lima, December 2014) and the pre-Conference session to be hosted by the Bolivarian Republic of Venezuela, was crucial as a means of making the case for health. The Fifth Assessment Report of the Intergovernmental Panel on Climate Change had concluded that the health of thousands of millions of people would be adversely affected by climate change, in particular in sub-Saharan Africa, where as many as 100 million people could die as a result. He therefore called on WHO to participate in the 55th Ordinary Session of the African Commission on Human and People's Rights (Luanda, April–May 2014), in order to consider climate change and the right to health. WHO should also take steps to ensure that the Green Climate Fund of the United Nations Framework Convention on Climate Change covered health, above all for those most vulnerable to the effects of climate change. He commended the Secretariat's continued work, emphasizing the need to articulate a human rights-based approach as potentially the most effective way of engaging the international community in actions to mitigate climate change.

Dr NEIRA (Public Health, Environmental and Social Determinants) expressed appreciation for speakers' comments. As to whether and how future progress reports on the WHO work plan on climate change and health were to be submitted following the expiry of the time frame for reporting under the Medium-term strategic plan 2008–2013, she would consult on the procedure to be followed over the period 2014–2019 and report back to the Board. Several speakers had supported a multisectoral approach in climate change-related work, with emphasis on strengthening the resilience of the health sector. WHO would continue to support the international dialogue in the context of the 20th Conference of the Parties to the United Nations Framework Convention on Climate Change in Lima in December 2014 and the pre-Conference session to be hosted by the Bolivarian Republic of

¹ Atlas of health and climate. Geneva: World Health Organization, World Meteorological Organization; 2012.

Venezuela, as well as at the 21st Conference of the Parties in Paris in 2015. The Secretariat would be producing reports on air pollution in response to strong demand from Board members; it would also be releasing new figures on the basis of evidence supplied by Member States, which should serve to raise awareness of the public health issues referred to by the representative of Norway and others.

Health systems

- I. Global strategy and plan of action on public health, innovation and intellectual property (resolution WHA61.21)**
- J. Availability, safety and quality of blood products (resolution WHA63.12)**
- K. Human organ and tissue transplantation (resolution WHA63.22)**
- L. WHO strategy on research for health**

Preparedness, surveillance and response

- M. WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies (resolution WHA65.20)**

Mr GALLINAL CUENCA (Brazil) welcomed the progress report on the global strategy and plan of action on public health, innovation and intellectual property. He thanked WHO and other partners for collaborating in the organization of a consultation on broadening access to HIV medicines in middle-income countries (Brasília, June 2013). The global strategy was directly connected to a range of elements being discussed at the present session, including strengthening regulatory authorities, prequalification processes and access to essential medicines, and consequently its implementation should help to fill many gaps in national health systems. As several members had clearly stated, the impact that intellectual property issues could have on health systems underscored the need to resist further obstacles to applying the flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights.

Ms GARCIA TUÑÓN (Spain)¹ welcomed the progress report on human organ and tissue transplantation. The WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation had already served to strengthen legislation on transplantation in many countries. As many medical products of human origin used in clinical practice were donated, they could pose both ethical difficulties and the risk of communicable disease. Safety would be assured through universally agreed standards for monitoring donors and recipients of medical products of human origin that recognized the non-commercial nature of the human body and its parts as such, and through strict traceability associated with biovigilance and surveillance. Although the non-commercial aspect was not incompatible with recovering the costs of medical interventions using medical products of human origin, incentives to elicit the consent of donors served to increase inequity and undermine social values. The Secretariat should continue to work with Member States to develop universally agreed principles for guiding the use of medical products of human origin, paying special attention to their origin, their non-commercial aspect and the need for traceability mechanisms.

Mr PIPPO BRIANT (Argentina) aligned himself with the statement made by the member for Brazil on intellectual property and endorsed the comments made by the representative of Spain on human organ and tissue transplantation, highlighting the problems that could arise from new developments in the commercialization of medical products of human origin. The latter posed serious ethical questions that WHO could not ignore, and he asked the Secretariat to prepare a report on the

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

feasibility of extending implementation of the WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation to other products of human origin.

Ms VUKOVIĆ (Croatia), speaking on behalf of the European Union and its Member States, recognized that, in the two years since the adoption of resolution WHA65.20, relating to WHO's response to humanitarian emergencies, WHO had made much progress, including the establishment of the Emergency Response Framework. She commended WHO's leadership in recent humanitarian crises, in particular its rapid response to typhoon Haiyan in the Philippines, and welcomed the enhancement of its preparedness and surge capacity. Having strengthened its leadership of the Global Health Cluster, WHO should encourage common needs assessments and strategic results-based planning and decision-making, and further improve its health cluster performance at all levels, and particularly in countries. WHO's humanitarian activities should allow for continuity in long-term development activities and recognize the importance of resilience.

