



WORLD HEALTH ORGANIZATION

SIXTY-FOURTH WORLD HEALTH ASSEMBLY

GENEVA, 16–24 MAY 2011

SUMMARY RECORDS OF COMMITTEES

REPORTS OF COMMITTEES

LIST OF PARTICIPANTS

GENEVA

2011

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 Sixty-fourth World Health Assembly was held at the Palais des Nations, Geneva, from 16 to 24 May 2011, in accordance with the decision of the Executive Board at its 127th session. Its proceedings are issued in two printed volumes, containing, in addition to other relevant material:

Resolutions and decisions, Annexes – document WHA64/2011/REC/1

Summary records of committees, reports of committees – document WHA64/2011/REC/3

The verbatim records of plenary meetings are available in a digital format at <http://apps.who.int/gb/or>

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 - 1.3 Election of the five Vice-Presidents, the Chairmen of the main committees, and establishment of the General Committee
 - 1.4 Adoption of the agenda and allocation of items to the main committees
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¹ Adopted at the second plenary meeting.

² Including election of Vice-Chairmen and Rapporteur.

- 12.2 Medium-term strategic plan 2008–2013: interim assessment
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 - 18.6 Interim progress report of the Working Group on the Election of the Director-General of the World Health Organization
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¹ Including election of Vice-Chairmen and Rapporteur.

- 20. International Agency for Research on Cancer: amendments to Statute
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 - 13.13 Infant and young child nutrition: implementation plan
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 - B. Onchocerciasis control through ivermectin distribution (resolution WHA47.32)
 - C. Climate change and health (resolutions WHA61.19 and EB124.R5)
 - D. Improvement of health through sound management of obsolete pesticides and other obsolete chemicals (resolution WHA63.26)
 - E. Improvement of health through safe and environmentally sound waste management (resolution WHA63.25)
 - F. Working towards universal coverage of maternal, newborn and child health interventions (resolution WHA58.31)
 - G. Female genital mutilation (resolution WHA61.16)
 - H. Strategy for integrating gender analysis and actions into the work of WHO (resolution WHA60.25)
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A64/3	Address by Dr Margaret Chan, Director-General, to the Sixty-fourth World Health Assembly
A64/4	The future of financing for WHO. World Health Organization: reforms for a healthy future
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A64/6	Medium-term strategic plan 2008–2013: interim assessment
A64/7 and A64/7 Add.1	Medium-term strategic plan 2008–2013 and Proposed programme budget 2012–2013
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A64/8 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly ²
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¹ See page xi.

² See document WHA64/2011/REC/1, Annex 6.

³ See document WHA64/2011/REC/1, Annex 2.

⁴ See document WHA64/2011/REC/1, Annex 1.

A64/10 Add.2	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly ¹
A64/11	Health-related Millennium Development Goals
A64/11 Add.1	Health-related Millennium Development Goals. Commission on Information and Accountability for Women's and Children's Health
A64/12	Health system strengthening. Improving support to policy dialogue around national health policies, strategies and plans
A64/13	Health system strengthening. Current trends and challenges
A64/14	Global immunization vision and strategy. Progress report and strategic direction for the Decade of Vaccines
A64/15	Draft WHO HIV strategy 2011–2015 ²
A64/16	Substandard/Spurious/Falsely-Labelled/Falsified/Counterfeit Medical Products
A64/17	Smallpox eradication: destruction of variola virus stocks
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A64/19	Malaria. Prevention and control: sustaining the gains and reducing transmission
A64/20	Eradication of dracunculiasis
A64/21	Prevention and control of noncommunicable diseases. WHO's role in the preparation, implementation and follow-up to the high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases (September 2011)
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A64/22	Maternal, infant and young child nutrition: implementation plan
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¹ See document WHA64/2011/REC/1, Annex 6.

² See document WHA64/2011/REC/1, Annex 3.

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¹ See document WHA64/2011/REC/1, Annex 4.

- A64/42 Collaboration within the United Nations system and with other intergovernmental organizations
- A64/43 International Agency for Research on Cancer: amendments to Statute¹
- A64/44 Awards. Amendments to the Statutes of the Dr LEE Jong-wook Memorial Prize for Public Health
- A64/45 Implementation of Programme budget 2010–2011: interim report. First report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-fourth World Health Assembly
- A64/46 Medium-term strategic plan 2008–2013: interim assessment. Third report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-fourth World Health Assembly
- A64/47 Medium-term strategic plan 2008–2013 and Proposed programme budget 2012–2013. Fourth report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-fourth World Health Assembly
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- A64/50 Interim report of the External Auditor. Seventh report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-fourth World Health Assembly
- A64/51 Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution and Special arrangements for settlement of arrears: Ukraine. Fifth report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-fourth World Health Assembly
- A64/52 Committee on Credentials

¹ See document WHA64/2011/REC/1, Annex 5.

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A64/55	First report of Committee B
A64/56	Election of Members entitled to designate a person to serve on the Executive Board
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Information documents

A64/INF.DOC./1	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan (report by the Ministry of Health of the Syrian Arab Republic)
A64/INF.DOC./2	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan (report by the Permanent Observer of Palestine to the United Nations and Other International Organizations at Geneva)
A64/INF.DOC./3	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan (report of the Director of Health, UNRWA, for the year 2010)
A64/INF.DOC./4	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan (report by the Ministry of Health of Israel)
A64/INF.DOC./5	The future of financing for WHO. Reforms for a healthy future: development plan

Diverse documents

A64/DIV/1 Rev.1	List of delegates and other participants
A64/DIV/2	Guide for delegates to the World Health Assembly
A64/DIV/3	Decisions and list of resolutions
A64/DIV/4	List of documents
A64/DIV/5	Address by Her Excellency Sheikh Hasina, Prime Minister of the Government of Bangladesh, to the Sixty-fourth World Health Assembly
A64/DIV/6	Address by Mr Bill Gates to the Sixty-fourth World Health Assembly

OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES

President

Dr Christos PATSALIDES (Cyprus)

Vice-Presidents

Professor C.O. ONYEBUCHI CHUKWU
(Nigeria)

Mr RI Jang Gon (Democratic People's
Republic of Korea)

Dr Enrique T. ONA (Philippines)

Dr Mohammad Hussein NICKNAM
(Islamic Republic of Iran)

Mrs Therese BAPTISTE-CORNELIS
(Trinidad and Tobago)

Secretary

Dr Margaret CHAN, Director-General

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Barbados, Costa Rica, Fiji, Gabon, Guinea Bissau, Latvia, Malawi, Maldives, New Zealand, Pakistan, Serbia, Uzbekistan.

Chairman: Dr Kevin WOODS (New Zealand)

Vice-Chairman: Professor David MPHANDE
(Malawi)

Secretary: Mr Xavier DANNEY, Senior Legal
Officer

General Committee

The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the Chairmen of the main committees, together with delegates of the following Member States: Albania, Botswana, China, Cuba, Egypt, Eritrea, Ethiopia, France, Gambia, Guinea, Hungary, India, Micronesia (Federated States of),

Paraguay, Russian Federation, United Kingdom of Great Britain and Northern Ireland, and United States of America.

Chairman: Dr Christos PATSALIDES
(Cyprus)

Secretary: Dr Margaret CHAN, Director-
General

MAIN COMMITTEES

Under Rule 33 of the Rules of Procedure of the World Health Assembly, each delegation is entitled to be represented on each main committee by one of its members.

Committee A

Chairman: Dr Walid AMMAR (Lebanon)

Vice-Chairmen: Dr Henry MADZORERA
(Zimbabwe) and Mr Nandi GLASSIE (Cook
Islands)

Rapporteur: Dr Mast KULZHANOV
(Kazakhstan)

Secretary: Dr Maged YOUNES, Director,
Food Safety, Zoonoses and Foodborne
Diseases

Committee B

Chairman: Dr Maria Teresa VALENZUELA
(Chile)

Vice-Chairman: Dr Ante-Zvonimir GOLEM
(Croatia) and Mr Zangley DUKPA (Bhutan)

Rapporteur: Dr T. Tuitama Leao TUITAMA
(Samoa)

Secretary: Dr Manuel DAYRIT, Director,
Human Resources for Health

PART I

**SUMMARY RECORDS OF MEETINGS
OF COMMITTEES**

GENERAL COMMITTEE

FIRST MEETING

Monday, 16 May 2011, at 10:40

Chairman: Dr C. PATSALIDES (Cyprus)
President of the World Health Assembly

1. ADOPTION OF THE AGENDA: Item 1.4 of the Agenda (Document A64/1)

The CHAIRMAN reminded the Committee that, under its terms of reference as defined in Rule 31 of the Rules of Procedure of the World Health Assembly, its first task was to consider the adoption of the agenda. In the absence of any objection, he took it that the Committee wished to recommend the deletion of two items included on the provisional agenda prepared by the Executive Board (document A64/1): item 5, Admission of new Members and Associate Members, as no new applications had been received; and, as a consequence, item 17.6, Assessment of new Members and Associate Members.

It was so agreed.

The CHAIRMAN further took it that the Committee wished to recommend the adoption of the agenda, as amended.

It was so agreed.

2. ALLOCATION OF AGENDA ITEMS TO THE MAIN COMMITTEES AND PROGRAMME OF WORK OF THE HEALTH ASSEMBLY: Item 1.4 of the Agenda (Documents A64/1 and A64/GC/1)

The CHAIRMAN said that the General Committee's recommendations on item 1 would be transmitted to the Health Assembly at the second plenary meeting. Items 2 to 4 and 6 to 9 would also be taken up in plenary. Given the heavy agenda provisionally allocated to Committee A, he proposed that items 13.13 to 13.17 should be transferred to Committee B.

It was so agreed.

The CHAIRMAN drew attention to the preliminary daily timetable set out in Annex 2 of document A64/1 and provided additional details of the proposed timing for consideration of specific items. In the absence of any objection, he took it that the Committee wished to recommend the preliminary daily timetable, as amended.

It was so agreed.

The CHAIRMAN announced that the second meeting of the General Committee would be held on Wednesday, 18 May to consider proposals for the election of Member States entitled to designate a person to serve on the Executive Board, and to review progress and decide on any alteration to the allocation of agenda items to the main Committees, or to the timetable, as it deemed necessary.

The General Committee then drew up the programme of work for the Health Assembly until Wednesday, 18 May.

It was so agreed.

The meeting rose at 10:55.

SECOND MEETING

Wednesday, 18 May 2011, at 18:05

Chairman: Dr C. PATSALIDES (Cyprus)
President of the World Health Assembly

1. PROPOSALS FOR THE ELECTION OF MEMBERS ENTITLED TO DESIGNATE A PERSON TO SERVE ON THE EXECUTIVE BOARD (Document A64/GC/2)

The CHAIRMAN reminded Members that the procedure for drawing up the list of proposed names to be transmitted by the General Committee to the Health Assembly for the annual election of Members entitled to designate a person to serve on the Executive Board was governed by Article 24 of the Constitution and Rule 100 of the Rules of Procedure of the World Health Assembly. In accordance with those provisions, the Committee needed to nominate 10 new Member States for that purpose.

To help the General Committee in its task, two documents were before it. The first indicated the present composition of the Executive Board by region, on which list were underlined the names of the 10 Members whose term of office would expire at the end of the Sixty-fourth World Health Assembly and which had to be replaced. The second (document A64/GC/2) contained a list, by region, of the 10 Members that it was suggested should be entitled to designate a person to serve on the Executive Board. Vacancies, by region, were: Africa, 4; the Americas, 1; the Eastern Mediterranean, 1; Europe, 2; South-East Asia, 1; and the Western Pacific, 1.

As no additional suggestion was made by the General Committee, the CHAIRMAN noted that the number of candidates was the same as the number of vacant seats on the Executive Board. He therefore presumed that the General Committee wished, as was allowed under Rule 78 of the Rules of Procedure, to proceed without taking a vote since the list apparently met with its approval.

There being no objection, he concluded that it was the Committee's decision, in accordance with Rule 100 of the Rules of Procedure, to transmit a list comprising the names of the following 10 Members to the Health Assembly, for the annual election of Members entitled to designate a person to serve on the Executive Board: Cameroon, Mexico, Myanmar, Nigeria, Papua New Guinea, Qatar, Senegal, Sierra Leone, Switzerland and Uzbekistan.

It was so agreed.

2. ALLOCATION OF WORK TO THE MAIN COMMITTEES AND PROGRAMME OF WORK OF THE HEALTH ASSEMBLY

Dr YOUNES (Secretary, Committee A), speaking on behalf of the Chairman of Committee A, reported on the progress of the work of that committee.

Dr GOLEM (Croatia), Vice-Chairman of Committee B, reported on the progress of the work of that committee.

The General Committee then drew up the programme of work of the Health Assembly for Thursday, 19 May and Friday, 20 May.

The CHAIRMAN proposed to review the progress of work during those two days with the chairmen of the committees and to revise the programme accordingly, if necessary.

It was so agreed.

The meeting rose at 18:20.

COMMITTEE A

FIRST MEETING

Monday, 16 May 2011, at 15:30

Chairman: Dr W. AMMAR (Lebanon)

1. OPENING OF THE COMMITTEE: Item 10 of the Agenda

The CHAIRMAN welcomed participants and introduced the representatives of the Executive Board, Dr Kőkény (Hungary), Dr Buss (Brazil), Mr Yusof (Brunei Darussalam) and Dr Mohamed (Oman), who would report on the Board's discussion of agenda items before the Committee.¹ Accordingly, any views they expressed would be those of the Board, not of their respective governments.

Election of Vice-Chairmen and Rapporteur

The CHAIRMAN informed the Committee that Dr Henry Madzorera (Zimbabwe) and Mr Nandi Glassie (Cook Islands) had been proposed as Vice-Chairmen and Dr Mast Kulzhanov (Kazakhstan) as Rapporteur.

Decision: Committee A elected Dr H. Madzorera (Zimbabwe) and Mr N. Glassie (Cook Islands) as Vice-Chairmen and Dr M. Kulzhanov (Kazakhstan) as Rapporteur.²

2. ORGANIZATION OF WORK

The CHAIRMAN said that, in view of the full agenda, delegates should limit their interventions to three minutes and that he would interrupt delegates who exceeded that time. If a delegate spoke on behalf of a group of countries, delegates from other countries within that group should limit their interventions. He further proposed that agenda item 13.4 should be covered during the current meeting and that agenda items 13.13, 13.14, 13.15, 13.16 and 13.17 should be moved from Committee A to Committee B.

It was so agreed.

Dr PÁVA (Hungary) recalled that, following an agreement between WHO and the European Commission in 2000, the European Union had participated in the World Health Assembly as an observer. She requested that it should also be invited to participate as an observer, without vote, in meetings of subcommittees and other subdivisions of the Health Assembly dealing with matters within the competence of the European Union.

It was so agreed.

¹ By virtue of Rules 42 and 43 of the Rules of Procedure of the World Health Assembly.

² Decision WHA64(3).

3. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda

Health system strengthening: Item 13.4 of the Agenda (Documents A64/12, A64/13, and EB128/2010/REC/1, resolutions EB128.R8, EB128.R9, EB128.R10, EB128.R11 and EB128.R12)

Dr KÖKÉNY (representative of the Executive Board) recalled that, at the 128th session of the Executive Board in January 2011, the Secretariat had presented two reports on health system strengthening¹ and the Board had adopted five resolutions with amendments. Board members had recognized two challenges, namely the health workforce crisis in many Member States and the lack of universal coverage. The resolutions recommended by the Executive Board in resolutions EB128.R8 and EB128.R9 aimed to guide the Secretariat in prioritizing those issues by following up implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel and by confirming the conclusions of *The world health report 2010*.

Dr MANGUELE (Mozambique), speaking on behalf of the Member States of the African Region, said that they were pursuing a multisectoral approach to health system strengthening. During the previous five years, priority had been given to strengthening health systems by focusing on people-centred primary care, universal coverage and the inclusion of health in all development plans. Global policy recommendations on retention of human resources for health were expected to help countries to increase the availability of health professionals in rural and remote areas. The adoption in September 2010 of the Framework for the implementation of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa represented a high-level commitment by African Member States to achieving better health for the Region's people.

The Secretariat was active in working to improve the quality, efficacy and safety of medicines in Africa through regulatory harmonization of medicines, information exchange and knowledge transfer. Many countries were striving to bring coherence to fragmented health systems and to develop and implement more robust national health policies, strategies and plans. The principles of the Paris Declaration on Aid Effectiveness were also being implemented in various African Member States. Increased and predictable external funding would be required in future years, and more domestic funds would also have to be raised to meet the demand for equitable access to health care and social protection in health.

In order to improve existing national health policies, strategies and plans, which had not always yielded expected results, it was important to heed good practice. Broad consultative mechanisms should include all relevant stakeholders. Priorities should be identified through balanced and comprehensive approaches. Policies, strategies and plans should be realistic and in line with available capacities, resources and constraints. They should match the national political agenda and link with operational plans and programmes in order to ensure coherence in planning and avoid problems in implementation.

The five resolutions before the Committee would support national policy, strategy and planning processes.

Dr VALENZUELA (Chile) expressed solidarity with the victims of the recent earthquake and tsunami in Japan. She welcomed the draft resolution on strengthening the national health emergency and disaster management capacities and resilience of health systems. Existing international mechanisms, such as the United Nations International Strategy for Disaster Reduction, had spurred action in an area that was rarely given priority until a disaster occurred. Following the earthquake in her country in 2010, various reforms had been undertaken in the area of civil protection and disaster preparedness and response, and an objective relating to emergencies and disasters had been included in the national health plan 2011–2020. As highlighted in the draft resolution contained in

¹ Documents EB128/8 and EB128/37.

resolution EB128.R10, a comprehensive intersectoral approach to disaster risk management was essential. All stakeholders should work together on all aspects of risk management: preparation, prevention, mitigation, response, reconstruction and rehabilitation. She encouraged Member States to support the draft resolution.

Dr HWOAL (Iraq) said that health system strengthening must be a continuing process. Primary health care and family medicine services formed the foundation of any health system and the basis for the provision of preventive care, and as such should be continually strengthened and modernized. It was important to ensure equal access to and distribution of health services across geographical areas. It was equally important to ensure the quality of health systems through the certification of health institutions and to strengthen their capacity to respond in emergency and disaster situations.

Dr PÁVA (Hungary), speaking on behalf of the European Union, said that the candidate countries Turkey, Croatia, The former Yugoslav Republic of Macedonia, Montenegro, Iceland, the countries of the Stabilisation and Association Process and potential candidates Serbia, as well as Ukraine, Republic of Moldova and Armenia aligned themselves with her statement. The European Union had adopted the principles of universal access to good-quality care, equity and solidarity, as reflected in the Conclusions of the Council of the European Union in 2006 on common values and principles in European Union health systems and the 2008 Tallinn Charter and the 2010 European Union Council Conclusions on global health.

Robust and adequately resourced health systems were essential for attaining the health-related Millennium Development Goals. The European Union would support partner countries in strengthening their health systems in order to ensure that they could provide universal coverage of quality care.

It was a cause for concern that a large proportion of the world's population still lacked access to or could not afford health care or medicines. Health system financing decisions were pivotal in ensuring effective and equitable access to health services, as had been highlighted in *The world health report 2010*. The European Union encouraged the transition towards risk protection systems and would support developing countries in establishing fair and sustainable financing schemes that pooled resources and risk, decreased direct payments at the point of delivery for vulnerable groups and aimed to achieve universal and equitable coverage of essential health services. Health financing reforms should be tailored to country contexts, and might involve both public and private approaches.

In order to support WHO in promoting sustainable health systems financing and affordable universal coverage, the European Union had drafted the resolution adopted as resolution EB128.R8, which underlined the contribution of financing structures to attainment of Millennium Development Goals 4, 5 and 6, and to meeting the challenge of noncommunicable diseases. Health financing systems should be more efficient, transparent and accountable, and should facilitate effective universal coverage, value for money, and elimination of waste of resources and corruption. Public financial management systems and purchasing mechanisms should be strengthened in order to create sustainable health systems.

The four other draft resolutions before the Committee should embody the agreed principles of gender sensitive people-centred care, equity, health in all policies and inclusive leadership. Ensuring access to medicines was a priority, as was addressing the global shortage of human resources for health. Member States should expand education and training and ensure an effective distribution of health workers in accordance with their needs. The European Union reaffirmed its support for the WHO Global Code of Practice on the International Recruitment of Health Personnel and encouraged Member States to implement it and to strengthen bilateral, regional and global cooperation for the sharing of experience and best practice.

The number of disasters around the world had doubled over the previous 30 years and no country was free from the risk of a catastrophic event. She encouraged Member States to be proactive in developing national plans for assuring health services during emergencies and in enhancing disaster preparedness and response in the health sector.

The European Union welcomed WHO's comprehensive and integrated approach to health system strengthening, and acknowledged its role within the International Health Partnership and related initiatives (IHP+), and its efforts to promote the alignment of donor support with country-led national health strategies. The approach of joint assessment of national strategies, developed within that Partnership, had been used successfully to assess and improve national health strategies and plans and would help to increase donor confidence in funding those plans.

Dr MYINT HTWE (Myanmar) urged WHO to prioritize human resource issues during the biennium 2012–2013, in particular by strengthening fellowships, study tours and training workshops and identifying good training institutions. Technical support tailored to national human resource needs should be incorporated into WHO's workplan for each country, and progress in implementing regional strategies for human resource development should be assessed with a view to planning activities for the next biennium. The activities undertaken in the current biennium with respect to other aspects of health system strengthening should also be reviewed in order to identify the areas to be emphasized in 2012–2013. Health system strengthening should be based on a realistic assessment of existing capacities. Technical cooperation was needed in order to strengthen health information systems and provide training in the analysis and interpretation of data at the different levels of the health system. Those activities should also be included in WHO's biennial workplan for 2012–2013. A country-level mechanism should be established, with the support of WHO country offices, to ensure that the roles played by various national stakeholders were recognized and to encourage a sense of ownership of activities and reduce duplication of work. The Organization's biennial workplan should be aligned with national health policies, strategies and plans. He supported the five draft resolutions.

Ms SILLANAUKKEE (Finland) underlined the need for a multisectoral approach that included health in all policies, as health depended on many factors outside the health sector. In her country, such an approach had long been used in local and national government policy-making, strategic planning, management and follow-up.

Primary health care was essential in addressing the causes of ill health, and shifting the focus of health services to patient-centred care, with emphasis on health promotion, disease prevention and better coordination of care. Universality and equity should be the cornerstones of health systems. The entire population should have access to health-care services that functioned well and were cost-effective. Strengthening health systems and primary health care was a key task of WHO, and Finland would continue to support the Organization's leadership in health systems development, including analysis and collation of existing evidence in that regard.

Health system financing should be fair and sustainable and should encourage the achievement of universal coverage and the reduction of health inequalities, as indicated in the draft resolution contained in resolution EB128.R8. Health systems not only needed financing for the provision of services, but also for planning, research, development, governance and health promotion.

A well-performing workforce was another key element in health system strengthening. It was essential to have a national framework for monitoring and planning the supply and demand of health workers, as well as national policies and strategies aimed at achieving workforce self-sufficiency. Her Government had begun to implement the WHO Global Code of Practice on the International Recruitment of Health Personnel. Cooperation between WHO, the European Union and OECD in monitoring human resources in health care was essential. Finland supported the implementation of WHO's efforts to strengthen nursing and midwifery, and would continue to cooperate with WHO in its valuable work to strengthen health systems.

Mr LARSEN (Norway) welcomed the approach to strengthening health systems outlined in document A64/13, with its focus on people-centred primary care, universal coverage of health services and health in all policies, but warned that its implementation would be limited by shortfalls in, and poor distribution of, human resources. Investment in human resources remained low, and greater effort was needed to resolve the global health workforce crisis. Population ageing in many countries,

including Norway, would further increase the need for health workers. To meet that need, high-income countries would likely continue to drain human resources from low-income countries unless decisive action were taken.

For that reason, his country had proposed the draft resolution contained in resolution EB128.R9 with a view to strengthening efforts to scale up health worker production, enhancing retention and equitable distribution of health workers, and ensuring implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel. WHO had played a crucial role in raising awareness of human resource problems by initiating and sharing research and providing practical policy advice; such as the global policy recommendations on increasing access to health workers in remote and rural areas. However, WHO's role could be further strengthened. A comprehensive mandate on health workforce matters was needed together with the resources required to fulfil it. The draft resolution, together with the WHO Global Code of Practice on the International Recruitment of Health Personnel, would provide such a mandate.

The draft resolution on sustainable financing contained a useful set of principles for improving or maintaining universal coverage of basic health services in all Member States. In April 2009, Norway had hosted a conference on health in times of global economic crisis, the outcome of which had been 12 key recommendations that were in line with the draft resolution. He expressed satisfaction that the draft resolution emphasized the importance of risk pooling at population level, prepayment, and the need to minimize direct payments for those in need of health care, but would have liked to see greater emphasis on the importance of financing structures being mandatory and redistributive. Solidarity and equity implied that the allocation of resources to basic health services should be based on the principle of need, not ability to pay.

Dr ALKAN (Turkey) observed that countries worldwide were seeking ways to provide universal access to equitable and high-quality health systems and implementing health policies aimed at improving social welfare. International cooperation would enable those goals to be met more rapidly and easily, and countries should therefore share knowledge and experience in health system strengthening through workshops and meetings. WHO should facilitate such exchanges. Turkey had made considerable progress in introducing radical policy changes and increasing access to health services, and would continue to cooperate and share its experiences with other countries.

Mrs REITENBACH (Germany) commended *The world health report 2010*, which outlined how countries could develop their financing systems to move more quickly towards universal coverage. The text of the draft resolution on sustainable financing structures and universal coverage built on the principles put forward in that report and underlined the contribution of fair and sustainable health financing structures to the achievement of Millennium Development Goals 1, 4, 5 and 6. It also called for Member States and the Director-General to ensure provision of adequate support to countries wishing to act on the recommendations of the report. WHO was well-positioned to promote national policy dialogue, development of reform options and harmonization with external partners.

Governments, too, had an important role to play in facilitating a dialogue that included parliaments, civil society and the private sector, so as to mobilize the full potential of each with a view to achieving universal coverage.

Germany was contributing technical and financial support to countries seeking to develop their financing structures, and also supporting the Providing for Health Initiative on Social Health Protection, which provided a base for increasing and harmonizing country support by development partners in the area of health systems financing. Strengthening the performance of health financing systems was essential to ensuring access to health services, and therefore deserved the increased attention of the international community.

Ms GUY (New Zealand) supported all the draft resolutions, which had the potential to refocus health sector priorities. As a registered nurse, she particularly welcomed the draft resolution contained in resolution EB128.R11. The contribution of nursing and midwifery was essential in building

effective and sustainable national health systems, improving universal access to comprehensive health services and achieving the health-related Millennium Development Goals. There was still a global shortage and poor distribution of nurses and midwives; and policies must be put in place to ensure a long-term supply of sufficient qualified health workers. Nurses and midwives should be involved in developing such policies.

As a well-resourced Member State, New Zealand was aware of its responsibility to achieve self-sufficiency in health workforce production, in line with the WHO Global Code of Practice on the International Recruitment of Health Personnel and the 2007 Islamabad Declaration on Strengthening Nursing and Midwifery. It was training more nurses than ever before and the Government had implemented a range of policies to strengthen nursing and midwifery and to improve access to comprehensive health services. An initiative to encourage nurses and midwives to practise in hard-to-staff areas had been introduced in 2009. Nurses were playing a greater role in primary health-care delivery – with, for instance, the authority to prescribe having been extended to appropriately qualified nurses and the development of nurse-led clinics – and in the management of chronic illnesses and noncommunicable diseases.

The importance of nursing advice and leadership at the highest level had been recognized, and the Ministry of Health's Chief Nurse now held an executive-level position, reflecting the national commitment to involving clinical leaders in the design of health services and policies. She urged the Secretariat to remedy the paucity of nursing leadership positions within the Organization, by *inter alia* reinstating the position of chief nurse.

With regard to the draft resolution on strengthening national health emergency and disaster management capacities and resilience of health systems, she noted that her country's health, emergency and disaster preparedness systems had been tested fully during the earthquake in February 2011 and had performed well. She thanked Member States for the assistance provided in the wake of that event. The response to the earthquake had highlighted the importance of partnerships and confirmed that the health sector could not work alone.

Ms CHEN Ningshan (China) expressed appreciation for WHO's contributions to national policy dialogue on health systems strengthening. Her Government attached great importance to primary health care, and in 2009 had launched a reform of its health-care system, with the aim of ensuring basic health care for all by revitalizing and extending access to good-quality primary care services, both in urban and rural areas. Within five years, China hoped to ensure access to basic health care for the entire population. China would continue its international cooperation and information exchange in order to progress further towards health system strengthening objectives in the Western Pacific Region. Her Government would communicate its views on the draft resolutions in due course.

Mr MANDABA (Central African Republic) said that equitable, effective and responsive health systems reduced morbidity and mortality, and contributed to the attainment of international development objectives such as the Millennium Development Goals. As part of a health system reform process launched several years earlier, his Government was implementing the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa in order to remove weaknesses identified during an evaluation of the health system. The reforms under way included a revision of standards for health-care facilities, equipment and staff; implementation of a system for monitoring financial resources; improvement of the medicines supply system; and development of a strategic plan for health system strengthening, including a plan for human resources development. With a view to achieving the health-related Millennium Development Goals, his Government was also working to strengthen infrastructure and capacity in the areas of reproductive health, HIV/AIDS, malaria, tuberculosis, integrated disease monitoring and response, and childhood vaccinations. He supported all five resolutions.

Ms WAKEFIELD (United States of America) said that her Government was committed to improving the performance of health systems, which would help to reinforce economic growth and

democratic governance and contribute to better and sustained health outcomes. She welcomed the emphasis in the report contained in document A64/12 on the alignment of priority-setting and operational planning among Member States; its recognition of the diversity of national health systems and political, social, economic, cultural, demographic and epidemiological contexts; and its call to engage a broader spectrum of stakeholders in policy dialogue in order to gain a broader understanding of the factors crucial to strategic planning. Appropriate policy decision-making, however, relied on up-to-date information and, hence, the strengthening of health information systems, and the report did not deal adequately with the need to develop and improve the metrics required to track progress over time.

The world health report 2006 had highlighted the disruption to health systems resulting from violence and human rights violations inflicted on health workers in conflict and post-conflict situations. It was therefore vital, in order to tackle the problem, to understand it. That would require research to generate data and build a sound evidence base, including best practices. Subparagraphs 3(2), 3(5) and 3(7) of the draft resolution contained in resolution EB128.R9 would pave the way for the necessary efforts to fill the gap in health workforce information and to determine the most appropriate protection strategies. Meanwhile, the Director-General should consider convening a meeting of experts to identify needs and plan a way forward. The participants could include experts from Member States, the Secretariat, the research community, humanitarian and development organizations, and medical and nursing groups; and the outcomes could form the basis of the report requested in subparagraph 3(9).

Mr CHANDRAMOULI (India) outlined the progress made to revitalize his country's primary health care system under its people-centred National Rural Health Mission, the focus of which had been on setting up integrated community-level service delivery networks to provide vulnerable population groups in underserved remote areas with access to skilled health-care providers. Ultimately, the aim was to ensure universal access to primary health care. Central and state authorities had invested heavily in the training and recruitment of large numbers of health workers; disease-control programmes had been integrated; and the rational use of medicines (including generics) had been promoted. A bottom-up, decentralized planning process had made it possible to respond to the specific needs of local communities. Like other countries, India requested the Secretariat to help it to meet the new public health challenges, including those associated with noncommunicable diseases. It should act as a catalyst for the development of a coherent set of effective and equitable health systems backed by sustainable and targeted financing.

Dr TAKEI (Japan), thanking Member States for their support in the aftermath of the recent earthquake and tsunami in his country, welcomed the emphasis placed on disaster relief in the context of health system strengthening. Japan had been striving to mainstream health system strengthening into its domestic and global policies and was supporting developing countries in strengthening their health systems as a means of improving progress towards achievement of the health-related Millennium Development Goals. Developing human resources for health, including strengthened administration, was a particular focus of that assistance, which fully respected the principle of country ownership. Strengthening the health workforce in developing countries required improved cooperation and coordination between ministries and agencies in the health, education, finance and foreign affairs sectors, which in turn called for support from WHO to review and analyse necessary measures. Capacity building for human resources for health was an increasingly important part of efforts to provide populations in remote areas with access to primary health care services and, hence, to achieve the overarching goal of universal coverage. Japan would continue to work with the Secretariat to attain that goal.

Dr FEISUL IDZWAN MUSTAPHA (Malaysia) acknowledged the need to pursue health-financing reforms in order to achieve universal coverage, to tackle health worker migration through a national health workforce plan within the overall national health plan, and to allocate adequate

resources to emergency and disaster risk management programmes. Better national health policy dialogue was required to build more robust policies, strategies and plans able to respond more effectively to expectations for better services and health outcomes. He endorsed the section of the report contained in document A64/12 on improving WHO's support to national policy dialogue.

His Government was examining options for ensuring the delivery of quality health-care services that were accessible, affordable and relevant to people's needs. The Ministry of Health was committed to fostering closer public- and private-sector cooperation, in providing such services. Malaysia looked forward to receiving further technical assistance from the Secretariat in its efforts to strengthen its health system, and would continue to collaborate in the Organization's efforts to help all Member States achieve that goal.

Dr CHISTYAKOVA (Russian Federation) said that efforts to strengthen health systems should emphasize the prevention of communicable and noncommunicable diseases. Promoting better nutrition, stress reduction and the cessation of alcohol and drug abuse would help to improve public health and to reduce health-care costs, as had been pointed out at the recent global conference on healthy lifestyles and noncommunicable diseases in Moscow, organized jointly with WHO. Her Government was about to launch a two-year health system modernization programme and requested the Secretariat to provide support in order to ensure a balanced approach.

The Government's focus in the short term was on the organization of primary health care. Under a new law on compulsory medical insurance, citizens could choose their own health service providers. She welcomed the approaches put forward in the Secretariat's reports and endorsed the relevant draft resolutions.

Dr SUWIT WIBULPOLPRASERT (Thailand) recalled that WHO's Constitution defined health in terms of physical, mental and social well-being. The fundamental purpose of health systems was therefore to achieve that goal. Nevertheless, the Secretariat and Member States tended to use morbidity, mortality and disease burden as the only yardsticks for measuring health and the effectiveness of health-care systems. Curbing the problems caused by disease and infirmity was undoubtedly important, but focusing solely on that aspect under the present agenda item was evidence that the Organization was in thrall to a biometric model driven mainly by pharmaceutical and vaccine company researchers and health professionals. Continuing in that direction would not lead to well-being. WHO must move into a new era of striving to achieve well-being with the active participation of public- and private-sector partners, civil society and local communities. Such an approach would not require any amendment of the Constitution, but rather a reform and reconceptualization of the Organization, both the Secretariat and Member States, and its work. He expressed regret that the Director-General had not touched on that fundamental issue in her proposals for reforming the Organization.

Mr ALABASY (Sudan), stressing the relevance of the recommendations in *The world health report 2010*, said that the differing nature and capacity of individual countries and their populations' differing needs must be taken into account in efforts to reform health systems and ensure universal coverage. WHO could provide support for the necessary exchanges of expertise to enable the countries in the Eastern Mediterranean Region to improve data collection and dissemination, strengthen their decision-making, succeed in undertaking reforms, and mobilize the appropriate human and financial resources needed to achieve universal coverage. Cooperation with other regional organizations, including the development of regional plans, was also crucial to producing good results.

Professor ONDOBO ANDZE (Cameroon) said that, in view of the wave of epidemics confronting developing countries in the African Region, strengthening of surveillance systems, especially at the community level, was an important aspect of health system strengthening. Current epidemiological surveillance systems performed poorly owing, inter alia, to low quality and incompleteness of the data. To remedy that situation it would be necessary to build capacity at the

various levels of the health-care system and to raise awareness among decision-makers of the importance of allocating sufficient resources for surveillance. It was also crucial to train community health workers and volunteers in early detection and prompt notification of diseases in order to ensure appropriate and timely action. Cameroon was incorporating community-based health activities into an integrated primary health care approach and was planning to integrate the management of noncommunicable diseases into HIV/AIDS services within a decentralized approach geared towards strengthening its health system while reducing stigmatization and discrimination of people living with HIV/AIDS. He supported the draft resolutions.

Mr SEAKGOSING (Botswana) concurred with the analysis in document A64/13 that the smooth and effective operation of health systems was crucial to achieving both national and international health goals. His Government had introduced some health system reforms in order to remove the obstacles impeding progress in service delivery. National health policy had been revised in line with new initiatives and changes in the epidemiological situation; responsibility for primary health care delivery, formerly divided between two ministries, had been unified within the Ministry of Health, thereby eliminating overlap, duplication of activities and poor resource use; and district health management teams had been set up to take charge of all public health facilities within their respective districts. Efforts were continuing to identify and engage partners to mobilize the much-needed technical and financial resources. The national health accounts methodology was being used to track health-sector resource allocation and expenditure; an essential health services package had been developed; a health research agenda had been devised to fill the information gaps and inform health-care delivery; and the country's many vertical and fragmented information and surveillance systems had been aligned in order to strengthen its monitoring and evaluation capacity. In addition, a medical hub had been established in order to identify ways in which health might contribute to overall economic development. He endorsed all five resolutions.

Mrs TOELUPE (Samoa) said that political commitment to health system strengthening in her country was contributing to the achievement of the Millennium Development Goals. She supported all five draft resolutions. However, although her Government acknowledged the responsibilities of Member States in respect of the recommendations in resolution EB128.R8 and was already applying some of those recommendations, it would find it hard to fulfil some of the responsibilities owing to health financing difficulties. Regarding the draft resolution contained in resolution EB128.R9, the global shortage of health workers, which had had a particular impact in Samoa, called for innovative approaches. Her Government had developed a human resource workplan and policy but had yet to secure the funding to implement it. She sought clarification of whether implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel was being monitored and what role WHO was playing in that regard.

Samoa, as a small island developing State that was especially vulnerable to natural disasters, firmly supported the draft resolution contained in resolution EB128.R10. It had had an opportunity to test its national health disaster and emergency preparedness plans in the wake of the 2009 tsunami and during the pandemic of influenza A (H1N1) 2009 virus infection, and had applied the lessons learnt to enhance those plans. Her Government encouraged the Secretariat to strengthen its partnership with other United Nations agencies, in line with the Paris Declaration on Aid Effectiveness, in order to support country-level implementation of the Hyogo Framework for Action. Samoa, like other small developing countries, depended heavily on nurses and midwives for the delivery of primary health care and so strongly endorsed the draft resolution contained in resolution EB128.11. With respect to the draft resolution in resolution EB128.12, it requested WHO to ensure more consistent alignment of country cooperation strategies with national health policies and strategies so as to facilitate monitoring and evaluation of the latter.

Ms CHASOKELA (Zimbabwe) said that her Government regarded capacity building for human resources for health as crucial to efforts to increase access to high-quality, integrated, comprehensive

and equitable health-care services for the most vulnerable members of society, namely women, children, youth and populations in remote areas. Nurses and midwives played a central role in that regard and in efforts to achieve the Millennium Development Goals; in primary health care, including disease prevention and health promotion; in combating communicable and noncommunicable diseases; in the management of emergencies; and in safeguarding patient and health worker safety. She supported the draft resolution contained in resolution EB128.R11 on strengthening nursing and midwifery and looked forward to receiving progress reports on its implementation every two years from 2012. She also supported the other four resolutions.

Mr PRAZ (Switzerland) expressed support for all five draft resolutions, especially the one contained in resolution EB128.R8 on sustainable health financing structures, given that health financing was crucial to all aspects of health system strengthening. Health costs were growing in every country in the world, and the lack of predictable, sustained funding at both the national and international levels made it hard to plan health spending in the medium to long term; local resources should be mobilized to cover those costs. Many countries had limited capacity to absorb funds into their health sectors and suffered from management constraints and a lack of analysis and planning capabilities. Investment in human resources for health remained a major challenge. Health financing was also a challenge for consumers in many countries, many of whom found it impossible to pay for access to health services. Switzerland was engaged in bilateral health-financing assistance programmes, especially in the area of social protection, and he encouraged Member States and the Secretariat to support the Providing for Health initiative and others striving to improve financing mechanisms in that area.

Dr MENESES GONZÁLEZ (Mexico) noted that health system strengthening was a complex exercise that had a number of different facets, including the achievement and funding of universal coverage, the establishment of an integrated health service delivery model, the availability of trained human resources for health, the development of strategies to permit equitable and free access to medicines and technologies to facilitate health-care delivery, and the development of a series of national plans, policies and strategies. He supported efforts to strengthen disaster management capacities and the resilience of health systems, and endorsed the draft resolution contained in EB128.R10 on that subject and the other four draft resolutions.

Ms GAMARRA (Paraguay) said that Paraguay was undergoing a radical change in health care and its health-financing model, and was implementing a health-care strategy focused on people-centred primary care and on the achievement of universal coverage. The aim was to achieve real results, strengthen the leadership of the health authority and to put in place national plans, policies and strategies that addressed the social determinants of health through intersectoral action. Essential medicines and health services were increasingly being provided free of charge, and population groups that had once been excluded now had access to health care. She agreed with the observations in *The world health report 2010* concerning the need to increase domestic resources for health, reduce financial barriers to access and enhance the efficiency and effectiveness of resource use, and she highlighted the importance in that regard of her country's efforts to improve the collection of taxes and prevent tax evasion. Human resources were a key element in health system strengthening, and Paraguay, which had seen many of its health professionals migrate to developed countries, had therefore welcomed the WHO Global Code of Practice on the International Recruitment of Health Personnel. She supported the five draft resolutions.

Mr GONZÁLEZ (Cuba) observed that the Committee's discussion had revealed the variety of different approaches that countries were using in order to strengthen their national health systems. An appropriate balance must be struck between primary health care and other services contributing to the health of the population, such as hospitals, specialized programmes, and social services. Primary prevention and health promotion activities were also important in tackling the problems associated

with noncommunicable diseases since palliative care should not be the sole focus. A strong and equitable health system that was accessible to all was important in normal conditions, but assumed even greater importance in the event of a disaster. In Cuba, the health-care system was universal, free of charge and accessible to all without any discrimination. Primary health care had always been the bedrock of the system and was continually being enhanced in order to provide more efficient and higher quality services. He supported the draft resolutions.

Ms WISEMAN (Canada) said that Canada strongly supported the comprehensive and integrated approach to health system strengthening promoted by WHO, and considered efforts to that end to be central to improving the health of populations, reducing health inequities, and achieving the health-related Millennium Development Goals. It fully supported all five draft resolutions. Regarding the draft resolution contained in resolution EB128.R8, her Government considered sustained health financing and universal coverage as integral to ensuring equitable access to crucial health-care services. It acknowledged the importance of human resources for health in the effective operation of health systems, and endorsed the objectives of the draft resolution contained in resolution EB128.R9, particularly those relating to the development of health workforce plans, and retention and training. Turning to the draft resolution contained in resolution EB128.R10 on national health emergencies and disaster management capacities, she said that Canada would continue its efforts to work with both developed and developing countries to share experience and expertise in the area of capacity development, risk reduction, response and recovery. Moving on to resolution EB128.R11, she stressed that the Secretariat must maintain internal capacity to provide expertise, leadership and advice in regard to nursing in order to fulfil its role in supporting Member States in strengthening their nursing services at the country level. She also supported the call for Member States to enhance their efforts to forge strong, interdisciplinary health teams to address health system priorities and to implement strategies to enhance interprofessional education and collaborative practice as part of people-centred care. Canada attached great importance to inclusive national policy dialogue as a means of developing robust health policies and therefore supported the adoption of the draft resolution in resolution EB128.R12.

Dr ABDELSSALEM (Tunisia), speaking on behalf of the Member States of the Eastern Mediterranean Region, acknowledged the work done to support health planning, strategy formulation and the strengthening of national policy dialogue. The countries of the Region had made much progress in those areas and in strengthening primary health care. The Qatar Declaration on Health and Well-being through Health Systems based on Primary Health Care, adopted in 2008 and signed by all Member States of the Region, had significantly boosted political support for the strengthening of primary health care, and resolution WHA62.12 on primary health care, including health system strengthening, adopted in 2009, provided useful guidelines for integrating the matter into their various plans and strategies. All Member States in the Region espoused a primary health care model covering the full range of services needed by their populations. However, they would need the technical support and expertise of the Secretariat in order to establish the health planning processes required to ensure equitable access to those services, particularly in the current context of uncertainty.

Dr MAINA (Kenya) said that maintaining sufficient resources and capacity for public health was crucial if Member States were to confront current and emerging challenges, including those associated with noncommunicable diseases. Kenya had taken steps to address some of the challenges, including introducing a health-care sector fund designed to take funding directly to health centres in order to overcome cost-related barriers to health care. Over the previous two years, the Government had significantly increased the size of its health workforce, hiring additional staff and distributing them uniformly across all the regions. In order to encourage the voluntary implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel, the Ministry of Health had developed a strategic plan for human resource development and deployment, which was currently being implemented. The Government was also strengthening national policy dialogue to

build more robust health policies, and had established multisectoral and multidisciplinary health sector coordinating committees to guide policy and planning within the sector. Health policies were disseminated through workshops and meetings organized at the national and provincial levels. The Government acknowledged the role of nurses and midwives in the delivery of health care and supported the five resolutions tabled for adoption.

Ms WAHLSTRÖM (United Nations Assistant Secretary-General for Disaster Risk Reduction), speaking at the invitation of the CHAIRMAN, said that disaster risk reduction required the engagement of all sectors of society. Participants from international organizations, national and local governments, the private sector and civil society had attended the third session of the Global Platform for Disaster Risk Reduction the previous week whose outcome would be reported to the United Nations General Assembly and the Economic and Social Council, and would provide input for the forthcoming United Nations Conference on Sustainable Development (Rio+20), and other global processes aiming to reduce poverty and to achieve the Millennium Development Goals. WHO had provided strong support in the area of hospital safety and basic community preparedness and health care. She welcomed the strong engagement of the health sector at the national, regional and international levels, which was crucial for risk reduction, crisis preparedness, reconstruction and recovery, and the draft resolutions relating to health system strengthening, which would make a valuable contribution to the efforts to reduce disaster risk and strengthen prevention mechanisms.

The CHAIRMAN proposed that further discussion of the matter be deferred to a later meeting.

It was so agreed.

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

The meeting rose at 18:05.

SECOND MEETING

Tuesday, 17 May 2011, at 09:20

Chairman: Dr W. AMMAR (Lebanon)

TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda

Implementation of the International Health Regulations (2005): Item 13.2 of the Agenda (Documents A64/9, A64/10, A64/10 Add.1 and A64/10 Add.2)

Dr FINEBERG (Chair of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009) recalled that the International Health Regulations (2005) made provision for a review of their implementation in 2010. The pandemic of influenza A (H1N1) 2009 virus infection had intervened, however, presenting the first “stress test” since the Regulations had entered into force in 2007. As agreed by the Executive Board at its 126th session,¹ the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009 had been established to examine the functioning of the Regulations, assess the role and performance of WHO in responding to the pandemic, and define lessons for the future. The Review Committee, consisting of 25 members from 24 countries, had held four meetings open to representatives of Member States and the media, along with various discussions restricted to its members. Its report to the Director-General had been forwarded to the Health Assembly in document A64/10.

The Review Committee had sought from the outset to base its findings, conclusions and recommendations on evidence obtained from a variety of sources, including experts, officials and observers. It had held interviews with WHO staff members and had been provided with access to WHO’s internal documents, including confidential material, that had a bearing on pandemic events. It had also reviewed the scientific literature, reports from countries and other documentation.

In the Review Committee’s view, five factors had shaped the response to the pandemic: the core values of public health; the unpredictable nature of influenza; the way in which the threat of avian influenza A (H5N1) had shaped general pandemic preparedness; WHO’s dual role as a moral voice for health in the world and as an organization that served its Member States; and the limitations of systems that were designed to respond to geographically-focal, short-term emergencies, rather than a global, sustained, long-term event such as a pandemic.