A major concern was the growing number of threats and violent acts against health care personnel, transport and facilities in humanitarian emergencies in conflict zones, not least because they restricted access to care for entire communities. She encouraged the Secretariat to participate in initiatives such as Health Care in Danger project, led by the International Committee of the Red Cross. She urged donors to provide financial support for WHO's humanitarian activities in the biennium 2014–2015, and highlighted the more general need to reverse the downward trend in the financing of the humanitarian health sector. She requested up-to-date information on overall funding of the sector, in particular on pooled funds such as the United Nations Central Emergency Response Fund. The Secretariat should ensure that its procedures, including financing and temporary recruitment, were apt for rapid responses.

Mr BERTONI (Italy),¹ commending progress on the availability, safety and quality of blood products, observed that Italy had long been self-sufficient in safe blood components for transfusion and had made substantial progress towards self-sufficiency in plasma-derived products. Remarking on the expansion in international commercial activities related to blood, plasma and cellular donations, he recalled that, at a high-level policy-makers' forum convened by WHO in collaboration with the Governments of Italy and Japan (Rome, October 2013), the Rome Declaration on Achieving Self-sufficiency in Safe Blood and Blood Products, based on Voluntary Non-Remunerated Donation had been adopted. The Declaration recognized that the commitment and support of national governments in developing and implementing policies to achieve self-sufficiency in safe blood and blood products, based on voluntary non-remunerated donation, were prerequisites for sustainable national blood and plasma programmes. In order to advance the initiative, his Government wanted to organize a side event on self-sufficiency in safe blood and blood products at the Sixty-seventh World Health Assembly and would welcome the collaboration of other Member States.

Dr BEJTJA (Albania) aligned himself with the statement made by the member for Croatia.

Dr MAKUBALO (South Africa) commended the Secretariat's work in implementing the global strategy and plan of action on public health, innovation and intellectual property. The Board's decision on the demonstration projects² marked an important step towards achieving the objectives set out in the global strategy, but much hard work lay ahead, as several Board members had pointed out. Noting that the global strategy outlined activities and responsibilities for other organizations of the United Nations system and Member States, as well as the Secretariat, she exhorted all those concerned to strive for progress in advancing the agenda.

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

² Decision EB134(5).

Dr USHIO (Japan) endorsed the statement made by the representative of Italy. The Government of Japan, having supported the Rome Declaration, would continue to contribute to ongoing work in that area.

Ms GABBASOVA (Russian Federation)¹ said that the WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation had contributed to better systems of organ donation and transplantation in many countries. In her country, the Principles had been used as the basis for a new law on organ donation and transplantation, including the establishment of a national register for donors and recipients as a measure to prevent the unlawful removal of organs. Preventing disease was an essential element in reducing demand for transplantation; nevertheless demand was increasing worldwide, and the number of transplants performed met only 10% of the global need. The proposals for a global coding system for transplants were important, as it would assure the quality and safety of donated material and prevent the unlawful trade in donor organs and cells. She commended the progress made in response to resolution WHA63.22 and emphasized the need for well organized, ethical donation systems, as well as innovative approaches to organ replacement, including the use of cellular technologies.

Ms LANTERI (Monaco),¹ referring to the statement made by the member for Croatia, noted the increasing frequency and severity of humanitarian crises. The progress report clearly showed that WHO was finding it increasingly difficult to mobilize the funding needed to respond to such crises. Recent deployments of WHO staff had included the Central African Republic, the Democratic Republic of the Congo, the Philippines, the Sahel region of Africa, Sudan and the Syrian Arab Republic. She therefore strongly requested that an item be placed on the provisional agenda of future Health Assemblies describing the situations where a WHO presence had been required, accompanied by data on cost and human resources, so as to give Member States a clear idea of the resources involved and, in the context of WHO reform and the financing dialogue, to allow those resources to be mobilized.

Mr KOLKER (United States of America),¹ endorsing the comments made by the member for Croatia and the representative of Monaco, welcomed the Secretariat's intention to accelerate plans for the systematic collection of data and the establishment of an evidence base on violence against health facilities and health workers, as called for in resolution WHA65.20. He praised the Director-General for speaking out against attacks on health workers and health facilities in, among other countries, the Syrian Arab Republic, Pakistan and Nigeria, as well as her continued attention to the situation.

Mr BOISNEL (France)¹ commended the efforts made to implement resolution WHA65.20, despite severe constraints. The Secretariat had also enhanced the speed and effectiveness of its response to humanitarian emergencies, which had proved invaluable in complex emergency situations, such as those in the Central African Republic and the Syrian Arab Republic. He urged the Secretariat to continue with the systematic collection and dissemination of data on attacks on health workers, patients, health facilities and medical equipment in humanitarian settings. The neutrality of all those concerned had to be protected at all costs, out of respect for international humanitarian law and WHO's vocation.

Ms WANJAU (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN and on behalf of the World Health Professions Alliance, expressed support for WHO's work as Health Cluster lead agency and the Secretariat's responses to the growing demands of health in humanitarian emergencies, as well as its collection and dissemination of data on attacks on health workers and health facilities, and its stronger advocacy for the neutrality of health

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

workers. In crisis situations, health workers, health facilities and transport were increasingly at greatest risk of assault, arrest and obstruction in their duties and were targets for parties in conflict. Health workers were exposed to serious risk of injury and death. Recent developments that undermined basic humanitarian principles and values, medical ethics and the right of populations to access health care were a matter of great concern. Reminding Member States of their obligations within the framework of resolution WHA65.20, she strongly recommended, as a matter of priority, the adoption of concrete measures to ensure that health care personnel, facilities and transport exclusively assigned to caring for the sick and injured were fully respected and protected in all circumstances, in accordance with humanitarian law.

Ms DURLING (World Vision International), speaking at the invitation of the CHAIRMAN, drew attention to the number of health workers who had been murdered in the performance of their duties in Nigeria, Pakistan, the Syrian Arab Republic, Colombia and Afghanistan and praised the Director-General for publicly condemning the violations. Resolution WHA65.20 strengthened WHO's role in responding to such aggression through the collection and dissemination of data on attacks on health facilities, health workers, transport and patients. The information gathered would enable the global health community to formulate strategies to protect health services. In addition to the current consultations with organizations of the United Nations system and outside experts, additional measures were needed as a priority, including a plan for implementation of the resolution, including identification of budgetary requirements and design of pilot projects. Her organization was ready to assist WHO in developing the evidence base in order to increase the security of people seeking care and those who served them.

Corporate services/enabling functions

N. Multilingualism: implementation of action plan (resolution WHA61.12)

Mr VEGA MOLINA (Spain)¹ commended WHO's efforts, including improvement of the website and expansion of the content of the Institutional Repository for Information Sharing. The importance of multilingualism in the efficient running of the Organization had recently been reinforced by United Nations General Assembly resolution 67/292, adopted in July 2013. Moreover, Rule 23 of the Rules of Procedure of the Executive Board stipulated that speeches made in an official language shall be interpreted into the other official languages in all meetings of the Board and of committees established by it. It was unacceptable to cite time constraints as excuses for non-compliance. He commended the efficient manner in which the meetings of the Board and its Programme, Budget and Administration Committee had been conducted.

Mr TSECHKOVSKI (Russian Federation)¹ commended the progress made since adoption of resolution WHA61.12, particularly the increase in the number of publications in Russian. In accordance with the action plan, 40 WHO publications had been identified as priorities for translation into Russian; 70% had already been translated and the rest would be translated imminently. All publications would be disseminated electronically through the WHO website to entities working in the Russian health sector and in other countries of the Commonwealth of Independent States. The number of Russian webpages on the WHO website had also increased, and more than 20 new subsites on technical subjects were available in Russian, including regular updates on important matters of international health. In 2013 two special compilations of articles from the *Bulletin of the World Health Organization* had been published in Russian. Such action on multilingualism had resulted in good interaction between Member States, headquarters and regional offices and exemplified good practice.

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

Mr BOISNEL (France)¹ commended the Secretariat's work to put the action plan on multilingualism into practice and endorsed the comments made by the representative of Spain. He asked that the web portal for the financing dialogue be made available in all official languages before practical work began on a subject that would change the culture of the Organization.

Mr GALINDO (Bolivarian Republic of Venezuela)¹ noted the progress made and endorsed the comments of the representatives of Spain and the Russian Federation.

The DIRECTOR-GENERAL thanked members and representatives for their comments and assured them that appropriate action would be taken.

6. CLOSURE OF THE SESSION

The DIRECTOR-GENERAL warmly congratulated the Chairman on her ability and discipline, as demonstrated by the timely completion of a challenging agenda, and thanked Professor Halton for her role in taking the Board through tough issues. She commended the way in which members had demonstrated that there could be effective governance within the Organization and, in particular, their determination to reflect the spirit of reform in their actions as well as words, as illustrated by the close attention paid to draft resolutions.

After the customary exchange of courtesies, the CHAIRMAN declared the 134th session of the Executive Board closed.

The meeting rose at 16:25.

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

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