He stressed two findings of the Review Committee’s report: influenza A (H1N1) 2009 had satisfied the definition of a pandemic, based on degree of spread of infection; and no evidence had been found of commercial influence on decision-making at WHO in connection with the pandemic. He drew attention to the three summary conclusions of the Review Committee, set out in paragraphs 16 to 18 of document A64/10, and the 15 recommendations that followed.

The experience of pandemic (H1N1) 2009 had provided an example of decision-making in conditions of uncertainty and great pressure, requiring a combination of technical expertise and the exercise of political responsibility. Bringing those two elements together in ways that took full advantage of the knowledge of experts without distorting political decision-making was a continuing challenge. He stressed the importance of advance preparation and building capacity to function in emergency conditions, neither of which could be successfully managed once an emergency was

¹ See document EB126/2010/REC/2, summary record of the second meeting, section 2.

already under way. The Review Committee had enjoyed the luxury of retrospection, whereas decisions in the event of an emergency must be made in real time, without knowing how events would unfold. Communication and public understanding were the bedrock of successful public health interventions.

Mr TUITAMA LEAO TUITAMA (Samoa) commended the commissioning of the independent review and welcomed the comprehensive and professional assessment provided by the Review Committee and its excellent recommendations. The International Health Regulations (2005) had enhanced global preparedness in the face of emerging public health threats. The situation would be further improved if core capacity requirements were met and the full potential of the Regulations realized.

Samoa, which had lost 22% of its population to the 1918 influenza pandemic, knew only too well the consequences of a lack of preparedness. Its experience with pandemic (H1N1) 2009 had made clear the value of the Regulations. National IHR focal points and information-sharing networks had allowed for a more effective response to the public health emergency represented by the pandemic.

The findings of the Review Committee reaffirmed the independence and value of WHO and tools such as the Regulations for countries like Samoa. He urged WHO to consider the Review Committee's conclusions seriously, in particular with regard to the problems faced by many countries in meeting core-capacity requirements and deadlines. Barriers to compliance must be identified as countries worked to meet the 2012 deadline. Lessons could be learnt on both sides. The definition of core capacity was an important issue. Although much effort had been devoted to developing tools and guidelines to support Member States in assessing their core capacities, the value of such tools was greatly diminished if they were not made available promptly.

Mr EL MENZHI (Morocco) welcomed the implementation of the International Health Regulations (2005), which had enabled Member States to be better prepared for influenza pandemics. He expressed appreciation to WHO and the Review Committee for their successful contributions in that regard. Lessons were still being learnt from pandemic (H1N1) 2009, during which many developing countries had been unable to access antiviral medicines and vaccines, despite WHO's support. If the Review Committee's recommendations were followed, the world would be better placed to tackle public health emergencies of international concern. The draft resolution (document A64/10 Add.1) was acceptable but a paragraph should be added requesting the Director-General to provide support to Member States in implementing the recommendations made by the Review Committee.

Ms HALTON (Australia) expressed appreciation to the Director-General for commissioning the review of the handling of pandemic (H1N1) 2009, which had been open, transparent and thorough. All who had participated in the global response or tackled domestic challenges were aware of the difficulties of dealing with a crisis of such magnitude, especially the strains on individuals. She welcomed the report of the Review Committee.

Australia had played an enthusiastic role in initial work on the International Health Regulations (2005), a fundamental instrument for global health security. Implementing a new instrument was a learning process requiring an open attitude to improvements. Her country would remain an advocate for the Regulations and would continue to work to maximize the benefits thereof. Expressing support for the Review Committee's recommendations, she requested further discussion of the contingency fund for public-health emergencies (recommendation 13) and how best it might be operated.

Mr FOURAR (Algeria) expressed support for the recommendation to create a contingency fund for public-health emergencies and suggested that countries should establish similar funds at national level. Algeria had a fund for emergencies, largely financed from tobacco tax revenue, that had been used to cover the country's response to pandemic (H1N1) 2009.

Dr AGOUDAVI (Togo), outlining his country's activities to implement and raise awareness of the International Health Regulations (2005) in accordance with its obligations as a State Party, said that the Regulations had been taken into account in the adoption of technical guidelines on integrated disease surveillance. When the Regulations had been applied in response to pandemic (H1N1) 2009, Togo had been one of the first African countries to benefit from vaccines. He expressed appreciation to the Secretariat for its technical assistance but requested that such assistance be strengthened in support of training staff in all departments involved in implementing the Regulations and preparing national implementation plans. He welcomed the report of the Review Committee.

Dr OBARA (Japan) expressed appreciation for the support provided to Japan by Member States and the Secretariat following the March 2011 earthquake. In the wake of the disaster, Japan had submitted reports to WHO, in accordance with the International Health Regulations (2005), on issues such as food and drinking-water containing radioactive substances as a result of the accident at the Fukushima Daiichi nuclear power plant. Collaboration with the International Food Safety Authorities Network on food containing radioactive substances was also important. WHO's global dissemination of reliable scientific information had been appreciated, particularly in the light of some media overreaction, and Japan would therefore continue to report information to Member States and the Secretariat as necessary through mechanisms such as WHO's Event Information Site for IHR National Focal Points.

In order for the Regulations to function optimally, all Member States should be prepared to implement them without geographical or time gaps. She looked forward to seeing improvements in the level of development of core capacities, in line with the recommendations of the Review Committee, and her Government would continue to monitor the situation closely.

Dr BRENNEN (Bahamas), welcoming the conclusions and clear recommendations of the Review Committee, underlined the unpredictability of influenza pandemics. In order to reduce morbidity and mortality, public health authorities must continue to focus on prevention, erring on the side of safety. WHO had an important role as a global moral voice to promote public health measures, while supporting recommendations made by public health officials to political leaders and policy-makers on the basis of core public health values through advocacy.

The Bahamas continued to support the emphasis placed on establishing systematic approaches to surveillance and early warning systems, particularly in developing island nations and in the light of human resource constraints, especially where health-care worker migration remained a concern. The intent of the International Health Regulations (2005) had been visionary, but meeting core-capacity requirements was a challenge for some countries. It was imperative for the Secretariat to support countries in making the best use of their resources to achieve that goal.

The Review Committee had highlighted the issues restricting the global response to influenza pandemics and other potentially vaccine-preventable pandemics and epidemics, such as the core-capacity requirements not yet met by many Member States. The Review Committee's recommendations aimed to fill gaps in both implementation of the Regulations and global pandemic preparedness and response. The underlying strength of a Member State's health system played a key role in its readiness to respond as expected.

Discussion relating to the recommendation to establish a contingency fund for public health emergencies should centre on possible contribution mechanisms, bearing in mind that those countries most likely to require assistance were often those least able to meet additional financial obligations.

He applauded the work that had been done to strengthen national capacity, but highlighted the importance of ensuring that training programmes for human resource development were provided equitably across all WHO regions. The Bahamas had benefited from training opportunities and looked forward to participating in the third IHR implementation course.

His country continued to monitor its progress towards implementing the Regulations. Developing core capacities at points of entry was hampered by human resource constraints, and he requested additional resources for enhancing capacity to detect and respond to chemical and

radionuclear events. Given that recent economic problems could delay work towards full implementation of the Regulations, consistent support from WHO was appreciated.

Dr HWOAL (Iraq) said that the International Health Regulations (2005) formed a foundation for public health partnerships. They served as a basis to strengthen partnership between countries for information exchange and response to epidemics, as could be seen from the report, especially in relation to pandemic (H1N1) 2009. Some successes had been recorded in surveillance and applying the Regulations. The experience of pandemic (H1N1) 2009 had proved that partnerships were functioning, but information needed to be exchanged effectively, and systematic regional measures should be taken in order to ensure timely responses to similar future events. Lessons had been learnt from pandemic (H1N1) 2009, particularly in terms of the need to establish regional surveillance systems, which should also cover comprehensive access. Databases had been created, allowing knowledge to be strengthened and serving as a basis for developing health systems and improving prevention. The experience of pandemic (H1N1) 2009 had furthered understanding of the basis for evaluating epidemiological exchange based on events and for carrying out observations at regional level. It had also favoured scientific advances in early detection and the avoidance of disease transmission.

Dr KUARTEI (Palau) expressed appreciation for the report of the Review Committee. He urged WHO to continue to follow the principles of consistency and transparency and to ensure that proper procedures and consistent terminology were used so as to facilitate the full and effective implementation of the Regulations for all partners.

Professor AHMED (Bangladesh), welcoming the report of the Review Committee, said that the International Health Regulations (2005) contributed significantly to global public health. However, more States Parties must report their implementation status: only 68% of responding countries had assessed their core capacities under the Regulations and only 58% had developed national plans.

The reports submitted revealed a lack of core capacities to detect, assess and report potential health threats, which would leave Member States unable to meet the 2012 deadline. The Review Committee had recognized that the implementation of the Regulations continued to present serious challenges and that some countries might not be able to meet core capacity requirements for surveillance and response by the deadline set. WHO should consider moving the deadline and should provide countries with technical assistance to fulfil their obligations.

The state of implementation of the Regulations in the South-East Asia Region was favourable. Provisions relating to chemical and radionuclear hazards displayed the lowest implementation rates. Despite its limited resources, Bangladesh had made good progress. Following a national assessment of country core capacities in 2009, a draft workplan for implementing the Regulations had been prepared. The Government had taken steps to designate points of entry. A second assessment of core capacities had begun in April 2011, and various important documents, such as guidelines and standard operating procedures, had been drafted.

He expressed concern that country capacities were not yet sufficient to tackle the mounting threats posed by avian influenza A (H5N1), pandemic (H1N1) 2009, the urgency of emerging and re-emerging diseases, and capacity building at points of entry. Financial, human and material resources in the health sector were inadequate to mitigate such problems. He requested the Secretariat to mobilize additional resources to support Member States in further developing their capacities to provide the best protection possible.

Dr NORHAYATS RUSLI (Malaysia) said that the importance and uniqueness of the International Health Regulations (2005) as a global framework for managing public health emergencies of international concern had been highlighted by pandemic (H1N1) 2009 and recent events in Japan. Although there had been improvement in some core-capacity areas, progress lagged in others. He drew particular attention to core capacities related to points of entry, one of the main

concerns covered by the Regulations. Responses at points of entry were of recognized importance in preventing or delaying the spread of diseases, but it was also important to respond to diseases “exiting” a country. He urged States Parties to the Regulations and WHO to pursue an approach based on evidence or risk assessment in establishing response procedures at points of entry.

He welcomed the establishment of informal working groups to map country-specific yellow fever risk and to examine WHO’s criteria for disinsection of departing conveyances.

Dr AL HAJERI (Bahrain) said that Bahrain had made good progress in applying the International Health Regulations (2005) and combating pandemic (H1N1) 2009 thanks to its infrastructure for surveillance and early detection. It was working with various stakeholders and in 2010 had established a multisectoral and multidisciplinary committee for implementation of the Regulations, which conducted surveillance and took action in emergency situations. Among other things, the Ministry of Health had formed a working group to monitor application of the Regulations, an action plan had been prepared for capacity building on surveillance, and shortcomings had been identified in several areas. Legislation had been drafted in relation to the Regulations and a mechanism on zoonoses had been put in place. She supported the draft resolution.

Mr LARSEN (Norway) welcomed the report of the Review Committee and endorsed its conclusions and recommendations, including those relating to crisis management and response by WHO. It was reassuring that there had been good reason to declare a pandemic, based on information available at the time, and that the Review Committee had found no evidence of commercial interest influencing decision-making within WHO. Nevertheless, he agreed that procedures for establishing expert committees should be improved in order to ensure transparency and avoid conflict of interest. The recommendations for improving preparedness and response were helpful to both Member States and the Secretariat, particularly in view of the conclusion that the world was ill-prepared to respond to a severe influenza pandemic or similar sustained global public health emergency. He therefore welcomed the important agreement reached in the Open-Ended Working Group of Member States on Pandemic Influenza Preparedness. A framework including standard material transfer agreements would significantly advance pandemic preparedness.

With regard to the draft resolution, he sought clarification about the scope of follow-up to the recommendations of the Review Committee. If follow-up applied to recommendations on both the functioning of the Regulations and pandemic (H1N1) 2009, he would support the draft resolution.

Dr MELNIKOVA (Russian Federation) welcomed the reports of the Director-General and the Review Committee. The former gave a good overview of progress made towards implementing the International Health Regulations (2005). Some countries had taken big strides in harmonizing legislation, training staff, strengthening national laboratory capacity, and improving epidemiological surveillance and health protection, whereas others still faced obstacles. Nevertheless, the fact that countries were able to use the monitoring mechanism and indicators to assess and build capacity was a positive step for all concerned. The evaluation had identified areas where more work was needed by all countries, particularly with regard to points of entry and chemical and radionuclear events.

Pandemic (H1N1) 2009 had been the first real test of the effectiveness of the Regulations. The Review Committee had drawn predominantly positive conclusions about their functioning during the pandemic and WHO’s response to the global threat it had posed. The various shortcomings identified should be examined carefully in order to learn lessons and take necessary measures to increase future preparedness for pandemics and other public health emergencies. She endorsed the Review Committee’s conclusions and recommendations, which should be followed up.

The Russian Federation supported WHO’s activities to build the capacities of countries with limited resources, including provision of financial resources and technical expertise to establish laboratory networks in Africa and Central Asia. Training activities on implementing the Regulations were being planned at Russian research institutes for experts and interested countries, particularly within the Commonwealth of Independent States. Such an approach would promote international

development and help to strengthen regional capacity to tackle infectious diseases. She supported the draft resolution.

Dr GOUYA (Islamic Republic of Iran), welcoming the work of the Review Committee, underlined the value of the International Health Regulations (2005) as a regulatory tool for expanding the core capacities of all Member States to prevent and control public health emergencies of international concern. Although pandemic (H1N1) 2009 had threatened global public health, it had also presented an opportunity for countries to assess their preparedness, weaknesses and core capacities in a range of areas. The Regulations should be taken seriously and capacities should be built through the Secretariat's support to all Member States, especially developing countries, to ensure better responses to future pandemics and other emergency situations.

Outlining his country's activities to implement the Regulations since their entry into force, he drew attention to certain challenges. More technical support was needed from WHO to strengthen core capacities. Subregional collaboration should be established in order to strengthen capacities at points of entry on borders between Member States located in different WHO regions. WHO should foster collaboration with related international agencies, such as FAO and OIE. Support was needed for training courses on the Regulations. WHO should support efforts to harmonize surveillance capacities and activities between neighbouring Member States.

Dr SAID (Brunei Darussalam) expressed appreciation for WHO's work on the checklist for monitoring progress in building the core capacities required under the Regulations, including measures for evaluating the experiences of Member States in order to enhance the tools for such monitoring. Efforts to encourage the participation of all States Parties in the self-assessment questionnaire should also be pursued given the approaching 2012 deadline for compliance with obligations under the Regulations. The reported variations in achievement of the eight core capacities for tracking implementation reflected the differing challenges facing Member States. On that score, his country was among those that lagged behind with respect to the provisions relating to chemical and radionuclear hazard types, and he called for WHO's continuing support and technical guidance as it strove to achieve the required capacities.

Mr HOHMAN (United States of America) said that the recommendations of the Review Committee would significantly improve universal application of the Regulations. It was for Member States to fulfil their obligations in that regard through open and transparent information-sharing concerning outbreaks of disease. To that end, the Secretariat should continue to seek their feedback in order to further enhance the utility and usability of information-sharing systems such as the Event Information Site, while bearing in mind the need to maintain security and confidentiality. Successful and timely implementation of the Regulations likewise depended on the establishment of sustainable systems to develop, enhance and maintain core competencies such as disease detection, laboratory diagnosis and disease control. In that regard, the Global Influenza Surveillance Network had proved critical to limiting the global impact of the pandemic (H1N1) 2009 virus.

Similarly important was the collaboration and support outlined in Article 44 of the Regulations. The Secretariat was therefore encouraged to continue its work to identify and address areas of need in the case of resource-constrained countries, just as Member States were encouraged to provide support for implementation of the Regulations beyond their own borders. Specifically, the Secretariat should work with Member States to ensure that their national plans were adequate to fulfil IHR core-capacity requirements, particularly in areas found through the annual questionnaire to be most in need of additional focus. The Secretariat's efforts to draw from the experiences of Member States in order to further enhance the use of monitoring tools were also welcome, given the importance of accurately monitoring the progress of IHR implementation. The same applied to its efforts to establish a web-based tool for online submission and monitoring of progress towards core-capacity implementation; additional strategies, metrics and tools for measurement and evaluation at the international, regional and country levels could also be considered. WHO's continuing leadership in

pandemic preparedness and in coordinating the global response was to be applauded; the Secretariat's close collaboration with Member States had helped significantly to strengthen the response. He noted with some concern, however, the reported financial implications of taking the work forward.

Dr PÁVA (Hungary), speaking on behalf of the Member States of the European Union, said that the candidate countries Turkey, Croatia, The former Yugoslav Republic of Macedonia and Iceland, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, as well as the Republic of Moldova, Armenia and Georgia aligned themselves with her statement. Recent natural catastrophes and their consequences had again proved the importance of the International Health Regulations in ensuring the security of global public health. Indeed, effective implementation of the Regulations was fundamental to the preparedness and response of the international community in the face of a potential public health emergency, as confirmed by the three overarching conclusions set out in the report of the Review Committee. Concerning recommendation 1 (Accelerate implementation of core capacities required by the Regulations), constructive but realistic engagement was required to overcome shortcomings with respect to the implementation of IHR core functions worldwide, taking into account not only financial resources but also the specificities of any global crisis and of individual Member States. In that regard, the activities of the WHO Lyon Office, among others, aimed at strengthening national surveillance and response systems, were welcome.

She also welcomed the actions provided for in recommendations 7 (Revise pandemic preparedness guidance), 8 (Develop and apply measures to assess severity) and 14 (Reach agreement on sharing of viruses and access to vaccines and other benefits). It would be useful, however, to shorten the time frame for the revision of pandemic preparedness guidance, given its importance in ensuring the ability of national surveillance systems to identify and describe the severity of an epidemic. In that regard, the recommendation for more open communication was particularly pertinent in the light of the Committee's finding that communication weaknesses had led to the confusion over changes in the definition of a pandemic. Efforts should therefore be made to find new ways of communicating matters relating to public health threats, including through the social media. It was nonetheless gratifying to note from the Committee's findings that WHO had in many respects performed well in the handling of pandemic (H1N1) 2009 and that allegations of malfeasance made against it had been unfounded.

Dr KIMANI (Kenya) said that the numerous steps taken by his country to implement the Regulations had included the establishment of a national IHR focal point; provision of guidance to senior management staff and health sector stakeholders on the substance of the Regulations; an assessment of IHR core capacities and distribution of the resulting report to stakeholders and partners; and the development of a plan of action. It was also in the process of incorporating the Regulations into its integrated disease surveillance and response initiative. Remaining challenges, despite those achievements, included the task of mobilizing the substantial amount of resources required to prepare and implement the necessary strategy and guidelines, and building capacities in terms of human resources, points of entry, laboratory facilities and surveillance systems, particularly at the community level. WHO was therefore requested to work with Member States to increase their core capacities for implementation of the Regulations within the established time lines. African governments were also urged to step up their financial support to that end with a view to maximizing resources received from development partners.

Dr BOKENGE (Democratic Republic of the Congo) said that his country needed WHO's support in order to improve its core capacities for tracking implementation of the Regulations and minimum capacity requirements at its 180 points of entry by 2012. On that score, it hoped to move to Level 2 following a national workshop to be held during the current year for the purpose of harmonizing its legislation with the Regulations. Of particularly acute importance, however, was the

need to strengthen its national capacities through training such as that delivered through the IHR implementation course held in France in 2011, in which his country had not participated.

Dr ZHANG Guoxin (China) said that the three summary conclusions drawn by the Review Committee were objective and comprehensive. Its 15 recommendations were also highly relevant as effective means of addressing the shortcomings identified. The reported progress on sharing influenza viruses was especially welcome, but many countries were not yet fully equipped to deal with major pandemics and other threats to public health. More robust technical guidelines in the areas of risk evaluation, monitoring and early warning would therefore be beneficial, as would an increase in support from developed to developing countries for response capacity building. On the basis of a comprehensive analysis of the functioning of the Regulations in relation to pandemic (H1N1) 2009 and the implementation of the Review Committee's recommendations, WHO should be able to strengthen the role of the Regulations and thus guarantee the protection of public health.

Mr MANDABA (Central African Republic) noted the gravity of communicable diseases and diseases with a high epidemic potential, not only for Africa. Operational surveillance systems were crucial for such matters as determining priorities, rational planning, resource mobilization and allocation, early warning and detection, and assessment of prevention programmes. The measures provided for in the Regulations were therefore essential for minimizing the risks to public health from diseases that all too easily spread across borders in the globalized world of international travel and trade, or indeed from other public health emergencies relating to chemical and nuclear events, for example. In addition, the Regulations set out the rights and obligations of countries with respect to the notification of events affecting public health required in those circumstances and the procedures to be followed by WHO in the interest of global health security.

With the addition of the Regulations to earlier instruments, such as the Millennium Development Goals, that were of relevance to the fight against diseases with a potentially global impact, progress had been made in several areas, including: the creation of a favourable institutional and regulatory climate; awareness and approval of the Regulations' procedures by States Parties; and national capacity building through WHO's country offices and inter-State and regional cooperation. Implementation of the Regulations could nevertheless be improved through measures to enhance the effectiveness of epidemiological surveillance and early disease detection; to strengthen technological capacity, particularly in terms of laboratories; to make use of the tool for monitoring progress in order to identify constraints and strengthen capacities; and to provide capacity-building support to Member States in the African Region.

Dr MEMISH (Saudi Arabia) said that the role of WHO and the Regulations was crucial to the prevention of the future spread of communicable diseases, particularly during such mass gatherings as the hajj, which attracted some two million pilgrims annually. His country's successful management of the hajj during pandemic (H1N1) 2009 with WHO's collaboration not only demonstrated the Organization's leadership role but highlighted the need for the adoption of evidence-based health-education and awareness-raising programmes applicable to mass gatherings. Such programmes should be scientifically monitored and coordinated with Member States. A recommendation to that effect had been adopted at a large international scientific meeting on mass gatherings health (Jeddah, Saudi Arabia, 23–25 October 2010).

Professor TJANDRA YOGA ADITAMA (Indonesia) said that his country was committed to comprehensively strengthening its core capacities with a view to full implementation of the Regulations in 2012. A national committee composed of relevant ministries and agencies had already been established and Indonesia's health programmes were systematically formulated to protect public health in line with the Regulations. A national IHR focal point had also been designated some years earlier. Its activities were likewise performed in conformity with the Regulations and it maintained

regular communication with WHO. Indonesia had published manuals on implementation of the Regulations, which were the basis for better preparedness for facing international health problems.

Dr CHAKRARAT PITTAYAWONGANON (Thailand) said that the vertical relationship between the structures provided for in the Regulations had worrying limitations. A single national IHR focal point was not sufficient for dealing with the risks covered by the Regulations and it was difficult for neighbouring countries in different WHO regions to collaborate closely under those structures. Member States had therefore established formal and semi-formal trust-based horizontal regional networks outside the WHO structure, which were linked under a new global network known as the Connecting Health Organizations for Regional Disease Surveillance (CHORDS). WHO should continue its constructive engagement with that network, the threads of which could be neatly woven into WHO's vertical structure to form a strong disease surveillance fabric. The network was, additionally, an excellent mechanism for collective capacity building through collaboration between developing countries.

He urged support for transparent and timely communication between national IHR focal points, through a secure mechanism, for the purposes of sharing information on unexplained outbreaks of potentially global diseases and indicating the mandate for prompt action by national IHR focal points in order to avoid delays in the prevention and control of public health threats. One of the many lessons learnt from the recent pandemic (H1N1) 2009 was the need for prudence when establishing travel and trade restrictions that might affect socioeconomic development in countries that shared their information in a transparent manner.

Dr FALL (Senegal) said that emphasis should be placed on identifying the phases of pandemic influenza in order to encourage better preparedness and the establishment of criteria for assessing the seriousness of the situation. WHO must also help to promote conditions conducive to the production of vaccines in quantities sufficient to meet the needs of countries, particularly developing countries. Senegal supported the recommendations of the Review Committee, notably with respect to the creation of a contingency fund for public health emergencies.

Dr SOE LWIN NYEIN (Myanmar) said that the recommendations of the Review Committee should be prioritized on the basis of regional and individual country situations and the availability of resources. A thorough review of those recommendations by WHO regional offices would be beneficial in terms of determining priority actions and singling out those for which the Secretariat's support to Member States would be necessary. The actions could then be reflected in WHO's workplans at all levels for the biennium 2012–2013. As to core-capacity building, the full benefits would be reaped only if it was carried out across the board. Countries could also usefully revisit their responses to the self-assessment questionnaire with a view to generating fresh thinking on ways to strengthen their core capacities in the coming biennium. Myanmar was currently reviewing its own responses and considering future actions on the basis of resources availability, and was grateful to the Regional Office for South-East Asia for the comprehensive support provided for building core capacities.

Mr BARBOSA (Brazil) said that, with respect to the question of disease severity, the detection and response capacities of each country should be supplemented by the capacity to conduct risk assessments in support of appropriate decision-making. Indeed, the recent pandemic (H1N1) 2009 had shown the importance of strengthening that capacity. Concerning the creation of a contingency fund for public health emergencies, much progress in public health had been made in response to crises and the need for such a fund had been borne out by the lessons recently learnt in that context.

For its part, Brazil had contacted PAHO about an external evaluation of its response to pandemic (H1N1) 2009, which had presented a unique opportunity for all countries to assess their national capacities for response in a situation of real crisis. Decisions could then be taken with respect to the need for capacity building and the development of a plan adaptable enough to cope with all potential health emergencies.

Ms LAWLEY (Canada) said that many of the findings of the report on implementation of the Regulations mirrored the Canadian experience during pandemic (H1N1) 2009. Some of the recommendations of the Review Committee would have implications for domestic preparedness plans and policies, as in the case of changes to pandemic phases and development of measures of severity. Member States should therefore continue to be closely engaged in developing implementation plans and subsequent activities. Implementation efforts should also be based on an “all-hazards” approach, where appropriate, to strengthen global preparedness for pandemics and other public health emergencies of international concern. Canada looked forward to continuing its work with the Secretariat and the international community towards the goal of bolstering global public health by applying the lessons learnt from pandemic (H1N1) 2009 and strengthening the functioning of the Regulations. She noted, however, that implementation of the recommendations would place significant additional pressures on the Secretariat’s resources; the Organization should prioritize implementation and provide Member States with details of what could be achieved with existing funds and what activities would need additional funding.

Dr SHUKLA (India) said that his country was working towards achievement of the core capacities set out in the International Health Regulations (2005). Substantial investments, concurrent evaluation and the application of on-course corrections had moulded its country-wide capacity for surveillance, which took advantage of information technology, and response into a sensitive system for the detection and management of disease outbreaks at community level. Other measures included the drafting of national legislation in support of the Regulations; the establishment of communication and coordination between the national IHR focal point and subnational levels; the operationalization of trained rapid response teams; and the guarantee of adequate laboratory support. The impact of the avian influenza outbreak and pandemic (H1N1) 2009 had been mitigated as a result of such measures.

Measures at points of entry were also being strengthened in accordance with the Regulations and a food safety and standards authority had been established as a statutory body to lay down science-based standards for food items and regulate their manufacture, storage, distribution, sale and import. The attainment of specialized capacities in connection with chemical, radiological and nuclear hazards remained a concern, however, and India had already sought the Secretariat’s support for the development of such capacities in Member States in order to ensure the versatility of the Regulations as an instrument for the achievement of global health security.

Ms GAMARRA (Paraguay) said that the effectiveness of the Regulations had been demonstrated during pandemic (H1N1) 2009, but there was still much room for improvement insofar as the process was conditioned by the capacities and characteristics of each country. Nonetheless, the lessons already learnt would strengthen the credibility of evidence-based decisions on matters of public health and show the way forward. The Regulations were a tool for global action in the face of global problems, such as pandemics that knew no boundaries. Each country should take responsibility for the implementation, improvement and articulation of the Regulations at the regional and international levels. Itself part of a subregion, Paraguay was committed to continuing its efforts to improve the implementation of such an important tool.

Dr ST. JOHN (Barbados) said that the various activities undertaken by her country towards full implementation of the Regulations included the successful introduction of protocols for the transfer of sick passengers; continuous training for non-health partners in obligations under the Regulations; participation by port health officials in a bioterrorism crisis-management simulation exercise; and participation in an IHR implementation course. Also, the ICAO’s Cooperative Arrangement for the Prevention of Spread of Communicable Disease through Air Travel had been implemented and adapted.

Barbados continued to focus on points of entry in order to reduce public health risks; it had established two quarantine centres at its main points of entry. PAHO had also facilitated a workshop for integration of the Regulations into national legislation. Other activities included workshops to

assess the readiness for addressing the spread of communicable diseases through air travel and preventing public health emergencies. Much work remained to be done, however, to prepare for chemical and radiological events. In that regard, WHO's intervention would be essential.

She supported the draft resolution.

The meeting rose at 11:15.

THIRD MEETING

Tuesday, 17 May 2011, at 14:45

Chairman: Dr W. AMMAR (Lebanon)

1. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Implementation of the International Health Regulations (2005): Item 13.2 of the Agenda (Documents A64/9, A64/10, A64/10 Add.1 and A64/10 Add.2) (continued)

Dr VENEGAS (Uruguay) said that the countries of the Union of South American Nations (UNASUR) welcomed the report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009 and were fully committed to the implementation of the Regulations. The South American Epidemiological Surveillance and Health Response Network was monitoring their implementation in its member countries. He supported the draft resolution contained in document A64/10 Add.1. Its adoption would contribute significantly to the implementation and strengthening of the core capacities listed in Annex 1 of the Regulations. The process for reporting on implementation to the Health Assembly should be refined in order to improve monitoring; the UNASUR countries stood ready to offer their experience. Reporting should reflect the real situation in countries and subregions. The need to meet the core capacity requirements listed in Annex 1.B of the Regulations, in respect of points of entry, was of particular concern. Further, Member States should be fully involved in the development of the evaluation mechanism in conformity with Article 54 of the Regulations.

Dr MALAU (Papua New Guinea) characterized the recommendations made by the Review Committee as precise, in particular Recommendation 13 on the establishment of a contingency fund for public-health emergencies. Papua New Guinea was continuing to implement the International Health Regulations (2005), with orientation from the Asia Pacific Strategy for Emerging Diseases, endorsed by the Regional Committee for the Western Pacific in October 2010,¹ and had strengthened its core capacity to respond to emergencies such as pandemic influenza and cholera. That momentum should be maintained to improve emergency preparedness and response capacity still further, which should include the establishment of stockpiles of essential medicines and relevant non-medical items. National IHR focal points in Papua New Guinea had used information-sharing mechanisms widely to notify and be notified by neighbouring countries of public health events of importance.

Dr MENESES GONZÁLEZ (Mexico) recalled that Mexico had been the first country to report the initial events of pandemic (H1N1) 2009. It had remained in close contact with WHO as the pandemic had developed, and that cooperation had enabled it to come through the emergency. The valuable report of the Review Committee provided the necessary elements for review by the international community, and clearly showed that the International Health Regulations (2005) had been implemented appropriately by States Parties and WHO during the pandemic. Its recommendations set out a useful theoretical approach on the basis of the lessons learnt. Member States should make every effort to meet their core capacity-building requirements well before the

¹ Resolution WPR/RC56.R4.

potentially extendable deadlines in relation to Recommendation 1. He supported the draft resolution and requested further information on the proposed contingency fund.

Mr SKERRITT (Saint Kitts and Nevis), welcoming the report, emphasized his country's commitment to implementation of the International Health Regulations (2005). Recognizing that they should ensure global health security through an agreed code of conduct within a specific legal instrument, his country would continue to develop and maintain its capacities to detect, report and respond to public health events, strengthen activities at points of entry and, in collaboration with the Caribbean Epidemiology Centre, provide justification for additional measures that significantly interfered with international travel. It was one of 17 countries of the Caribbean Community to have evaluated its communicable disease surveillance system, and had written a plan of action. Reinforcement of its disease surveillance capacity had enabled it to perform well in terms of reporting during pandemic (H1N1) 2009. A National IHR focal point had been designated and further action was planned to strengthen port health capabilities, monitor continuously and evaluate the surveillance system, conduct simulation exercises and adhere to the Caribbean Epidemiology Centre's minimum standards for implementation of the Regulations by countries with small populations. He supported the draft resolution and commended WHO's continued commitment to transparency and consistency with regard to all Parties under the Regulations.

Mr TOBAR (Argentina) said that the report by the Director-General (document A64/9) made scant reference to Annex 1.B of the Regulations on core capacity requirements for designated airports, ports and ground crossings, except in the section on "Global Partnership", which mentioned international organizations that had a clear influence on the operation of points of entry. The report focused on information corresponding to various aspects of event detection covered by the national surveillance systems, the subject of Annex 1.A. There were notable omissions from the list of bodies consulted by WHO, such as ILO and in particular IMO. Also, notably few experts on points of entry appeared to have contributed to the report. Despite the 65% response rate to the questionnaire on monitoring progress in implementing the Regulations, he sought clarification on the countries that had responded using other instruments, how the various types of information had been made compatible, or whether those countries had been treated as having not responded. The latter approach would not be acceptable, given that WHO had reiterated that using such an instrument to measure the progress in the development of core capacities was an option for States Parties. Member countries of MERCOSUR and UNASUR stressed the need to have a response instrument agreed upon by all States Parties. Further, the report stated that WHO was continuing to enhance the monitoring tools. All those considerations raised doubts about the potential validity of the results and their representativeness.

Similarly, the Review Committee's report (document A64/10) barely responded to the needs of Annex 1.B, with the significance of points of entry in the information collected being hardly reflected in its conclusions. It failed to examine in detail the facts on which its summary conclusions were based.

Mr IDIR (Tunisia) expressed appreciation for the Review Committee's report and WHO's work on implementation of the Regulations. That process should take into account the economic aspects of the transport of goods and persons and the issue of new health emergencies. Pandemic (H1N1) 2009, which had proved a test of cooperation between countries and between individual experts, had permitted the evaluation of capacities to deal with such events and their management at all levels. The report's valuable conclusions should assist WHO in facilitating the implementation of the Regulations in all countries.

Dr MOHAMED FIKRI (United Arab Emirates), speaking on behalf of the Member States of the Eastern Mediterranean Region, commended the report of the Review Committee, and thanked WHO for its support during the pandemic (H1N1) 2009. Implementation of the International Health Regulations (2005) was a common responsibility for all Member States and partners. The report's

conclusions on the response to the pandemic had taken into account the experiences of a wide range of partners and experts, and the lessons learnt would contribute to the strengthening of capacities to deal with future emergencies. The countries of the Region would require further support to implement the Review Committee's recommendations and to assess progress since 2005. The Secretariat should categorize countries according to their capacity to implement the Regulations by the 2012 deadline.

Dr AYDINLI (Turkey) welcomed the Review Committee's hard-hitting report which indicated that, while the full benefit of the International Health Regulations (2005) would not be felt for some time, progress was being made. Countries should make efficient use of their experiences during pandemic (H1N1) 2009 and cooperate effectively under the guidance of WHO during the next phase of implementation. The Regulations would not be fully implemented until every country had met their basic requirements. Countries should continue to update their knowledge, and Turkey was therefore pleased to be hosting an exercise meeting on the Regulations (Ankara, 7–10 June 2011), and stood ready to join in regional cooperation and information-sharing activities.

Professor ONDOBO ANDZE (Cameroon) commended the Review Committee's recommendations. Cameroon had endeavoured to implement the Regulations during the various epidemics it experienced. The global surveillance using targeted indicators being elaborated by the Secretariat with Member States would make a valuable contribution to the evaluation of progress in implementing the Regulations at regional and national levels and the formulation of national plans. The countries of the African Region, which were facing financial constraints, would require continued support from WHO to facilitate the strengthening of the capacities of national IHR focal points and other relevant personnel. Cameroon would, it was to be hoped, receive support from WHO and development partners for the organization of a large-scale multisectoral simulation exercise to improve its emergency preparedness. He supported the establishment of a contingency fund for public-health emergencies, which would provide a legal framework for action, based on international solidarity. The fund, which would operate alongside other mechanisms, ought to improve access to financing, and the proposal for its establishment was in line with resolution AFR/RC59/R5 adopted at the fifty-ninth session of the Regional Committee for Africa in 2009. He supported the draft resolution.

Dr Feng-Yee CHANG (Chinese Taipei) expressed appreciation of WHO's timely sharing of information and dissemination of guidance to national IHR focal points in relation to the Fukushima nuclear accident in Japan, which had expedited global coordination of appropriate responses. Chinese Taipei had completed the self-assessment questionnaire on monitoring progress in implementing the Regulations, despite a delay in its receipt, and reported having met the requirements for 2012 (Level 2) or higher (Level 3). However, further support from WHO was needed to meet the remaining challenges in its regions. Chinese Taipei had initiated activities in order to meet the core-capacity requirements for points of entry set out in Annex 1.B of the Regulations by the 2012 deadline, and was ready to cooperate in activities in that area with partners in the Asia-Pacific region.

He welcomed the report of the Review Committee and supported several of its recommendations. The Secretariat and Member States should be encouraged to implement the recommendations and the Secretariat should facilitate the full, effective implementation of the Regulations in line with the principles of transparency and consistency. Chinese Taipei looked forward to collaborating actively with the Secretariat and Member States in future work, under the Regulations, on health issues of global concern.

Dr FUKUDA (Assistant Director-General) thanked delegates for their supportive comments, which clearly demonstrated the value accorded by them to the Regulations and their wish for the Secretariat to implement the recommendations made by the Review Committee. He had taken note of the concerns expressed and the shortcomings and gaps identified. In particular, he had noted the importance given by Member States to the need to accelerate strengthening of core capacities, especially at points of entry and in relation to chemical and radionuclear events, and to improve

training; to ensure adequate funding; to provide further information on the proposed contingency fund and its operation; and to simplify the pandemic influenza preparedness phase structure, to focus on assessment of severity, and to clarify related definitions. The amendment to the draft resolution had been noted. In reply to the request made by the delegate of Norway for clarification of paragraph 2 of the resolution, he indicated that the paragraph applied to all the recommendations of the Review Committee, not just those related to the functioning of the Regulations. He also thanked all those countries that had offered support in particular areas.

He paid tribute to the Review Committee for its report and recommendations.

Dr FINEBERG (Chair of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009) expressed appreciation for delegates' positive comments on the report. He thanked the many parties that had made significant contributions to its preparation and paid tribute to the hard work of the WHO Secretariat staff assigned to the Committee. However, compilation of the report was the easier part of the project; translation of the recommendations into reality in all countries worldwide would be much more difficult. He had been encouraged by the willingness shown by Member States to participate individually and collectively in activities to attain the implementation goals, and endorsed the comment by the delegate of Turkey that full implementation of the Regulations would not be a reality until every country had completed its work.

The DIRECTOR-GENERAL thanked the Review Committee and its Chair for their hard work. The robust, independent review process had resulted in a valuable report and set of recommendations that deserved to be widely read. She also thanked delegates for their comments, which she would take into account in implementing the recommendations in collaboration with Member States and other partners.

The CHAIRMAN drew attention to the draft resolution contained in document A64/10 Add.1.

Dr YOUNES (Secretary) recalled that the delegate of Morocco had proposed that paragraph 2 should be amended by the addition of a new subparagraph 2(2) to read "to provide technical support to Member States in implementing the recommendations of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009".

The draft resolution, as amended, was approved.¹

2. THE FUTURE OF FINANCING FOR WHO: Item 11 of the Agenda (Documents A64/4, A64/4 Add.1 and A64/INF.DOC./5)

The DIRECTOR-GENERAL said that the report in document A64/4 represented the start of a long process and set out a broad and ambitious reform programme. Some people had asked why the agenda item was entitled "The future of financing for WHO" when it obviously covered much more than financing. The initial discussions had indeed focused on how WHO was financed but they had inevitably led to consideration of WHO's changing roles and priorities in global health in the twenty-first century and how those priorities should be funded. WHO must become more nimble and agile, shedding outdated management structures and approaches to work that threatened to hold back the Organization and make it less influential than it deserved to be. So the agenda had evolved from the future of financing to reforms for a healthy future.

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA64.1.

It had been argued that the process was merely a response to the financial crisis, without which WHO would not have needed to change. That was emphatically not the case. The world and health challenges were changing rapidly, and if WHO failed to act to ensure that it was fit for purpose and ready to meet the needs of all its Member States, now and in the future, it would lose influence; to retain its relevance, WHO must change and be effective, efficient, responsive, objective, transparent and accountable. Clearly, the financial crisis had added urgency to the process. She recognized that for many people working in WHO the focus was the present: their jobs and their future. She was therefore doing everything possible to ensure that the process of change was transparent, strategic and, most importantly, fair.

The report attempted to show the breadth of the planned reforms and give a clear sense of direction in terms of focus, priorities and the management and organizational changes needed to support more effective ways of working. The development plan set out in document A64/INF.DOC./5 provided an overview of the outcomes and outputs for each of the main components of the reform programme. Detailed preparatory work had already been undertaken; much more would follow in the coming months.

She envisaged reform as the outcome of a strategic interaction between the Secretariat and the Member States, which directed the Organization. Many of the views expressed by Member States in earlier consultations and points made in the briefing for all Geneva missions in April 2011 were reflected in document A64/4. The views expressed in the current debate would further shape future action. With that in mind, she particularly looked forward to hearing delegates' views and advice in several areas.

On priority setting, she was interested in further sharpening the focus of WHO's core business and hearing how the Organization's governing bodies might help to ensure a clear strategic focus. There had been several exchanges in respect of WHO's role in global health governance, and she would welcome further comments on how to pursue the objectives of greater coherence and inclusiveness in global health in ways that strengthened support to countries and complemented the Organization's intergovernmental nature. WHO faced a new financial reality. The value of its assessed income had been seriously eroded through inflation and exchange-rate fluctuations. Some donor countries faced financial constraints of their own, yet it would take time before other countries with fast-growing economies could step up to take their place, although their commitment was not in doubt. WHO must therefore be realistic and seek new sources of income and new ways in which it could be raised. Equally, it must revisit assumptions that had limited the growth of core predictable resources.

She was committed to leading the reform. Many Member States had already requested more details on how the work would proceed and such details would be provided. She intended to consult extensively with Member States, partners and staff members at every stage of the development plan; and she would submit specific information on the proposed world health forum to the Executive Board in January 2012. In respect of the independent evaluation, the intention was to conduct a light but high-impact review of a thematic area of WHO's work of critical importance to Member States, in the first instance: health systems. Improvement of WHO's governance would be considered further by the Board at its 129th session in the next week.

Dr NICKNAM (Islamic Republic of Iran) said that the proposed reforms should be Member-driven and consensus-based, focusing on the improvement of efficiency and the revitalization of core functions and responsibilities, in particular promotion of health and the setting of norms. The Organization's normative function needed enhancement. Member States should remember that WHO was not a commercial concern but an international organization with lofty ideals.

The roles and responsibilities of country and regional offices and headquarters should be better delineated, and interaction between the three levels should be better coordinated. Furthermore, greater emphasis should be given to WHO country offices in developing countries, which were well placed to determine local needs; dynamic country offices clearly enhanced the Organization's collective capability. Innovative modalities were needed to strengthen national capacity in developing countries.

He supported the proposed convening of a multi-stakeholder world health forum, but it should conform to established United Nations procedures and practices. WHO's central role in global health governance should be enhanced and the Organization's independence should not be compromised. By the end of the reform process, WHO must be better positioned and better able to secure predictable financing. Donor countries should be more flexible in allowing the Organization greater discretion in the use of financial contributions to fulfil its mandate. His Government stood ready to participate actively in further consultations.

Dr PAVLOV (Russian Federation) said that the decisions taken by the Health Assembly would determine the future leadership role of WHO in health matters and its success in discharging its basic responsibilities, and in responding rapidly and effectively to emerging global health challenges. He commended the extensive consultations and generally supported the reform approaches advocated, and the attendant tasks and goals. WHO would be unable to tackle changing realities without adequate reform. Moreover, financial constraints meant that the Organization should concentrate on areas in which it had an obvious advantage and could achieve significant results, which included: setting of international health norms and standards; provision of guidance and technical support to Member States; development of policies and strategies for national health systems; responses to emerging and re-emerging health threats; prevention and control of communicable and noncommunicable diseases; and responses to emergencies. In addition, more attention should be given to support for good-quality strategic budget financing and planning, the flexible use of financial and human resources, enhancement of accountability and transparency, and administrative discipline in the field to avoid delays. Even with reduced staff levels, WHO could strengthen its authority. He supported the proposed convening of a world health forum with broad participation. His country stood ready to cooperate further in the reform process.

Dr SIRIWAT TIPTARADOL (Thailand), recalling Thailand's comments at the 128th session of the Executive Board, commended the Director-General's courage in addressing the difficult topic of reform. Unfortunately, the Organization faced several serious problems. It had inherited the many rules and regulations embedded in the United Nations system since the Second World War, leading to domination by lawyers. It also appeared to follow the Peter principle, whereby most of its staff were eventually promoted up to their level of incompetence. Its regional and country office structures and WHO collaborating centres were outdated and inefficient, yet consumed more than two thirds of its budget. For example, the Democratic People's Republic of Korea continued to be included in the South-East Asia Region, requiring long travel times to meetings and preventing effective cooperation with neighbouring countries that were included in the Western Pacific Region. The "States only" membership of WHO, excluding other partners, such as academia, civil society and the private sector, had resulted in the development of the current plethora of global health partnerships, which competed with and diminished the role of WHO. There had been no real increase in the regular budget over the past decade, with the consequence that 80% of expenditures were currently financed by donors. Moreover, the largest donor, which provided 30% of voluntary funding, earmarked 99.98% of its contributions. The de facto result was a "donor-driven" Organization. The contributions of the Member States covered the office and salary costs of all staff, from janitors to the Director-General, but the Organization worked mainly in accordance with donor mandates. WHO was no longer co-owned by its Member States. He supported the Director-General's call for a reduction in departments and programmes. As such action would involve difficult choices, he urged her to stand firm and to ignore recent criticism from a biased, colonialistic medical journal. Member States might also wish to consider their position in respect of association with such a journal that appeared to be lacking in neutrality.

Regrettably, the proposed reforms touched only superficially on the problems he had outlined. An inclusive organization was essential. In the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria, for example, States worked alongside civil society and the private sector. Thailand's national health commission, national health office and health assemblies were examples of

inclusive bodies at the national level, and such inclusiveness was extended to the provincial level. Different types of partner must be able to work together on a basis of trust and public spirit, rather than greed, without being hemmed in by rules and regulations and with minimum intervention from lawyers. There should be no earmarked contributions; members should co-own the Organization.

Thailand had concluded that it would be impossible to produce such a global health organization through reform of WHO in its current form. Member States would need to withdraw from WHO to ensure the birth of a new organization with a new governing structure. It was not convinced that the proposed world health forum would provide a good starting point for the necessary dialogue. Nevertheless, Thailand placed full trust in the Director-General and would support her proposed reforms, although it feared that they were doomed to failure.

Mr JAZAÏRY (Algeria), speaking on behalf of the Member States of the African Region, commended the consultation process initiated by the Director-General, which had ensured thorough preparation for the current debate. The global financial crisis had restricted the Organization's capacity to fund its growing activities and had added urgency to the necessity for reforms. The urgency of the situation had been made more acute by the calls at the Executive Board during its 128th session for a considerable reduction in the Proposed programme budget 2012–2013. The Director-General had long called for greater predictability and stability of funding, and for Member States to take the necessary action, without which global health governance could be seriously undermined. The proposed reforms represented a timely response to the need to reinvigorate the Organization's work as the leading authority of technical health issues and to redefine its role in a changing world, given the growing number of organizations working on health issues. Obviously, the Organization should always seek ways to improve its effectiveness, efficiency, and timeliness of response and thereby meet the expectations of Member States. He supported the aims of the ambitious and realistic reforms proposed by the Director-General,¹ which were geared to improving governance within the Organization, and took note of the proposals, including a multi-stakeholder world health forum, an independent evaluation of WHO, and the refocusing of its priorities.

Technical cooperation remained of great relevance in the Region, particularly for the development of national capacity, and was a critical factor in the intensification of efforts to achieve the Millennium Development Goals. Recent cuts in budget allocations had seriously affected priority programmes to combat the Region's main causes of mortality, namely HIV/AIDS, malaria and tuberculosis. There should be greater flexibility in the allocation of resources to WHO's regional and country offices, taking into account specific local contexts, in order to maximize the efficiency of interventions and their outcomes. WHO should vigorously continue to support the implementation of public health priorities at the national level, despite current financial constraints. The reforms should not entail any diminution in WHO's commitment in favour of African countries in particular, and developing countries in general. The gaps in development must be taken into account in any burden-sharing initiative.

WHO's central role in the governance of global health focused on health safety, humanitarian action and health development, areas in which its coordinating capacity should be strengthened, especially in relation to surveillance, responses to health threats, humanitarian action in emergencies, and the implementation of development programmes related to health.

The reform process must be driven by Member States and should not undermine the exclusive role of WHO's governing bodies in the setting of norms and standards, which should remain a core function of the Organization. Member States should be involved in the process at all stages and it should follow a clear, detailed timetable which would include: strengthening of planning and budgeting; regular evaluation; measures to avoid duplication with the activities of other international organizations working in the health field; strengthening of national capacities for health policy-making and planning; support to Member States to ensure coordination with development partners; priority-setting based on disease burden and the requests of Member States; structural reforms of country

¹ Document A64/4.

offices in close collaboration with the Member States concerned; implementation of a balanced and geographically equitable human resources policy; and elaboration of a reinvigorated resource mobilization policy to maintain the interest of traditional donors, attract new ones and increase unearmarked voluntary contributions. He would have liked a much broader scope for the discussions on the future financing of WHO, including other areas where improvements were needed to the functioning of the Organization.

Dr DIXON (Jamaica) commended the proposed reforms outlined in document A64/4 and noted that some of the proposals were in line with Jamaica's national agenda. Jamaica had already taken steps to re-establish a central epidemiology unit at the national level, to unify the national public health laboratory and blood-transfusion service, and to strengthen capacity for risk communication. The proposed strengthening of health systems and institutions coincided with one of Jamaica's priorities. She requested the Secretariat to enhance its communication with Member States on the reforms, with better information sharing and benchmarking of best practices, and to provide technical assistance to Member States for enhancing their capacity to undertake appropriate reforms at the national level.

Dr CUTTER (Singapore) welcomed the Director-General's decisive leadership in regard to the difficult steps taken to make WHO more effective and responsive. Her programme for reform was a significant step towards achieving that objective, but there would inevitably be some resistance to such large-scale change. Political commitment was needed from all Member States to address those challenges and support the Director-General in the difficult journey ahead.

Dr PÁVA (Hungary), speaking on behalf of the European Union, said that the candidate countries Turkey, Croatia, The former Yugoslav Republic of Macedonia, Montenegro and Iceland, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Serbia as well as the Republic of Moldova aligned themselves with her statement. She expressed appreciation for the Director-General's report (document A64/4) and the way it had built on previous discussions at the 128th session of the Executive Board. The European Union fully supported the proposed reforms, believing that they were an essential step towards establishing WHO's future role in global health governance and in addressing major global health challenges. The European Union hoped for an inclusive consultation process ahead of the 130th Executive Board session, in line with the milestones detailed in the annex to the Director-General's report.

Once it had identified its core functions, WHO should prioritize tasks and focus on key areas of its functioning, such as planning and management and human resource policy. The financial aspect of those areas should be defined and independently evaluated by an external entity. She stressed the strong link between the reform process and the future budgetary planning of the Organization. The two issues would need to be managed simultaneously if the much-needed organizational changes were to be achieved. The European Union attached great importance to ensuring a more disciplined approach to setting priorities and increasing efficiency, effectiveness, accountability and transparency, and would actively support all efforts by management to maintain the Organization's independence and credibility. In that regard, better alignment between budget and revenue would be essential and the European Union would support WHO's efforts to assess the advantages of a replenishment model to improve predictable funding. Member States and other donors should also be encouraged to move away from earmarked funding to funding the general budget. WHO also needed a more flexible workforce, whose size should be adjusted according to the budget and whose competence profile should be consistent with the Organization's priorities.

Over the years, WHO had adjusted its programmes and work to meet new threats and accommodate new technologies but a new approach would need to be established under the reform process if it was to continue to fulfil its obligations. One element of that approach would be the more transparent and inclusive participation of stakeholders; the European Union was open to the proposal for a global health forum but noted the importance of ensuring that WHO maintained its independence

and credibility while allowing stakeholders genuine opportunities for transparent and open consultation.

The European Union requested the Director-General to devise a detailed plan for the reform process, with specific actions and timelines for each of its elements, including governance, future of financing, organizational and staffing matters and evaluation. Member States should be closely involved in the process. Given the importance of governance, she endorsed the request contained in the draft resolution that the Executive Board should establish an appropriate process to examine the issues identified in the report that related to WHO's governance.

Ms SILLANAUKKEE (Finland), speaking on behalf of the Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, said that her statement was aligned with that made on behalf of the European Union. She fully endorsed the reform agenda proposed by the Director-General, particularly its emphasis on efficiency, results-based management, objectivity, transparency and accountability. Reform might be a difficult process for WHO's staff members, but it was clear that a more flexible staffing model was essential.

In seeking to identify the areas of core business, a distinction had to be made between the role and the priorities of the Organization; the focus should be on identifying the functions of WHO within the different areas of core business, as priorities could change over time. Despite the increasing complexity of the global health arena, WHO remained the lead agency for health and still had a unique role to play in promoting the health perspective in other forums. WHO should maintain its focus on activities that were expected to have the greatest impact and which were most needed; the Organization had a particularly important role in providing strategic support to Member States and as the lead agency in the Global Health Cluster in emergencies involving humanitarian crises. The Nordic countries strongly supported discussions on governance as part of the reform process so as to foster a more strategic approach to priority setting. The Executive Board played a key role in the governance of WHO and as such should have a central role in the reform process. Improved governance and more transparent budgeting would certainly be a challenge for the Organization, but improving results-based planning, auditing and evaluation were particularly important.

Enhanced transparency and accountability were needed at all levels of WHO, but would depend on the ability of Member States rigorously to define WHO's role and set priorities as well as the process for channelling funds from headquarters to the regional and country offices. Strengthening the Office of Internal Oversight Services was crucial in that regard.

Increased flexible funding from Member States was a key element of reform, as improved alignment between resources and decision-making was closely linked to the availability of flexible and predictable funds. In the search for new and innovative financing, WHO must take care not to jeopardize its independence and credibility and should act consistently with the priorities that had been set.

She welcomed discussions on independent evaluation, but its modalities and scope should be further elaborated in consultation with Member States. She also welcomed the discussion on a world health forum, but careful consideration needed to be given to its exact purpose and how to ensure that it was representative, legitimate and transparent.

Professor AZAD (Bangladesh) welcomed the report on the future of financing for WHO and the emphasis it placed on reform. If WHO wished to remain dynamic in an increasingly globalized world, it needed to adapt to the changing needs of its Member States. He welcomed the Director-General's recognition of that necessity, regardless of the level of financial resources available.

Despite the criticisms made by an earlier speaker, WHO had made many valuable contributions to improving global health. Advances in technology had created new challenges and rising expectations in the health sector and, at the same time, WHO faced increasing financial constraints; however, WHO remained in a position to take on new responsibilities, confront new challenges and exploit the new opportunities with success.

The objectives of the proposed reform were particularly pertinent to his country and the South-East Asia Region, but both would require additional attention in the areas of vulnerability to disasters, disease burden and other local health factors. Adequate flexibility would therefore be needed to ensure that regional and country-specific workplans and budgets could be revised when necessary and that adequate numbers of WHO staff could be deployed at the regional and national levels to carry forward the Organization's core business.

Dame Sally DAVIES (United Kingdom of Great Britain and Northern Ireland) expressed strong support for the proposed WHO reforms, noting that the Director-General's report echoed the recent findings of a review by her Government of WHO and other multilateral agencies, which had concluded that WHO was a key partner in meeting international development objectives, but that there was scope to improve the Organization's performance. The United Kingdom would maintain its voluntary core contributions at current levels for the next two years, in addition to its assessed contributions, but it was vital for WHO to become more results-driven, efficient and cost-conscious, focusing on its strengths. The United Kingdom would review WHO's performance again after two years and adjust its contributions accordingly.

It was to be hoped that the priorities for reform identified in document A64/4 could be successfully delivered but she needed more detail on the relationship between the global, regional and country levels of such delivery. Linking budgets to output would help to improve accountability as well as delivery, and the proposed results framework should measure both the increased effectiveness of WHO and its efficiency and cost control. Her Government would also support any mechanism to help to strengthen governance processes within the Organization, but considered that a world health forum should only be convened if it was clear that it would fill a gap in international health governance and that the costs of establishing such a consultative mechanism were justified.

Implementing the necessary changes would be challenging, but she welcomed the efforts already made by the Director-General to consult Member States in order to shape the reform process. All Member States would have to work with the Secretariat to drive that process forward, including through establishing a clear system of monitoring and reporting on implementation.

Dr LIU Peilong (China) welcomed the proposed reform measures, which demonstrated that both Member States and the Secretariat had a clear and in-depth understanding of the challenges facing the Organization. The reform agenda adequately reflected the opinions expressed by Member States at the 128th session of the Executive Board.

The core functions described in the Director-General's report were an expression of proactive and appropriate strategies consistent with WHO's core role in global health governance and in facilitating coherence and coordination. China welcomed the Organization's attempts to enhance health governance mechanisms, for instance through the promotion of inclusiveness. Experiences could usefully be accumulated as a basis for setting rules for multi-stakeholder participation.

China supported the expected outcomes of the development plan, particularly the goal of at least 40% flexible funding. In that regard, China called for donors to increase their margin for flexible donations and hoped that the Secretariat's reform would enhance efficiency and accountability so as to attract higher levels of unearmarked funding.

In regard to the reform process, he emphasized that the key players should be Member States, whose opinions and concerns should be carefully balanced. His Government supported the broad participation of nongovernmental organizations, the private sector and others, but that participation should be consistent with common United Nations rules. Reform should be gradual and begin in areas where there was already consensus among Member States before advancing to discussions on how to innovate and enrich financing and how to improve human resource management. Efficiency should be improved, with existing mechanisms being integrated into the reform process to facilitate coherence and coordination. Regional and country-specific plans should be tailor-made, in order to strengthen capacity building in individual developing countries, particularly least developed countries, and thereby make up for gaps and weaknesses in the global health fabric. The global and domestic aspects

of coherence and coordination were intrinsically linked and Member States should therefore improve coordination with agencies in order to facilitate WHO's role in global health governance. Also, WHO should provide the relevant assistance to countries to help to build national capacities.

He supported the draft resolution and expressed the hope that the Secretariat would work with Member States to generate more detailed plans on internal reform, coordination between WHO headquarters and regional and country offices, and the improvement of financing.

Dr TAKEI (Japan) expressed support for the Director-General's efforts to facilitate reform of WHO by clarifying the Organization's priorities and identifying ways to ensure feasible future financing. Japan also supported the efforts that had been made to enhance WHO's core functions, including its normative roles, technical assistance, health system strengthening, health risk management and data management, which would help to make the Organization more efficient in the future. Such efforts should improve WHO's activities in several areas, including the provision of health information through strengthened dialogue with stakeholders; improving transparency, performance and accountability; working more closely with regional and national offices; securing sustainable financing and setting standards and legally binding frameworks.

Since WHO's creation, the global health architecture had changed markedly, but the Organization was still able to demonstrate its leadership and had adapted its roles accordingly.

With regard to staffing levels, consideration would have to be given to ensuring an appropriate balance in the different categories of staff, bearing in mind the 1:4 ratio of assessed to voluntary contributions. That was particularly important in view of the financial shortfalls in the current biennium.

Mr KÜMMEL (Germany) expressed support for the reforms proposed in the Director-General's report. WHO played a unique coordinating role in global health, being the only organization with a comprehensive mission and universal legitimacy in that field. However, given the growing number of global health actors, WHO needed to assume the role of a superordinate coordinator in order to avoid inefficiencies and duplication of work.

WHO faced major challenges in its reform process. As far as the focus on core business was concerned, it would need to identify activities that would not be priorities in the future alongside those that would be. That could be accomplished if transparency was enhanced and the Organization's 13 strategic objectives were properly explained. A transparent organizational chart of WHO below director level was needed, so as to facilitate understanding of the clusters and programmes at the headquarters and regional levels as a basis for defining the division of labour between WHO and partners. Germany supported fundamental changes to results-based management and accountability, which could be initiated under the programme budget 2014–2015.

He commended the Director-General's quest for an effective framework on accountability and transparency, but that goal could not be achieved if the programme budget continued to be regarded as the main instrument for resource mobilization. Increased oversight of the regional offices and improved coherence and accountability across the Organization as a whole were also needed and Germany was pleased to see that the report hinted at the need for a clear mechanism to regulate interaction between the different levels of the Organization.

The section of the report on financing and resource mobilization appeared to be based on the assumption that a significant increase in flexible unearmarked funding was essential. However, it should be remembered that 50% of voluntary contributions currently came from donors other than Member States and that 99.7% of such contributions were earmarked. WHO should therefore carefully consider whether exploring other sources of funding would actually increase flexibility. Earmarking was not necessarily an issue, as long as funding was better coordinated and streamlined. A centralized approach to fund raising was needed, presupposing a frank discussion of ways to avoid using assessed contributions to subsidize the overhead component of earmarked projects.

Mrs BADJIE (Gambia) drew attention to the significant contributions that WHO had made to advancements in public health throughout its existence, but noted that the effects of globalization, including new technologies, increased international travel and movement of goods and services, and increased risk of global pandemics and health emergencies had given rise to many new challenges. Large-scale disease threats went beyond the scope of bilateral responses and thus required the resources, expertise and networks that WHO was well positioned to provide.

WHO's core strengths were essential to continued progress in global health and to ensuring the Organization's effectiveness. Those strengths included public health surveillance; setting of standards and regulations; catalysing global initiatives and partnerships; and advocating for policy and behaviour change to combat emerging noncommunicable disease pandemics. However, in recent years, WHO had been stretched beyond its core strengths so that its impact had been diluted. She therefore welcomed the fact that the Director-General had begun to refocus the Organization on those strengths and to phase out areas of activity better suited to other institutions.

All Member States, stakeholders, donors and others should actively support the reform process and internal capacity building in the core areas. WHO could not continue to be all things for all dimensions of health, nor did it need to be; with the rise in the number of nongovernmental organizations, civil society groups, private commercial entities and other multilateral organizations offering their expertise, finance and implementation capacities, WHO's role and responsibilities had changed. The changing landscape did not diminish WHO's leadership in global health but called for that leadership to be more carefully focused. The Organization needed to detect and respond to pandemic threats, coordinate effective responses following disasters, ensure quality and safety of health products and interventions, support multilateral partnerships and lead changes in policy and behaviour to combat the threat of noncommunicable diseases.

Mrs MALLIKARATCHY (Sri Lanka) said that the report by the Director-General provided a good basis for discussion on ways in which the Organization could improve. She expressed appreciation for the recent informal consultations on the issue of reform, which had been conducted in a transparent manner.

Clear guidelines needed to be defined in consultation with Member States on the intended outcomes of the reform and its impact on WHO's governance. She drew attention to the statement in the report (document A64/4, paragraph 85) that the immediate governance challenges were to improve coherence and increase inclusiveness. In that regard, a clearer definition was needed of the rules of engagement with other global health actors, and of their responsibilities.

She would have liked further details on how the Organization would undertake certain reform activities with regard to its programmes, administration arrangements and ways to strengthen WHO presence at the country and regional levels. She looked forward to the report on the evaluation of the work of the Organization and the report on a world health forum to be submitted to the Executive Board at its 130th session.

The objective of the reform process must be to strengthen the role of WHO in public health and enhance its leadership in addressing global health needs. To that end, the reform should encompass the development of a normative framework to address the increasing challenges in health governance.

Mr PELLET (France) said that the future of WHO depended in large part on the reform process that the Director-General was launching. It was certainly one of the greatest challenges of her tenure, and it was essential to meet that challenge in the interests of the Organization. There was no time to lose. Her report constituted the appropriate framework for reform, but more detail would be needed on each of its component undertakings, with a precise timetable.

WHO's stated intention to refocus on its core functions was welcome. Standard-setting, tracking of epidemiological and health trends and strengthening of health systems were among the essential pillars of the Organization's activities. In the area of standard-setting, the heart of WHO's mandate, the work being done on medicines was crucial, the more so as WHO was the only body able to take on that role at international level. Rather than creating new partnerships in that area, those already in

existence should be strengthened, in particular that with the European Agency for the Evaluation of Medicinal Products. However, that essential work was jeopardized by a shortage of resources, and greater support for it was needed.

Given the Organization's current financial difficulties, great circumspection was called for in the selection and targeting of the meetings it might organize. If a choice had to be made, that type of undertaking might sometimes be considered to have lower priority than the elaboration of concrete standards or provision of technical assistance to countries for their implementation. The proposal for a world health forum also needed careful consideration, if such an exercise was to be effective and produce valuable outcomes without creating additional impediments to the smooth functioning of the Organization.

Technical assistance had not been given sufficient attention in the report. WHO had to maintain that essential activity so as to facilitate the application by countries of the standards that it developed, standards that would remain a dead letter if they were not applied. It might be necessary to review the way in which technical assistance was implemented, slanting it towards more targeted missions in response to specific needs on the ground.

With regard to the interaction between WHO headquarters, the regional offices and country offices, France took note of the principle of subsidiarity, but urged coherence in the Organization's activities. The regional offices must work more closely with headquarters, and the principle of top-down decision-making must be observed.

The quality of personnel in the field was essential to WHO's credibility and effectiveness. In that connection, he supported the measures proposed by the Director-General and in particular improvements in the rotation of staff. With regard to the programme budget, he welcomed the planned introduction of a clear and transparent decision tree to guide resource allocation between topics, functions and levels of WHO.

An independent evaluation could be useful as part of the proposed reform. However, such an exercise must have precisely defined objectives, enabling the investment made to produce usable results and specific recommendations.

The issue of transparency within the Organization was fundamental, and he fully supported the emphasis placed upon it by the Director-General. Transparency must be not only one of the most fundamental objectives of reform but an underlying principle of the functioning of the Organization. It was needed in the distribution of resources, in human resources management including the choice of experts, at headquarters and in the regional offices and in decision-making in general. In a context of budgetary constraint, Members had to be able to trust the choices made by WHO.

The Organization evidently needed new donors, taking great care to align properly the funds gathered with the priorities of the Organization and being vigilant as to the risk of conflicts of interest. But considerable prudence was also required in associating private donors with the definition and orientation of policies approved by the Member States and coordinated by WHO. The staff of WHO should be closely involved in reform-related decisions affecting their collective interests.

The internal governance of the Organization would be reflected in the manner in which reform was undertaken. Profound changes in organizational structures were occurring, and more would follow, as a result of reform. In that difficult area, there must be close consultation with the Member States, given the major strategic implications of such changes for the success of reform and for the departments concerned.

It was to be hoped that Member States at the present Health Assembly would adopt a responsible attitude by not asking the Organization to take measures inconsistent with its mandate, and by not adopting resolutions whose content was unrealistic because their budgetary and financial impact and the financing for them had not been clearly identified.

Dr SHUKLA (India) said that any reforms should focus on global health initiatives that contributed to reducing poverty, reducing the costs of health care and ensuring standards for safety of water, food, urban air, pharmaceutical products and industrial chemicals. The reform process should

also take account of the global rise in chronic noncommunicable diseases and mental illness, which would require new strategies and competencies within WHO.

India welcomed the valuable suggestions made by the Commission on Information and Accountability for Women's and Children's Health and was keenly watching progress in the work of the Consultative Expert Working Group on Research and Development: Financing and Coordination. It noted also that the International Health Regulations (2005) provided WHO with a powerful tool to increase health security. A priority in the reform process would be to implement the recommendations of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009, particularly those relating to the strengthening of epidemiological surveillance, laboratory capacity and risk communication, as well as the stockpiling of essential commodities as part of preparedness. In that connection, he drew attention to paragraphs 52 and 53 of the Director-General's report (document A64/4) and emphasized WHO's role in enhancing country capacity to respond to emergencies.

The report offered no suggestion on how to increase flexible financing and it was therefore not clear how the target of 40% flexible funding would be achieved, particularly as it was recognized in the report that many voluntary contributions would continue to be earmarked.

He had noted with surprise the proposal to establish a world health forum, as there had been no discussion on that idea at previous sessions of the Executive Board or the Health Assembly. There was no clarity on the format, membership or role of such a forum, and he therefore called for the more transparent participation of Member States in discussions on its establishment, which could not be decided by the Executive Board alone.

With regard to the draft resolution, he requested more discussion and deliberation on the matters to which it referred, as they were of paramount importance.

Ms WISEMAN (Canada) welcomed the elements of the reform agenda, particularly the focus on priority setting and results-based management. She strongly supported the proposal to reduce the number of strategic objectives so that WHO could better focus on key areas where it was best placed to deliver results within its core business, as well as the focus on increasing country-level effectiveness and improving coordination across the Organization.

A key condition for the success of the proposed reforms and for WHO to assume its proper global strategic role was improved performance by the governing bodies. Guidance would be needed from the Secretariat on how to achieve that aim, but it would have to be driven by the Member States. She supported the proposal that the Executive Board establish a process to look at ways to foster a more strategic and disciplined approach within the governing bodies.

She underscored the importance of ensuring continued strong action by the Secretariat to implement its gender strategy and achieve gender mainstreaming in the Organization. It was thus important that the Gender and Women's Health Department should remain strong.

In principle, she welcomed the proposal to hold a world health forum, but stressed the need for clear criteria for the selection of participants and to identify sources of funding for the undertaking. Also, the forum would not suffice by itself to ensure effective engagement by WHO with its stakeholders, which would require a much broader approach involving more consultations and greater transparency across the Organization's activities.

She expressed support for the idea of an independent evaluation of the work of WHO.

Dr HWOAL (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, emphasized the principle of cooperation between the Secretariat and Member States. That cooperation should be based on strategic principles, particularly of a financial nature, that allowed for better organization of the work of WHO. Financial resources could be used more effectively through better cooperation between all institutions that participated in the work of the Organization. In addition, priorities needed to be defined at the country level so that all Member States were working with the common goal to improve national health systems and health-care coverage in accordance with recognized principles.

To further benefit from existing financial and human resources, certain health principles needed to be reaffirmed in all WHO's activities, taking into account the level of those resources at the country level. Cooperation between WHO and other organizations also needed to be strengthened if the Organization was to increase its levels of funding.

Noting the particular needs of the Eastern Mediterranean Region, he said that the number of WHO officials working in all regions should be adequately balanced to ensure that the Organization's activities were carried out effectively and efficiently.

Dr SILBERSCHMIDT (Switzerland) agreed with the delegate of Thailand that the Director-General deserved the full trust of Member States, but said that he was more optimistic about the outcome of the reform process. No part of the Organization's work was unimportant, and there was thus an overriding need, for both the Organization and the governing bodies, to establish a process that would set true priorities.

He endorsed the need for financial reform, including the budgetary process, and also supported the idea of an independent evaluation, in particular the Director-General's proposal for a focused evaluation on health systems, which was a particularly important part of the Organization's work. There was an important need for managerial reform, including in human resources management, and in that context he thanked the staff for the support they had given thus far to the reform process.

WHO had to strengthen both its governance and convening roles and to improve stakeholder involvement. The organization of a world health forum would be a major step towards that objective.

All the envisaged reforms were closely interlinked; none could be tackled without addressing the others. Therefore, making the right choices for the actual reform process was crucial.

He supported the proposal that the initial process of reform should be led by the Director-General, in close consultation with Member States, and that a report thereon should be submitted to the Executive Board at its 130th session. Additionally, however, the governing bodies had to examine their own functioning and how it could be improved. He agreed with the delegate of China that there was also a need for greater coherence at the national level.

He fully supported the reforms needed to put WHO at the centre of global health governance.

Dr DAULAIRE (United States of America) observed that the Director-General's report, although necessarily general, formed a solid basis from which to move forward, particularly in view of the strong consultative role envisioned for Member States in the draft resolution. He supported the draft resolution and commended it to other Member States. He commended the Director-General and Member States for the inclusive and transparent way in which the discussions around the issue of reform had been conducted both before and after the previous session of the Executive Board, urging that the same spirit and practice should continue to prevail as the process moved forward into implementation.

The further development of a detailed implementation plan would be an important part of the implementation effort, both for working out the details of partially fleshed-out concepts like a world health forum and for bringing greater clarity on some of the interesting ideas that still needed more work, such as, for example, the idea that WHO should examine the advantages of a replenishment model for attracting more predictable voluntary contributions.

The link between WHO's budget and the broader reform agenda could not be overemphasized. The United States appreciated the work that had gone into improving the Proposed programme budget 2012–2013 and giving it the form of a transitional budget. It was clear that there was strong support for moving to a results-based budgeting model. It was essential to execute that process correctly, while not downsizing or reducing the impact of the Organization.

The Director-General's leadership in promoting independent evaluation was also to be applauded, showing as it did the strength of her confidence in the Organization. The evaluation process should be implemented in a way that built on well-known and successful WHO practices for such outside reviews, such as the recently concluded work of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009.

Such an evaluation should look at a limited area of WHO's broad remit; the Director-General's suggestion of health systems as a possible area for that focus seemed an eminently reasonable one.

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

The meeting rose at 17:30.

FOURTH MEETING

Wednesday, 18 May 2011, at 09:30

Chairman: Dr W. AMMAR (Lebanon)

1. FIRST REPORT OF COMMITTEE A (Document A64/53 (Draft))

Dr KULZHANOV (Kazakhstan), Rapporteur, read out the draft first report of Committee A.

The report was adopted.¹

2. THE FUTURE OF FINANCING FOR WHO: Item 11 of the Agenda (Documents A64/4, A64/4 Add.1 and A64/INF.DOC./5) (continued from the third meeting, section 2)

Dr MAKUBALO (South Africa), observing that self-examination by an organization was an important step towards achieving better results, welcomed the proposals for reform, which, guided by certain principles, could constitute a turning point in the Organization's history. The process must be inclusive, participatory and transparent, with the constructive engagement of global partners but Member States remaining the key players. WHO's core functions, particularly its normative role, should not be compromised. WHO should remain a specialized agency of the United Nations and be so structured as to ensure a swift response to needs, especially at the national level. It should be seen to produce results, so strong performance and results management was vital. Finding the balance between assessed and voluntary contributions, together with the availability of funding, was one of the main financing challenges for WHO. A clear mechanism and process for addressing those issues were required. The Secretariat should work closely with Member States to develop a more detailed plan for the reform process, which should proceed as quickly as possible.

Ms BENNETT (Australia) expressed support for the Director-General's reform initiative and welcomed her commitment to involving Member States in all stages of the process. The reforms detailed in her report were crucial to ensuring that the Organization was appropriately equipped to provide high-quality support to developing countries for health system strengthening and to respond to emerging global health challenges. She welcomed the focus on strengthening the core areas of WHO's mandate, including the development of evidence-based norms and standards, the monitoring of health trends and the coordination of responses to health security issues, as well as the emphasis on allocating sufficient funding to the strategic objectives related to Millennium Development Goals 4 and 5. She supported the call for a broader accountability framework, the introduction of independent evaluation mechanisms, greater clarification of the roles and responsibilities of WHO headquarters, regional offices and country offices and the relationships between those bodies, and the proposed staffing reforms. Endorsing the comments by speakers in the previous meeting, she highlighted the need to ensure that the proposed world health forum was necessary and, if it were held, that it was a cost-efficient and transparent mechanism for consultation.

¹ See page 337.

Ms GAMARRA (Paraguay), voicing general support for the reform principles and objectives contained in the report (document A64/4), stressed the need for WHO to continue to lead intergovernmental and other negotiations of global strategies and legal instruments, establishing science- and ethics-based priorities. She welcomed the report's emphasis on strengthening of health systems and health information systems, which would help to optimize the use of resources and facilitate research and information dissemination activities; on the International Health Regulations (2005), which were a key tool for enhancing health security; and on results-based management, accountability and decentralization, which were the key to increased effectiveness of WHO's activities at the country level. She supported the comments by other delegates on transparency, conflicts of interest and donor financing and, because the reform process should be co-managed by Member States, acknowledged the need for a strategic consultation process in which each Member State would assume its share of responsibility for the reforms.

Dr MUKONKA (Zambia) noted that WHO's operating environment had changed drastically in recent years. Many new entities had emerged in the global health arena, often with competing demands and objectives. WHO played crucial normative and technical support roles, and its reform must not result in the loss of gains made in those spheres. Special attention should be paid to strengthening the regional and country offices in order to increase efficiency and effectiveness. He appealed to bilateral and multilateral partners to increase their flexible voluntary contributions in order to increase the Organization's capacity to provide support to countries in priority areas such as maternal and child health and communicable and noncommunicable diseases. He also urged Member States to pay their assessed contributions in a timely manner.

Ms ESCOREL DE MORAES (Brazil), welcoming the report by the Director-General and the efforts made to respond to Member States' comments and opinions during the consultations, stressed that inclusiveness and transparency were central to building confidence and ensuring Member States' sense of ownership of the reform process and the Organization. The reform process must be Member State-driven, based on consensus, and incremental. Member States must contribute constructively to the process, identifying ways and means to ensure adequate funding for WHO. The Organization's role as the main coordinating health authority should be reinforced. To that end, it must adapt to new demands and to an increasingly complex international environment. It must pay more attention to the opinions and concerns of civil society and less to those of private donors, prioritize collective interests and improve management of conflicts of interest. WHO's main goal should be social justice and equality and fairness in access to health care for all. In order to fulfil its mandate, it must have an adequate structure, appropriate internal governance and competent staff who had the capacity to think strategically and develop and implement policies and programmes in accordance with resolutions of the governing bodies.

She welcomed the report's recognition of the importance of health system strengthening, access to medicines and attention to social and economic determinants of health, but how would activities in those areas be supported and implemented? With regard to the programme for reform activities, although expert opinions and advice might be sought for reference purposes, consultations with Member States should take precedence, and, in order to avoid conflicts of interest, only regular budgetary resources should be used to finance the process. She expressed deep concerns about some aspects of the proposed development plan for the reforms (document A64/INF.DOC./5), particularly the reference to a mechanism to pool funds from private entities, and was not prepared to approve such a proposal. As the document had been circulated late, more time was needed to analyse and fine-tune the various elements of the proposal.

Mr SOAKAI (Nauru), welcoming the proposed reform agenda, asked that small island States be included in all subsequent consultations on the issue, in order that the unique challenge presented by the lack of WHO presence in those countries be taken into account. With regard to staffing, he urged the Secretariat to honour previous Health Assembly resolutions regarding gender and geographical

representation among its staff, as 12 of the 15 countries that were not represented in the Secretariat came from the Western Pacific Region.

Although he agreed with the comments about the bureaucratic nature of the current rules and regulations, the Global Fund to Fight AIDS, Tuberculosis and Malaria was not necessarily a good model to follow, as its procedures tended to be inflexible.

Mr EL MENZHI (Morocco) said that the aim of the proposed reforms should be to make the Organization more agile, reactive and better financed so that it could respond to growing global health needs. They should also improve operational aspects of the Organization's work through the establishment of more detailed and realistic programmes and the development of specific performance indicators for a detailed evaluation of activities. Furthermore, the reforms should help to restore WHO as a supranational body responsible for coordination, advice, international health surveillance and dissemination of international health guidelines. The organizational restructuring reforms put forward in the report should make it possible for local stakeholders to take more responsibility for activities. They should also encourage the reallocation of resources to operational posts and a focus on the quality of technical support activities, which should always be done in collaboration with local health authorities in order to enable more concerted action at the national level. He welcomed WHO's efforts to mobilize more flexible funding and the proposed world health forum, which could foster a participatory approach to priority-setting and allow differing viewpoints to be heard.

Mr TUITAMA LEO TUITAMA (Samoa) congratulated the Director-General for her bold and visionary efforts to reform the Organization, whose outcome should enhance WHO's core activities in global health governance. A conscious effort must be made, however, to mitigate any negative impacts of reform on the personnel of the Organization.

Mr CHIREH (Ghana) also commended the Director-General's reform efforts. He observed that some donors were requesting countries to report on activities that previously had been overseen by WHO, a requirement that caused difficulties for the countries in question. It was therefore important to redefine the Organization's core activities. It was equally important for donors to provide support for those activities, and he called on all donors to cooperate fully in the reform. The process should involve Member States at every stage in order to allow reservations to be expressed, and the outcomes should be communicated in a transparent manner. WHO's governance structure needed to be reorganized to reflect modern technologies and ensure accountability.

Ms CHASOKELA (Zimbabwe), affirming the Director-General's report as a good basis for further discussion of reform measures, stated her country's willingness to work with the Secretariat and other Member States in order to make WHO fit for purpose. It was important to remember that the main objective of the reforms was financing for WHO. A review of the Organization's functions was vital in order to ensure sufficient focus on its core mandate, especially the provision of technical support to developing countries, as developing norms without providing support to Member States that needed them would have little tangible impact at country level. WHO should remain a Member State-driven organization.

She expressed scepticism about the proposed world health forum and asked the Director-General to submit a detailed rationale for the proposal. She also had concerns about the timing of the proposed independent evaluation: it should precede, not run concurrently with, managerial and governance reforms, as the results of the evaluation should inform those reforms.

Mr VAN DE PAS (*Medicus Mundi Internationalis*), speaking at the invitation of the CHAIRMAN and observing that public health was a collective responsibility, urged Member States to increase stewardship, debate health issues at the national level, and involve the public more in decision-making processes. On the global level, the proliferation of new actors had diluted WHO's role as defined in its Constitution. WHO should not be solely a technical agency and should seek to

reclaim its political and legal roles. Its priorities and programmes should be shaped by the needs of people, not the power of money or the influence of private corporations. The roles of all actors should be clearly defined and any conflicts of interest identified before any world health forum was convened, and decision-making should remain the responsibility of the governing bodies, which should be independent of the forum.

Ms KEITH (World Vision International), speaking at the invitation of the CHAIRMAN, welcomed the reform proposal's identification of, *inter alia*, health system strengthening, social determinants of health, and primary health care as focal areas for WHO's activities, but suggested a greater emphasis on health issues that affected the poorest and most marginalized populations. She welcomed WHO's commitment to work more closely with nongovernmental and civil society organizations and requested that the latter be included in the identification of areas requiring greater capacity with regard to health system strengthening. Member States should reassess their financial contributions to WHO with a view to ensuring that at least 40% of voluntary funding was flexible. All WHO's funding should be in line with the priorities agreed by Member States, and she urged the Secretariat to exercise caution in seeking funding from the corporate sector. With regard to the proposed world health forum, a small council of representatives from various constituencies might be a more effective way of enabling other actors to make their voices heard.

Ms BODINI (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN, said that WHO should take the lead in global health governance and not be restricted to a technical role. The proposed reforms might reduce the Secretariat's scope of operations and provide new opportunities for corporations and private foundations to influence WHO's agenda through the proposed world health forum. Input from a wide variety of actors was valuable, but it was important that decision-making authority should remain with Member States. The growing imbalance between assessed and voluntary contributions was undermining the independence of the Organization. Member States should commit themselves to increasing their assessed contributions so that within five years such contributions would account for 50% of the total budget; that would ensure that WHO remained an independent organization and was better able to serve its Member States.

Ms RUNDALL (Corporate Accountability International), speaking at the invitation of the CHAIRMAN, expressed serious reservations about the proposed world health forum, which could undermine the principles of democratic governance and independence, diminish WHO's effectiveness, and harm its integrity and reputation, while increasing the influence of the for-profit private sector. The absence of a clear WHO policy on conflicts of interest, together with the participation of the private sector in policy- and decision-making, could distort agreed national and international public health priorities. The current focus on transparency in dealing with conflicts of interest, although important, was not sufficient, as it served only to identify potential conflicts of interest, not to resolve them. She urged Member States to reconsider the draft resolution.

The DIRECTOR-GENERAL said that she had listened carefully to all the comments and concerns, and acknowledged the calls by Member States both for a transparent, incremental and inclusive process and for more details on the reform process. She would continue to consult both Member States and partners, including civil society organizations and other actors such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance. In some areas, it would also be necessary, and indeed desirable, to work with the private sector; for example, cooperation with the Serum Institute of India had led to the production of a meningitis vaccine for African countries at a price of US\$ 0.50 per dose. Although decision-making power lay solely in the hands of the Member States, it was important to listen to other points of view.

With regard to the proposed multi-stakeholder forum, she acknowledged the concerns expressed and assured the Committee that no action would be taken on the matter without further consultation with Member States. As indicated in document A64/4, more detailed plans would be submitted to the

Executive Board at its 130th session in January 2012. Responding to concerns about the independent evaluation, she explained that the aim would be to assess whether WHO had the internal capacity to carry out its core role and provide Member States with the technical support that they needed in order to strengthen the performance of their health systems and implement their health policies, strategies and plans. She thanked Member States for their endorsement of the Organization's role as the lead agency in global health and their commitment to contribute to the reform process, and reiterated her pledge to oversee the reforms personally.

The CHAIRMAN invited the Committee to consider the draft resolution contained in document A64/4.

The draft resolution was approved.¹

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

3. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Prevention and control of noncommunicable diseases: WHO's role in the preparation, implementation and follow-up to the high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases (September 2011): Item 13.12 of the Agenda (Documents A64/21 and A64/21 Add.1)

The CHAIRMAN drew attention to the draft resolution contained in document A64/21 and noted that it had been proposed that a drafting group be set up to continue work on the text. In the absence of any objection, he would take it that the Committee wished to proceed in that manner.

It was so agreed.

(For approval of the draft resolution, see the summary record of the tenth meeting, section 2.)

4. PROGRAMME AND BUDGET MATTERS: Item 12 of the Agenda

Implementation of Programme budget 2010–2011: interim report: Item 12.1 of the Agenda (Documents A64/5 and A64/45)

Dr MOHAMED (Oman), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, read out the report contained in document A64/45, which summarized the Programme, Budget and Administration Committee's discussions on the mid-term review of the implementation of the 2010–2011 programme budget.

Mr PELLET (France) considered that the report of the Programme, Budget and Administration Committee had not provided sufficient information for Member States to have a proper discussion of the interim report on implementation of Programme budget 2010–2011. Generally speaking, the valuable preparatory role that that Committee could play in respect of budgetary and financial issues and audit and evaluation activities was not fully exercised. It should produce a general, composite

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA64.2.

report which should be considerably more comprehensive than the existing, mainly insubstantial reports so that they could serve as a real basis for the discussions of the Board and the Health Assembly on such issues. In addition, greater clarity was needed about the distribution of items between Committee A and Committee B and the expected outcomes of their discussions on finance- and budget-related matters.

Dr HWOAL (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the mid-term review would undoubtedly lead to changes in workplans and financing for the remainder of the biennium and would serve to guide the preparation of plans for the biennium 2012–2013. Although significant progress had been made in the Region on health system strengthening, access to medicines, support for people living with HIV/AIDS and other areas, lack of adequate funding was a serious obstacle to further improvement, particularly with regard to strategic objectives 3, 4, 5 and 6. The Secretariat should support Member States in devising mechanisms for mobilizing funding and optimizing the use of resources, particularly through capacity-building and training of health personnel in accordance with the epidemiological and demographic needs of each country. It should also support health system strengthening, especially in the area of emergency preparedness and response.

Dr PHUSIT PRAKONGSAI (Thailand) expressed disappointment that almost one third of the Organization-wide expected results were considered to be “at risk”, particularly as half those results were related to strategic objectives 4 and 10. More than half the budget had been allocated to strategic objectives 1 and 2, which was evidence of WHO’s inability to reallocate resources to crucial areas, such as those covered by strategic objectives 4, 6 and 9, to which he urged the Secretariat to pay special attention. The poor distribution of resources ran counter to the objectives for organizational reform laid out by the Director-General. The imbalance between assessed and voluntary contributions was a serious concern, and he encouraged the Secretariat to negotiate with donors with a view to ensuring that at least 50% of voluntary contributions were fully flexible.

With regard to strategic objective 2, countries wishing to implement the new guidelines for earlier initiation of antiretroviral therapy would need support from the Secretariat in order to strengthen their health-care systems and ensure good patient adherence to treatment, train counsellors and put in place a strong drug-resistance monitoring system. The Secretariat should take into account the differing stages of health system development among Member States and the financial implications of the new guidelines. As to strategic objective 4, long-term investment and capacity building were needed in respect of vital statistics and health information systems in order to improve the accuracy of data on maternal and child health, especially in developing countries. With regard to strategic objective 5, WHO had a key role to play in collecting and disseminating lessons learnt by Member States with experience in dealing effectively with emergencies and disasters. Concerning strategic objective 11, he encouraged WHO to dissociate itself from the activities of the International Medical Products Anti-Counterfeiting Taskforce, extend the mandate of the Working Group on Substandard/Spurious/Falsely-Labelled/Falsified/Counterfeit Medical Products and implement the recommendations of the first Global Forum on Medical Devices. In relation to strategic objective 12, the Secretariat should review the roles and functions of the regional offices in order to improve their efficiency and increase their accountability to Member States.

Dr LIU Peilong (China) expressed his Government’s concern that two thirds of the expected results linked to the achievement of Millennium Development Goals 4 and 5 were rated “at risk”. Distribution of the impact of the decrease in income across the strategic objectives and the three budget segments was unequal, with some showing significant shortfalls, whereas others had resources above the approved budget level. He supported the decision of the Global Policy Group to reduce, merge or eliminate certain activities in order to manage the financial deficit. The unbalanced distribution of financing was a structural problem that could only be solved by reducing activities or increasing voluntary contributions.

Dr KO KO NAING (Myanmar) observed that the findings of the mid-term review revealed that major programme changes were needed at country level. The Secretariat should study the feasibility of such changes. The guidelines for the Proposed programme budget 2012–2013 should reflect the findings of the mid-term review, including challenges and areas needing special attention, and should include simple and practical review mechanisms. Quick review mechanisms were especially useful at the country level.

It was important to delineate clearly the technical support role of WHO staff at headquarters and at country and regional levels in order to avoid conflicts of ideas and actions, particularly in the case of country offices with strong national professional staff. Special attention should be given to follow-up of agreements for performance of work in order to ensure their effective and efficient implementation. He expressed appreciation to the Regional Office for South-East Asia for conducting several internal reviews and technical assessments of WHO country offices, which had improved their performance, and suggested that the Regional Office should fine-tune its review and assessment methods, which might be useful for other regional offices.

Dr GULLY (Canada) said that the mid-term review had highlighted the pitfalls of aspirational budgeting and the need to re-examine WHO's budgeting process as part of the overall organizational reform initiative. He welcomed WHO's efforts towards achieving a more realistic budget. He sought further detail of the concrete actions that would support specific priorities, noting that the report indicated that the mid-term review would assist the staff in devising corrective action to be taken in areas that were lagging, but did not specify how that would be done. A clear strategic approach to risk management that was in line with the Director-General's reform agenda was needed.

Ms MOE (Norway) underlined the importance for donors of receiving information on results achieved by WHO. Such information was an important aspect of WHO's accountability to Member States. She noted with concern that the expected results in several important areas were at risk of not being achieved and that corrective action was needed, especially in relation to strategic objectives 4 and 10. With regard to the latter, increased awareness of the vital importance of health systems was a positive sign, and she encouraged the Secretariat to give priority to that area. It was gratifying that the Global Policy Group had identified areas that could be downsized, combined or eliminated, but she wanted further information on how those decisions would be implemented, including a timeline; how they might affect the achievement of expected results; and what financial effect they would have. In order to give Member States a better basis for decision-making, future mid-term reviews should include a prognosis for income in the remainder of the biennium, and there should be better correlation between budget implementation reports and the financial report.

Dr JAMA (Assistant Director-General) said that the mid-term review had provided valuable information on the different strategic objectives and had confirmed that none was in trouble. The results would enable the Secretariat to reprogramme and reallocate resources. The Secretariat was currently looking at ways to pinpoint results that might not be achieved owing to lack of resources or increased demand, and assessing how many of the targets could be achieved before the end of the year. Since the review, significant progress had been made in some areas and new resources had been made available; the Secretariat expected to receive additional resources before the end of the year which should make it possible to achieve the expected results under strategic objective 4. Estimates were being made on a daily basis to adjust the targets for each of the Organization-wide expected results. At present, no programme was identified for closure, although some would be scaled down. The figures on projected income against expenditure in the interim report and in the financial report for 2010 were consistent. Income for the biennium 2010–2011 was projected to total nearly US\$ 4 billion, including US\$ 3.5 billion in cash and some US\$ 200 million in in-kind contributions. Total expenditure was expected to be about equal to income.

The DIRECTOR-GENERAL thanked the delegate of France for his observations on the work of the Programme, Budget and Administration Committee and how it should feed into the work of the governing bodies. His remarks had highlighted the urgency of improving internal governance as part of the reform process. The role of both the Programme, Budget and Administration Committee and the Executive Board was to facilitate the work of the Health Assembly, and clearly their methods of work needed to be revised in order to enable them to play that role in a more effective, efficient and coherent manner. Members participating in the 129th session of the Executive Board might wish to discuss reforms that could be undertaken quickly in order to accomplish that.

The Committee noted the report.

Medium-term strategic plan 2008–2013: interim assessment: Item 12.2 of the Agenda (Documents A64/6 and A64/46)

Dr MOHAMED (Oman) speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, read out the report on the Programme, Budget and Administration Committee's discussions on the interim assessment of the Medium-term strategic plan 2008–2013, contained in document A64/46.

Professor OULD AHMEDOU (Mauritania), speaking on behalf of the Member States of the African Region, noted that the interim assessment had been based on self-assessment of progress by Member States and the results therefore reflected respondents' perceptions, knowledge and awareness of their respective health systems, and accuracy and openness in responding to questions. Moreover, 46% of Member States had not responded. Countries from the African and South-East Asia regions had assessed themselves as having made the most progress. Overall, the responses had indicated that the Secretariat was meeting Member States' expectations. Technical support to Member States, particularly in building national capacity, had been identified as a top priority for the Organization during the remainder of the period covered by the Medium-term strategic plan.

Dr HWOAL (Iraq) said that quality control and management were crucial to the performance of health systems. It was also important to strengthen financial systems and administrative capacities, bearing in mind local contexts and epidemiological changes. A holistic approach should be taken in order to optimize the use of resources and strengthen and support the work of the health sector, including through capacity building.

Dr WACHARA RIEWPAIBOON (Thailand) said that it was important to bear in mind that the assessment had been based on subjective self-reporting and that the response rate had been only 54%. It was worrying that no significant progress had been made on 29 of the 45 health outcome indicators and in one case ground had been lost. The least progress had been noted in respect of obesity and harmful use of alcohol, which perhaps suggested a failure by WHO to "walk the talk". If the Organization was serious about combating noncommunicable diseases, it should take aggressive action to tackle those problems.

The report confirmed that the Secretariat had been unable to mobilize and manage resources to address major global health priorities properly. She appealed to the Director-General to stop accepting earmarked contributions as a means of moving WHO away from being a donor-driven agency and maintaining its status as a credible global public agency. The finding that not all countries considered the Medium-term strategic plan useful owing to differences in planning cycles and the structure of national plans and priorities highlighted the need for more flexible indicators and should be viewed as a lesson learnt for WHO. A more participatory and evidence-based approach should be used for the next interim assessment, with appropriate timing and feedback.

Dr KO KO NAING (Myanmar) said that the Secretariat should implement a clear-cut process for ensuring that the findings of the interim assessment would be used to inform future planning and strategy development, although the responses to the questionnaire should not necessarily be taken at face value; it might be necessary to verify some of the data. Countries should review their responses in order to identify priority areas for technical support from WHO. It should also try to determine the reasons for the relatively low response rate. For example, might it be related to the type of questions asked? Every effort should be made to increase the response rate for future assessments, and consideration should be given to working with an external assessment team. Staff from ministries of health, WHO collaborating centres, centres of excellence, and other stakeholders should also be involved.

Dr LIU Peilong (China) observed that the report had shown from different angles how different levels of progress had been achieved and had revealed that the Secretariat's contributions had met Member States' expectations, particularly in the areas of technical support and leadership and engagement in partnerships. The report had also revealed a lack of progress in some areas, notably reducing obesity in adults, children and adolescents and curbing the harmful use of alcohol. More work needed to be done with regard to noncommunicable diseases. He encouraged the Secretariat to take careful account of the findings of the assessment and to try to achieve even progress across all strategic objectives. It might need to re-examine some aspects of the assessment methodology in order, for example, to detect regional disparities in progress levels, and it should work to ensure higher response rates to future surveys.

Dr GONZÁLEZ (Nicaragua) said that, despite the assessment's methodological limitations, it was valuable because it showed the areas in which health systems urgently needed to be improved in order to respond effectively to demographic and epidemiological changes, and it thus also showed the areas in which the Secretariat should concentrate its support activities and allocate more budgetary resources. The Director-General should take those findings into account in adjusting the budget. With regard to the assessment methodology, it was insufficient to ask governments and health institutions to provide the relevant information; public opinion of health system performance should also be sought in order to determine whether the system was meeting people's needs.

Dr JAMA (Assistant Director-General) thanked delegates for their comments regarding areas of weakness and suggestions for improvements, and for highlighting the importance of using the assessment as input for future strategic planning. The Secretariat recognized that self-assessment was subjective, but considered that the exercise had nevertheless yielded important lessons, which would be applied in the next phase of work under the Medium-term strategic plan.

The DIRECTOR-GENERAL commended the Thai delegate's detailed analysis of both the interim assessment of the Medium-term strategic plan and the mid-term review of the Programme budget 2010–2011, which had brought into sharp focus the problems faced by WHO as a result of the imbalance between voluntary and assessed contributions. However, she could not heed the delegate's request to refuse earmarked money, some of which was used for notable purposes, including control of communicable diseases such as HIV/AIDS, tuberculosis, malaria and poliomyelitis. She shared Thailand's view that the budget was insufficient for strategic objectives 4, 6, 9 and 10, but if she refused earmarked money and tried to fund activities related to those objectives out of assessed contributions, 80% of the workforce in those areas would have to be cut. With regard to the delegate's concerns about money received from private foundations and corporations, the Secretariat had to rely on such funding to cover the cost of its work in crucial areas such as tobacco control because it received little funding from Member States for that work. Hence, Member States also had to "walk the talk", especially by providing more non-earmarked contributions which could be used as needed to fill funding gaps.

The Committee noted the report.

Medium-term strategic plan 2008–2013 and Proposed programme budget 2012–2013: Item 12.3 of the Agenda (Documents A64/7, A64/7 Add.1, A64/7 Add.2 and A64/47)

Dr MOHAMED (Oman), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, recalled that the Executive Board had considered the Medium-term strategic plan 2008–2013 and the Proposed programme budget 2012–2013 at its 128th session. Both documents had been examined earlier by the Programme, Budget and Administration Committee at its thirteenth meeting. The Board had asked the Secretariat to revise the budget proposal, bearing in mind the prevailing financial situation and the concerns raised by Member States, and to submit a more realistic proposal for consideration by the Health Assembly. The Programme, Budget and Administration Committee had examined revised versions of the Medium-term strategic plan and the budget proposal at its fourteenth meeting, immediately preceding the present Health Assembly. He summarized the Committee's views, noting inter alia that the revised Proposed programme budget met many of the Board's concerns and requests, the need to revisit and improve the Organization's results-based management framework, and that the programme budget should function as an accountability tool, not as an aspirational fund-raising instrument. The Committee had also pointed out that the Organization had to be ready to extend effective interventions and work towards better alignment of voluntary contributions with the programme priorities, noting the need to address that issue in the discussions on the future of financing for WHO.

Mr NAVARRO (Panama), speaking on behalf of the Member States of the Region of the Americas, said that, in the past, the distribution of resources among the regions and headquarters had not been consistent with the allocation levels approved by Member States. In the case of the Americas, the amount received had historically been far below the amount budgeted, even when WHO's budget had been fully funded. He called upon the Director-General to exercise equity and fairness in the distribution of available resources, including both assessed and voluntary contributions, in implementing the Programme budget 2012–2013, respecting the allocation levels set out in document A64/7 and approval by Member States. He further asked the Director-General to include a review of budget and allocation mechanisms as part of the WHO reform process so as to ensure congruence and transparency in the overall process and enable all countries to contribute to global health security and the achievement of shared health goals and commitments.

Dr JARUAYPORN SRISASALUX (Thailand) welcomed the three principles of integration, continuity and change reflected in the revised budget proposal, but questioned whether those principles could be implemented in the next biennium, as the proposal did not appear to envisage any clear mechanism for translating them into practice. The distribution of the proposed budget among the strategic objectives was disappointing, as there was no significant change in resource allocation for responding to the global health priorities on which the least progress had been made, especially in relation to Millennium Development Goals 4 and 6. The 2% increase and 0.5% decrease in the budget allocated to strategic objectives 4 and 9, respectively, were inconsistent with efforts to accelerate progress towards the health-related Millennium Development Goals. She supported the Secretariat's initiative to ensure that at least 40% of voluntary contributions were flexible in the next biennium and urged it to negotiate with funders to that end. She asked the Secretariat to try to reduce its carbon footprint by half within three years, in particular by reducing staff air travel.

Mrs RUPPEN (Switzerland), acknowledging the difficult decisions that the Director-General had had to make in revising the Proposed programme budget, said that Member States must do their part in making the budget as realistic as possible by providing contributions that were flexible and in line with the Organization's priorities. She fully supported the proposal, which was consistent with the Director-General's reform agenda.

Fluctuations in exchange rates would continue to have a considerable impact on the resources available to the Organization, and it was essential that the Secretariat adopt a contingency mechanism. In addition, in anticipation of the biennium 2014–2015, it would be important to review the budget planning process and the format of the budget in the context of the reform process.

Dr PÁVA (Hungary), speaking on behalf of the European Union, the candidate countries Turkey, Croatia, The former Yugoslav Republic of Macedonia, Montenegro and Iceland, the countries of the Stabilisation and Association Process and potential candidates Bosnia and Herzegovina and Serbia, as well as Ukraine, the Republic of Moldova and Armenia, said that the revised Proposed programme budget was much more realistic than the proposal submitted to the Executive Board in January 2011, and the European Union was prepared to support it. It also supported the priorities identified by the Director-General in paragraph 6 of the proposal, and stressed that those priorities must be respected as the budget was implemented. To that end, she encouraged Member States to consider increasing their flexible contributions.

In order to assess the adequacy of the proposal, Member States needed a comprehensive picture of the financial status of the Organization, particularly updated information on any expected shortfall in income. She strongly favoured a revision of the programme budgeting process with a view to ensuring that the Organization would not be endangered by further shortfalls. The programme budget must not be viewed as an instrument for resource mobilization, but rather as a framework for ensuring accountability, transparency and efficiency. Programmes should only be launched if there was a secure source of revenue to pay for them, and Member States should restrict their requests to WHO for new activities.

Mr PRASAD (India) said that he had noted the reduction in the Proposed programme budget and that in 2012–2013 the emphasis would continue to be on strategic objectives 3, 4, 6, 9 and 10, while the budget for strategic objectives 1, 4, 5, 12 and 13 would be drastically reduced. He expressed particular concern about the substantial reduction in the budget for strategic objective 5 for the South-East Asia Region, which was prone to natural disasters and other emergencies.

Progress had been made towards the achievement of the health-related Millennium Development Goals, but it had been uneven across regions and countries, with much remaining to be done. In addition, health challenges such as noncommunicable diseases and mental health problems had to be tackled. He welcomed the focus on mental and neurological disorders in strategic objective 3. Noting that 76% of the Organization's finances would come from voluntary contributions that were already earmarked, he expressed support for a flexible and sustainable approach to financing that would allow for better alignment of resources with agreed priorities.

Dr HWOAL (Iraq) said that the budget for the forthcoming biennium had to be distributed rationally, taking into account countries' needs with respect to capacity building. Allocations between programmes and activities should support capacity-building and strengthening of health systems. High-quality management should be emphasized as a means of promoting programme complementarity and optimal use of resources and ensuring the effectiveness and impact of programmes. In the next biennium, programmes and activities should be harmonized with the strategic plans of each country.

Mrs REITENBACH (Germany) fully supported the Director-General's plan to provide a new results-based planning framework for WHO which incorporated the programme budget. In the course of negotiating the budget, it had become apparent that a fundamental revision of the budgeting process was urgent. The budget needed to become an accountability tool that showed how the resources available to WHO were to be deployed and that established results for which WHO would be held accountable. The budget was first and foremost an expression of the political will of Member States; it was not an instrument for resource mobilization and should not be a fund-raising tool. It was therefore

imperative that all Member States should be involved in the reform of the budgeting process, which should begin immediately.

She regarded the Proposed programme budget as a transitional budget that did not fully meet the standard that would have to be met in the future. Nevertheless, although she had concerns about whether the proposed budget amount of US\$ 3959 million could be mobilized, she would support the proposal. Henceforth, however, she would not accept a budget based on aspirations.

Ms MOE (Norway) welcomed the Secretariat's efforts to achieve closer alignment of the Proposed programme budget with available resources and programme implementation. Such alignment was crucial if the budget was to become a tool for greater accountability. She acknowledged the difficulties created by earmarking of funds and encouraged donors to provide more flexible funding. She supported the programmatic emphases identified in paragraph 6 of the document and encouraged the Organization also to prioritize the achievement of Millennium Development Goal 3 (Gender equality), which was crucial to the achievement of the other Goals. She sought information on the areas that would be given less priority or scaled down under the revised Proposed programme budget and on how those changes might affect the achievement of the various strategic objectives and Organization-wide expected results, in particular those that were rated "at risk".

The meeting rose at 12:30.

FIFTH MEETING

Wednesday, 18 May 2011, at 14:50

Chairman: Dr W. AMMAR (Lebanon)

1. PROGRAMME AND BUDGET MATTERS: Item 12 of the Agenda (continued)

Medium-term strategic plan 2008–2013 and Proposed programme budget 2012–2013: Item 12.3 of the Agenda (Documents A64/7, A64/7 Add.1, A64/7 Add.2 and A64/47) (continued)

Dr TAKEI (Japan) acknowledged the revision of the Medium-term strategic plan and the Proposed programme budget 2012–2013 in line with comments from Member States, particularly in the light of the Director-General's initiatives for reform. He welcomed the realistic transitional budget, with its increased allocations for high-priority strategic objectives, and he supported the modifications. However, given the current global economic situation, it would be hard to increase the total budget by increasing contributions and he therefore assumed that the total contribution would be the same for the biennium 2012–2013. Further efforts must be made to ensure the implementation of the current budgeted programme and, in particular, to ensure revenues, for example, by strengthening positive incentives for contributions similar to the practice within ILO. Also, donor contributions should be made more transparent.

The suggestion that the deficit in voluntary contributions for some programmes could be covered by using assessed contributions could lead to a reduction in productivity across the Organization. Less-productive programmes, instead of being financially supported, should be re-evaluated and show improved performance before receiving additional allocations.

He welcomed the 27% and 25% increases in budget allocations for strategic objectives 3 and 6 respectively, but asked how the increased budget would be managed during the current financial crisis. Japan would continue to support and work closely with the Secretariat to tackle the global health agenda and improve health for all.

Dr EZAATI (Uganda), speaking on behalf of the Member States of the African Region, said that the programme budget must be aligned with the Organization's core functions, with the emphasis on efficiency in expenditure. He commended the embrace of change and continuity within limited resources, without losing the focus on the Millennium Development Goals. A significant portion of appropriations for the strategic objectives had been earmarked for use in the African States, which required support in order to be able to tackle the heavy burden of disease. It was unfortunate that the total budget had been reduced in all regions, but especially so given the specific problems affecting Africa. He expressed concern regarding the large reductions in financing for health systems, HIV/AIDS, tuberculosis and malaria, and maternal and child health, which would impede the Region's attainment of the Millennium Development Goals. Additional resources should be sought in the medium term to finance those and other underfunded essential programmes. Innovative funding mechanisms should be developed and more predictable and reliable sources found in order to reduce WHO's dependence on voluntary contributions. He also urged Members in the African Region to fulfil their commitments as regards assessed contributions to the programme budget.

Dr LIU Peilong (China) noted the draft Proposed programme budget of US\$ 3959 million, which was US\$ 581 million lower than that for the preceding biennium. In the light of identified potential income, that figure was more realistic, and he therefore supported the budget proposals.

Given the current global financial difficulties, the Proposed programme budget emphasized the strategic objectives for meeting the health-related Millennium Development Goals, in particular maternal and child health, chronic diseases and health system strengthening, funding for which areas had increased from 17% to 27% over the previous budget, an increase that he welcomed.

Most financing for the Proposed programme budget would come from earmarked contributions, and only 34% from un-earmarked contributions, a proportion that was beneath the 40% objective outlined in the reform process. Voluntary flexible contributions should be encouraged, and the reform provided an ideal opportunity in that regard. He supported the draft appropriation resolution.

Mr PELLET (France), endorsing comments made by the delegate of Germany, supported the budget that had been revised at the request of Member States and which provided a good basis for discussions on the future of financing for WHO. He made two specific recommendations about the rebalancing of resources. The first was to break the equation between the strategic objectives and the earmarking of voluntary contributions. That could be done by means of different formulations between the earmarking and the 13 objectives, which could be regrouped or specifically and individually earmarked. Further, the net of international organizations implicated in funding could be cast wider, as the themes did not belong uniquely to WHO but to the United Nations system. WHO's partners could contribute, also thereby breaking the equation.

Secondly, increased private and non-State contributions (almost exclusively earmarked) must be systematically linked to a better alignment of contributions on priorities. It was necessary to be absolutely clear about which activities could be financed by non-State partners; anything to do, on the other hand, with the modernization and governance of WHO must come under its regular budget since what was at stake was the management of the Organization in the interests of all its Member States.

Ms BLACKWOOD (United States of America) supported the proposed budget, which was based on projected income and which indicated a further move towards results-based management. She looked forward to additional progress in that regard during the reform process and to regional perspectives being addressed.

Ms BENNETT (Australia) supported the Proposed programme budget 2012–2013, which included a pledge to redouble efforts on child and maternal health and health system strengthening. However, she shared concerns expressed by other delegates about the reduced allocations for the corresponding strategic objectives 4 and 10, which were essential for attaining the health-related Millennium Development Goals 4 and 5.

She welcomed the planned increase in fully and highly flexible funding, and encouraged all donors to support WHO with core voluntary contributions, to ensure a flexible response to priority issues.

Dr GULLY (Canada), supporting the Proposed programme budget 2012–2013, commended the Secretariat's efforts in bringing it closer to predicted income levels. However, the budget would probably still result in a deficit at the end of the biennium. As moving too quickly from an aspirational budget to a realistic balanced budget might create short-term savings but long-term damage, he supported the adoption of the budget as proposed on the understanding that it was transitional and that any subsequent budget would be fully balanced.

Changes to the budget planning cycle should be considered during discussions on financial reform, with particular regard to improving the function of governing bodies. It was to be hoped that the Programme, Budget and Administration Committee and the Executive Board would be further engaged in the budget process.

Concerning the statement made by the delegate of Panama, he emphasized the importance of the final paragraph on the need to review budget and allocation mechanisms as part of the reform process.

Dr JAMA (Assistant Director-General) welcomed all the comments made on the budget proposal, which had been subject to long consultation. The improvements already made would be further strengthened during the upcoming review process.

The revised budget was based on the expenditure level from the biennium 2008–2009 and the projected income for the biennium 2010–2011. Funding for strategic objectives relating to Millennium Development Goals 4 and 5 had been increased as requested by Member States, and allocations would be further increased by as much as 30% if contributions rose. He reiterated that strategic objective 4 was not alone in addressing the Goals; strategic objectives 1 and 2 both contributed to improving maternal and child health through immunization programmes, poliomyelitis eradication, programmes on HIV/AIDS, tuberculosis and malaria, and health system strengthening. Further emphasis would be placed on the equal distribution of funds across the WHO major offices and between the strategic objectives. It would be important to seek more predictable and flexible financing to address the need for resources.

Projected income, as stated to the Programme, Budget and Administration Committee, remained at US\$ 4000 million; however, some parts of the Programme budget 2010–2011 would not be fully funded. WHO would continue to seek additional flexible contributions in order to align funding with identified priorities. Should the projected income for the biennium 2012–2013 increase, the overall budget and budget allocations would also be reviewed. Any approved work plans would need to be based on detailed projected income and spending both in regional offices and at headquarters.

The reduction and redistribution of budget allocations meant that resources for strategic objectives 12 and 13 had been reduced by 3% and for headquarters by 5%; however any extra income would be directed to those strategic objectives to ensure all results indicated in the Proposed programme budget. It was hoped that direct financing of some programmes such as the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases would also raise additional funding.

The DIRECTOR-GENERAL said that work on a new budget process would begin immediately after the current session of the Health Assembly. Particular attention would be given to evaluation of the existing validation mechanism, to ensure that the budget allocations to the six WHO regional offices and to headquarters were fair and equitable. Greater clarity was indeed needed about the respective roles and functions of different levels of the Organization. The allocation of resources should reflect those functions and produce results. She intended to improve the articulation of what had been achieved with the resources provided. Work on those issues would begin immediately.

Referring to the comments by the delegates of France and Germany, and on the understanding that their comments were in line with the position of the European Union, she asked whether the Committee wanted budget appropriations in the Proposed programme budget 2012–2013 to be provided for each of the existing strategic objectives or grouped into two consolidated sections, one covering strategic objectives 1–11 and the other strategic objectives 12 and 13. Those options could necessitate having two appropriation resolutions, or one with two sections. She pointed out that if the strategic objectives were consolidated, it would not be possible to generate comparative data for the last budget cycle of the Medium-term strategic plan; she recognized that Member States on balance accepted that limitation in view of the advantages of a transitional budget and the accountability offered by the new budgeting process. She asked Member States for guidance.

Dr PÁVA (Hungary) clarified that the European Union was prepared to accept the Proposed programme budget as a transitional budget.

Mr PELLET (France) specified that he had spoken on behalf of his country and not the other Member States of the European Union, whose statement he supported. He was prepared to accept the Proposed programme budget as had been presented to the Committee, on the understanding that it was transitional. The priority should not be the superficial look of the budget but the future funding reform,

as he had noted earlier. He had provided the Secretariat with recommendations on how to move forward, but was not requesting that the budget be reformulated.

The DIRECTOR-GENERAL thanked Member States for their clarifications and expressed the hope the Committee would therefore approve the draft resolution as it stood.

The CHAIRMAN took it that the Committee wished to approve the draft resolution contained in document A64/7 Add.2.

The draft resolution was approved.¹

The future of financing for WHO: Item 11 of the Agenda (Documents A64/4, A64/4 Add.1 and A64/INF.DOC./5) (continued from the fourth meeting, section 2)

Ms ESCOREL DE MORAES (Brazil) reiterated her grave concern about the content of document A64/INF.DOC./5, which outlined a plan for implementing future financing reforms. She was particularly concerned at the reference to “a mechanism to pool funds from the private sector”. She sought clarification as to whether, when approving the draft resolution during the previous meeting, the plan contained in the information document had also been approved by the Committee, as she disagreed with its content and was unable to endorse it.

The DIRECTOR-GENERAL said that she had taken note of the comments made by the delegate of Brazil, and specified that the Committee had only approved the draft resolution. The suggestions contained in document A64/INF.DOC./5 were for information only and would form the basis of any future implementation plan only after further consultations.

2. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Health system strengthening: Item 13.4 of the Agenda (Documents A64/12, A64/13, and EB128/2011/REC/1, resolutions EB128.R8, EB128.R9, EB128.R10, EB128.R11 and EB128.R12) (continued from the first meeting, section 3)

Ms BARRY (International Council of Nurses), speaking at the invitation of the CHAIRMAN, welcomed the close alignment between Member States’ priorities and the WHO document *Strategic directions for strengthening nursing and midwifery services – 2011–2015*.² The global financial situation presented a major challenge to health system strengthening; and the shortage of human resources for health made optimal progress unlikely. Making good that shortage was most important, and WHO should lead the way by filling the vacant nursing and midwifery posts at all levels as well as that of Chief Scientist. Such posts made for effective and efficient solutions that would build on proven results and facilitate partnerships with nurses and midwives.

The International Council of Nurses closely monitored the global nursing situation and sought policies and practical solutions that reduced costs and improved quality. Member States must work together through technical cooperation to provide capacities by establishing and achieving country-focused priority targets. In the past, nurses had proved their ability to meet the needs of the public, as well as expand their scope of practice and assist in health system design. However, WHO needed to make wise investments to address the workforce crisis by encouraging flexible working practices and

¹ Transmitted to the Health Assembly in the Committee’s second report and adopted as resolution WHA64.3.

² Document WHO/HRH/HPN/10.1.

positive work environments. Inadequate educational investment and outdated regulatory mechanisms were restricting nurses' contributions and preventing an increase in access to primary and other health-care services. Investment needed to be increased at all levels, and stakeholders must work together to achieve the health-related Millennium Development Goals, renew primary health-care systems and implement sustainable health delivery networks.

Ms BREARLEY (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, reiterated the call she had made during the 128th session of the Executive Board for increased commitment to equitable health financing. She urged Member States to ensure that the draft resolution contained in resolution EB128.R8 fully reflected the evidence-based recommendations contained in *The world health report 2010* on how health financing could help countries to move towards universal coverage of quality and essential health care. That would require large risk and resource pools, as well as the removal of regressive direct payments for health care. The word "significant" should therefore be deleted from subparagraph 1(1) of the draft resolution.

Governments and development partners that provided Member States with technical and financial support on health financing, backed by WHO, should increase their commitment to implementing the findings of the report and ensuring that support was harmonized and evidence-based.

She welcomed the two draft resolutions on human resources for health contained in resolutions EB128.R9 on health workforce strengthening and EB128.R11 on strengthening nursing and midwifery. Member States should develop or strengthen their health workforce plans to include retention strategies in rural and remote areas and address inequitable workforce distribution. All health workers were entitled to a living wage paid promptly and reliably, which required sufficient resources. She called on the Secretariat and Member States to influence IMF to ensure that countries with critical shortages had the flexibility required to allocate an adequate budget share to health.

In order to build on momentum created by the launch of the United Nations Secretary-General's Global Strategy on Women's and Children's Health in September 2010, she called on Member States to further commit themselves to the need for new, substantial and specific actions to expand, equitably distribute and better support their health workforces.

Ms BRIDGES (International Confederation of Midwives), speaking at the invitation of the CHAIRMAN, welcomed WHO's recognition of the valuable contribution of midwives and nurses to the provision of health services, as they constituted the majority of the health workforce in many countries. However, in some Member States, midwives and nurses were not included in the development and planning of recruitment and incentive programmes and, as a result, recruitment and retention strategies for midwives and nurses were omitted. When midwives and nurses were included, they ensured the development of context-specific recruitment and retention appropriate to their contribution to health-care provision. That included measures such as remuneration, conditions of employment and improvement of work environments. Such measures would go a long way to curbing migration rates, which harmed health-care provision.

Professional associations such as hers were well placed to interact with governments and policy-makers. It had recently produced documents on midwifery education, regulation framework and competencies, which were available to governments when planning human resource programmes and developing workforce improvement strategies. Midwives' associations were a powerful conduit for the flow of information and expertise between governments and the profession. She therefore urged Member States to include midwives and nurses in policy-making at government level to develop and plan appropriate human resource programmes.

Ms STAFFELL (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, said that health systems across the world were under pressure and would not be able to cope if they continued to focus on the disease and not the patient. A sustainable approach to health system design and delivery needed to be based on patient-centred health care, which encompassed

respect for the unique needs, preferences and values of individuals as well as their autonomy and independence; choice and empowerment; patient involvement in health policy; and access and support to receive safe, quality and appropriate health-care services and information. Those principles should be at the core of WHO's activities.

It was essential that robust national or district health policies and strategies be based on broad and continuous consultation and engagement of all relevant stakeholders, including patients; Member States should establish frameworks to involve patients in all policy development. WHO had a key role to play in both exemplifying patient involvement in its own practice and helping governments to establish models of patient involvement. The Alliance would continue to work with WHO and Member States in that regard.

Ms VICTOR (World Vision International), speaking at the invitation of the CHAIRMAN, supported the primary health-care principles of equity and participation through a multisectoral approach, in particular in planning and budgeting, as well as the strengthening of national health systems, policies, strategies and plans to ensure that evidence-based approaches were used. WHO should speak out at national level to encourage more nurses, midwives and communities to be involved in health system and policy dialogue, planning and evaluation, to improve workforce retention and performance. In that respect, she supported the draft resolution contained in resolution EB128.R11. Engaging in health policy dialogue required an understanding of political influence. More national positions should, therefore, combine technical capacity with experience in navigating the political environment.

In the draft resolution on sustainable health financing structures and universal coverage, as contained in resolution EB128.R8, she requested that the word "significant" be removed from the first line of subparagraph 1(1), as it would be hard to measure and any direct payment would be a barrier to access. Tools should be developed to assist countries moving away from user fees towards pro-poor measures, supporting the implementation of evidence-based approaches.

With regard to human resources, more investment was required to improve training and retention strategies in countries with the highest numbers of maternal and child deaths. Coercive mechanisms should be replaced by better incentives such as housing and educational opportunities for those agreeing to work in rural areas.

She supported WHO's role in developing enhanced systems for regulating and coordinating international health efforts in developing countries, which would give resources a greater effect on health outcomes, but requested that any involvement in such activities be more transparent.

WHO should continue to provide technical leadership in global health governance in line with discussions being held on the future of financing of WHO. Her organization would continue to work with Member States, the Secretariat and partners towards the strengthening of health systems in an effort to achieve the health-related Millennium Development Goals.

Dr CHIKERE KADURU (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, said that the report on health system strengthening showed a move towards people-centred primary care, as well as towards the protection and promotion of health in communities. Such an approach should be rooted in the education of health workers. There was a need globally to scale up and transform health workers' education, with sharper focus on primary health care. Innovative curricula with emphasis on the social determinants of health should be developed to promote social accountability and multidisciplinary teamwork. National health plans should include approaches to strengthen relevant educational institutions.

Increased funding, an adequate educational infrastructure, and the scale-up of education would ensure an adequate number of graduates in relation to a country's population size and burden of disease. It was also important to link educational institutions with health systems where graduates would be practising. Engaging students in the community and in rural outreach services during their education would give them a further understanding of the reality of health-care delivery and the population's health needs. He urged Member States to implement the WHO Global Code of Practice

on the International Recruitment of Health Personnel, in order to ensure a sustainable health workforce appropriate to national health needs. It was important to reduce countries' dependence on active recruitment and ensure the better distribution of the health workforce through planning, education, training and retention strategies. The Federation would continue to offer a student perspective at the global and national levels to ensure that policies and systems were developed in consultation with health-care students.

Professor BERO (The Cochrane Collaboration), speaking at the invitation of the CHAIRMAN, supported the draft resolutions on health system strengthening contained in resolutions EB128.R8, EB128.R9, EB128.R11 and EB128.R12. She welcomed the fact that the Health Assembly urged Member States to use and implement evidence-based findings related to health worker education and training, as outlined in EB128.R9. Such evidence was available, and should be evaluated and used to inform all resolutions and policies related to health system strengthening. Research summaries and policy briefs derived from systematic reviews were also available to inform decisions.

Dr Chung-Liang SHIH (Chinese Taipei) said that, since the universal single health insurance system had been established in 1995, coverage in Chinese Taipei was more than 99% and was funded by 6.9% of the gross domestic product. The health-care system had been successfully integrated into the social security system so as to establish a comprehensive and people-centred delivery network. In response to an ageing population, decreasing birth rate, and significant immigrant population, the Department of Health had become the Ministry of Health and Welfare. It would provide a well-rounded social security system, including geriatric medical care, long-term care facilities, rehabilitation for physical or mental health disability, protection of children and women's rights and social insurance, in order to enhance community welfare while developing an efficient and effective public health system.

Increasing suicide rates were becoming a global issue. In 2005, Chinese Taipei had made suicide prevention a major health policy area, setting up a Centre for Suicide Prevention which provided a 24-hour toll-free counselling service, home visits and a suicide notification network. Locally, community centres provided education on mental health issues and substance abuse. Suicide had been reduced by 12% over the previous five years, and was no longer among the top 10 causes of death. Suicide prevention was still a priority, despite the country's being affected by recent financial difficulties and natural disasters.

Dr ETIENNE (Assistant Director-General) noted the unanimous view that health systems were important in achieving health outcomes, and the need for integrated, comprehensive, well-functioning health systems that were able to respond to existing challenges but that also possessed the resilience and flexibility to respond to emerging challenges, including emergencies and disasters. She had also noted the emphasis on an overall country-specific approach that included all stakeholders. The Secretariat was committed to expanding efforts to promote national health policy dialogue and to support the definition of national health strategies, policies and plans. Such national instruments were the best ways to deal with country-specific issues, reach balance and coherence between specific life-cycle programmes and other health system elements, and form the basis for donor alignment and harmonization.

Health systems must, indeed, be strengthened through the primary health-care approach, encompassing the principles of equity, solidarity and social justice for human rights. The Secretariat was actively pursuing that approach which embodied universal coverage, people-centred primary care, health in all policies, and inclusive governance, as exemplified in its strategy on HIV/AIDS and the report on noncommunicable diseases.

The world health report 2010 on the financing of universal coverage had been broadly accepted, but had led to an increase in demand by Member States requiring support for reform. Limited capacity meant that the Secretariat was engaging directly with partners to meet that demand.

The health workforce crisis was a long-standing problem in many countries and the Secretariat was working on transformative education, retention policies, monitoring and evaluation especially in countries in crisis, and the plan of action for the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel. Nursing and midwifery constituted an important component of the health system, and as such deserved the emphasis being given by the Secretariat.

Given the financial crisis, the Secretariat was exploring new ways of working to maintain the momentum on health system strengthening, and it would work with all partners to support Member States in that endeavour. The leadership of Member States would be crucial in building national health systems able to address the full range of challenges.

The CHAIRMAN invited comments on the draft resolution contained in resolution EB128.R8.

Dr JADEJ THAMMATACHAREE (Thailand) said that the draft resolution was a landmark in the support for countries to move towards universal health care, and thereby attain the Millennium Development Goals. In January 2012, Thailand would host a global conference on universal health care, facilitating discussion on how to move from commitment to implementation, in which he invited policy-makers from all Member States to participate. The move to universal health care needed to be an intersectoral initiative and in Thailand involved various ministries and stakeholders, including the ministries of finance, and labour and development, as well as trade unions and the private sector. The universality of health care should be a global priority and, as such, discussed by the United Nations General Assembly.

He proposed four amendments to the draft resolution. A new subparagraph 1(1) should be inserted to read: “to consider proposing an agenda item on universal health coverage to be discussed by the forthcoming United Nations General Assembly;”. New text should be inserted at the end of subparagraph 1(11): “, including tracking the flows of health expenditures through the application of standard accounting frameworks;”; a new subparagraph 2(1) should read: “to communicate with the United Nations Secretary-General in order to insert an agenda item on universal health coverage to be discussed by the forthcoming United Nations General Assembly;”; and at the end of subparagraph 2(5) the phrase should be added: “, including strengthening capacity in tracking resource flows through the application of standard accounting frameworks;”.

Dr PÁVA (Hungary), speaking on behalf of the European Union, said that she needed more time to consider the amendments proposed. She asked for clarification from the Legal Counsel on the feasibility of requesting that an item be submitted for inclusion on the provisional agenda of the United Nations General Assembly. Further clarification was also required on the extra workload that might result from the amendment to subparagraph 2(5), with regard to the obligations of national health governance.

Ms WAKEFIELD (United States of America) requested that the words “comply with” in the second line of subparagraph 1(4) be deleted and replaced with “implement”. She furthermore asked to see all the amendments proposed by the delegate of Thailand in writing.

Ms McKEOUGH (Office of the Legal Counsel), speaking at the request of the CHAIRMAN, said that her Office also wished to see the amendments proposed by the delegate of Thailand in writing before commenting on the inclusion of an item on the provisional agenda of the United Nations General Assembly.

The CHAIRMAN suggested that the Secretariat should prepare and circulate a paper containing all the proposed amendments to the draft resolution contained in resolution EB128.R8, and that the Committee should turn its attention to the draft resolution contained in resolution EB128.R9.

It was so agreed.

Ms WAKEFIELD (United States of America) requested that the word “synergies” in the fourth line of subparagraph 2(1) be deleted and replaced with “coherence and coordination”.

Dr JARUAYPORN SRISASALUX (Thailand) proposed the addition of a new fourth preambular paragraph bis, reading: “Recognizing the transformative scaling-up of faculty members in health professional training institutions, both quantity, quality and attitude are prerequisites for sustainable, transformative scaling-up of health professionals;”. Furthermore, a new subparagraph 1(5)bis should be added, reading: “to expand, strengthen and reorient the faculty members of health professional training institutions in terms of quantity, quality, skill-mix and attitudes relevant to the implementation of the transformative scaling-up of health professionals;”.

Dr PÁVA (Hungary) asked for more time to consider the proposed amendments and requested that they be distributed in writing.

Ms BENNETT (Canada) supported the amendment proposed by the delegate of the United States of America and seconded the request to see the changes proposed by the delegate of Thailand in writing. She asked for clarification of terms such as “attitudes” with respect to the workforce.

The CHAIRMAN suggested that the Secretariat should prepare and circulate a paper containing all the proposed amendments to the draft resolution contained in resolution EB128.R9, and that the Committee should turn its attention to the draft resolution contained in resolution EB128.R10.

It was so agreed.

Ms WAKEFIELD (United States of America) suggested that the third preambular paragraph of the draft resolution be amended to read: “Reaffirming that countries should ensure the protection of the health, safety and welfare of their people and should ensure the resilience and self-reliance of the health system ...”.

Dr ORAPAN THOSINGHA (Thailand) said that the draft resolution would provide Member States with guidelines for the effective emergency preparedness and response to reduce the death tolls, disabilities and suffering caused by increasing incidences of human-made and natural disasters. To reinforce the message regarding the need for greater political and financial commitment, however, she suggested that the words “and effective law enforcement in the management of health hazardous agents” be inserted after “and other measures” in the fourth line of subparagraph 1(1); and that the word “protect” at the end of that line be deleted and replaced with “increase”.

In order to reflect the increasing importance of chemical emergency management, a new subparagraph 1(2)bis should be added, reading: “To establish transparent inventories and transportation of hazardous chemicals and share among concerned government and other related agencies responsible for emergency and disaster management in order to support specific emergency preparedness and appropriate responses to different chemical agents;”.

Subparagraph 1(4) should be amended to read: “to establish, promote and foster regional and subregional collaboration, not limited to the WHO regional structure, including the sharing of experience and expertise...”; and subparagraph 1(5) should be amended to read: “to strengthen the role of the local health workforce in the health emergency management system including preparedness, responses and recoveries to provide local leadership and health services, through enhanced planning, training for all health-care workers, and access to other resources;”. Furthermore, in view of the Director-General’s duty to support regional and subregional networks, including those outside the WHO regional structure, a new subparagraph 2(5)bis should be added, reading: “To support regional and subregional networks in their collaboration on emergency and disaster management, including those outside the WHO regional structure;”. The fourth line of paragraph 3 should be amended to read: “... for the World Health Organization’s role in health emergency and

disaster management matters.”. As it was customary in Health Assembly resolutions to present requests to the Director-General in the final operative paragraph, the order of paragraphs 2 and 3 should be reversed and the numbering amended accordingly.

The CHAIRMAN suggested that the Secretariat should prepare and circulate a paper containing all the proposed amendments to the draft resolution contained in resolution EB128.R10, and that the Committee should turn its attention to the draft resolution contained in resolution EB128.R11.

It was so agreed.

Ms WAKEFIELD (United States of America) requested that the word “must” on the fifth line of subparagraph 1(4) be deleted and replaced with “should”. Meanwhile, the word “renumeration” on the third line of subparagraph 1(8) should read “remuneration”.

Dr SUCHITRA LUANGAMORNERT (Thailand) said that the text represented another milestone in the Secretariat’s continuing efforts to strengthen frontline nursing and midwifery services, which formed the backbone of health systems. Outlining the progress made by professional bodies in Thailand in terms of monitoring and improving the education, working conditions and health of nurses and midwives, she welcomed the release of the Strategic Directions for Strengthening Nursing and Midwifery Services for 2011–2015, which would be translated into the country’s 10-year national nursing and midwifery development plan (2007–2016).

She proposed several amendments. In paragraph 1, the words “demonstrate their commitment to strengthening nursing and midwifery by” in the introductory sentence should be deleted; the words “and systems for sustaining the competencies” should be inserted before “consideration must be given” at the end of the fourth line of subparagraph 1(4); the end of that subparagraph should be amended to read: “midwifery researchers, educators and administrators;”; the words “career development and advancement” should be added to the third line of subparagraph 1(8), after “conditions of employment”; the word “introducing” at the beginning of subparagraph 1(9) should be deleted and replaced with “establishing national mechanism in order to develop infrastructure that supports”; and the end of subparagraph 1(10) should be amended to read: “...loss of trained nursing staff; as well as implementing effective rural retention policies and interventions;”. The end of subparagraph 2(1) should be amended to read: “...and regional posts, including chief nurse scientist at WHO headquarters;”; and a new subparagraph 2(5)bis should be inserted, reading: “to strengthen nurse and midwife datasets as an integral part of the national health workforce information systems, and maximize use of this information for evidence-based policy decisions;”.

Ms CHASOKELA (Zimbabwe) suggested that, in order to align the text on different educational models, the words “entry-level” in the third line of subparagraph 1(4) should be deleted and, further to the amendments proposed by the delegate of Thailand, that the words “and systems of maintaining ongoing competencies” should be added to the fourth line after “nurses and midwives”. Secondly, to strengthen the reporting cycle and ensure continuity, the words “and thereafter every three years” should be inserted after “World Health Assembly” in subparagraph 2(6).

Mr RAKUOM (Kenya) observed that the draft resolution aimed at strengthening services at the primary, secondary and tertiary levels of health care, including prevention, promotion, curative care and rehabilitation. To that end, it urged Member States and requested the Director-General to invest in the education, production, recruitment and retention of more nurses and midwives, who formed the bulk of the health workforce at the country level and who were key to progress in efforts to achieve the Millennium Development Goals. Kenya, which had participated in the development of transformative education for nurses and midwives, was concerned that their numbers within WHO were dwindling; that inadequate resources were made available to convene regular meetings of nursing and midwifery leaders in Africa; and that governance of the professions needed strengthening

nationally, regionally and globally. The resolution would facilitate national, regional and global strategic planning and implementation of efforts to tackle the problems, and he supported the amendments proposed by the delegates of Thailand and Zimbabwe.

The CHAIRMAN suggested that the Secretariat should prepare and circulate a paper containing all the proposed amendments to the draft resolution contained in resolution EB128.R11, and that the Committee should turn its attention to the draft resolution contained in resolution EB128.R12.

It was so agreed.

Miss NANOOT MATHURAPOTE (Thailand) said that, in the light of the need for capacity-building to enable countries to develop national health policies, strategies and plans tailored to their respective socioeconomic, political and cultural circumstances, she supported the draft resolution but had some amendments to propose in order to strengthen the text.

The second line of the fifth preambular paragraph should be amended to read: "...within and beyond government, including civil society organizations, the private sector, health professionals and academia, ...". Second, the words "evidence-based" should be added to subparagraph 1(5) before "evolving challenges", and a new subparagraph 1(6)bis should be inserted, reading: "to empower civil society and communities, the private sector, health professionals and academia to actively and efficiently participate in the policy dialogue and the evaluation and monitoring process, as well as to be actively involved in reviewing the performance of the national policies, strategies and plans;". Furthermore, given the importance of emphasizing each country's autonomy and specificity in the implementation of national plans, as well as the need to recognize the role of development agencies and donor countries, the words "and specificity," should be inserted after "country ownership" in the third line of paragraph 2.

Emphasis should be placed on inclusiveness in the policy dialogue at the Health Assembly, which at present permitted the equal participation only of governments and not other partners. Some countries had included representatives of local civil society organizations, academia, professional bodies and even the private sector in their delegations. Others should be encouraged to follow suit as a sign of their inclusiveness. It was to be hoped that WHO reform would lead to a reform of the governing bodies that would enable all partners to participate on an equal footing in meetings of the Health Assembly and the Executive Board.

The CHAIRMAN suggested that the Secretariat should prepare and circulate a paper containing all the proposed amendments to the draft resolution, and that the Committee's consideration of the agenda item should be suspended and resumed later in the week.

It was so agreed.

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

Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits: Item 13.1 of the Agenda (Documents A64/8, A64/8 Corr.1 and A64/8 Add.1)

The CHAIRMAN invited the Committee to consider the draft resolution contained in document A64/8, attachment 3.

Ms HALTON (Australia) recalled that the Sixtieth World Health Assembly in 2007 had considered the serious concerns about the largely informal system of sharing influenza viruses, on which health security greatly depended in the event of a pandemic. Many Member States had expressed doubts about the system's fairness, especially with regard to sharing benefits, and had called for it to be formalized. The Health Assembly had decided to begin intergovernmental negotiations to

establish a framework providing for governance, transparency and the equitable sharing of viruses and benefits. Those negotiations had been intense and had lasted for four years. The Open-Ended Working Group of Member States on Pandemic Influenza Preparedness had recently submitted its report. It was particularly satisfying that all the issues causing such concern in 2007 had been fully debated, and she thanked Mexico and Norway, the Co-Chairs of the Group, for having brought the negotiations to an historic conclusion. The most recent discussions, in April 2011, had resulted in the excellent Pandemic Influenza Preparedness Framework, and Australia had accepted a mandate to carry out further informal work on the unresolved issue concerning the Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Utilization. In its report, the Working Group had strongly recommended that the Health Assembly should consider the options presented in square brackets in the draft resolution. It would be extremely difficult to reach a consensus on either of the options or on any other wording, yet it would be a major failure if the Health Assembly postponed adoption of the Framework until 2012. She therefore proposed deleting the whole of the fifth preambular paragraph of the draft resolution. Reaffirming the need for governance, transparency and fairness in a system that provided all countries with the necessary protection from an influenza pandemic, she urged the Health Assembly to adopt the draft resolution as amended.

Mr BARBOSA (Brazil) welcomed the historic agreement reached on the Pandemic Influenza Preparedness Framework, and the accompanying Standard Material Transfer Agreements as a result of the negotiations called for by Member States in 2007. The negotiating process had highlighted the critical importance of WHO's intergovernmental mechanisms. Although Member-driven, the process had brought in other parties, including civil society and industry, proving that greater participation in decision-making resulted in agreement on a more institutional, predictable, inclusive and democratic mechanism.

Crucial agreements had moved the process in the right direction. Thanks to the adoption of the two Standard Material Transfer Agreements, one on the relationship within the network and the other on that among vaccine manufacturers, a legal regime had been established for WHO, influenza laboratories and interested manufacturers. The mechanism encouraged contributions by the pharmaceutical industry and other bodies, whose access through the WHO network to viruses of pandemic potential enabled them to produce vaccines. Preparedness for an influenza pandemic was essential and would depend on long-term commitments and substantial financial contributions by all concerned, in particular those able to contribute more. Each recipient country should be treated differently, with income levels being taken into account.

The Health Assembly would have to ensure that the Framework and the accompanying Standard Material Transfer Agreements were implemented in a way that met countries' expectations for improving the system. That included the provision of a reasonable level of benefits for developing countries. Similarly, intellectual property rights would play a central role in the new system. Although those with the technology should profit from their investments, in times of a pandemic they should share that technology through solidarity. It was crucial to provide developing countries with access to the processes and technologies to produce vaccines and other products by granting non-exclusive licences with no or affordable royalties.

Thanks to the Framework, the system would become more predictable, provided that all players met their obligations. Throughout the process everyone had shown flexibility but in the future, predictable – albeit not legally binding – rules would create moral and ethical obligations. It was for governments, the industry and the Secretariat jointly to monitor the fair, efficient and transparent implementation of the Framework while meeting their respective obligations. In particular, the industry's contribution was long overdue. An intergovernmental mechanism should be established to oversee the functioning of the Framework. The Advisory Group would play a central role in ensuring that it was properly implemented and that the agreed rules were observed. The Framework would ultimately be judged by the number of lives saved in the event of a pandemic, by its ability to provide for a universal response and, moreover, by an increase in – and a geographical diversification of – the

global capacity to produce vaccines to deal with pandemics. The in-built review clause was another important instrument, provided that it resulted in timely improvements to the Framework rather than in its undoing. Once adopted by the Health Assembly, it would serve to strengthen cooperation among Member States but it should be balanced, effective and transparent, helping those unable to respond unaided to the outbreak of an influenza pandemic.

Mr SOAKAI (Nauru) said that, in his country vaccination against pandemic influenza A (H1N1) 2009 virus had been conducted in two phases, with the aim of immunizing 90% of the population, which in 2010 had been estimated at 9550 people. Phase I had targeted WHO's recommended at-risk groups, and by March 2010, 10% of the population had been vaccinated. By the end of Phase II, in January 2011, 96% of the population had been vaccinated, a figure above the initial target. The exercise had been coordinated by a multisectoral pandemic taskforce, which had met every month and had led the response in surveillance and reporting, infection control, medicine stockpiling, clinical services, media awareness, health promotion and education, screening at the border and providing travellers with health education. WHO and Chinese Taipei had provided 9800 vaccine doses for the campaign.

Important lessons had been learnt, including the need to obtain enough political and community support for a campaign on such a scale to succeed. Furthermore, specific and targeted media and awareness-raising campaigns before and during the exercise had proved vital. It had been found necessary to have a communication network and a call-back or referral focal point to answer the public's queries. The multisectoral approach had given ownership to the stakeholders. According to hospital-based surveillance, no case of infection with pandemic (H1N1) 2009 virus had been identified in Nauru since October 2010, apparently indicating that the vaccination exercise had been successful. He thanked WHO and partners for their support. He endorsed the amendment to the draft resolution proposed by the delegate of Australia.

Dr SEDYANINGSIH (Indonesia), speaking on behalf of the Member States of the South-East Asia Region, fully endorsed the proposal by the delegate of Australia to delete the fifth preambular paragraph of the draft resolution. The finalized Pandemic Influenza Preparedness Framework provided a coherent and unified international approach aimed at ensuring the availability of influenza viruses to WHO and the sharing of such benefits as equitable access to vaccines, antiviral agents, diagnostic kits and intellectual property licences, while strengthening national surveillance systems. Member States had been actively involved in the intense negotiations of the previous four years. Under the astute leadership of the Co-Chairs of the Open-Ended Working Group, and with the support of the Director-General, all stakeholders, including the pharmaceutical industry and civil society, had pulled together successfully in a collective effort to design a reliable and transparent pandemic influenza preparedness and response system. The contributions of the pharmaceutical industry in particular, together with the legally binding provisions of the Standard Material Transfer Agreements, would be the key to the system's credibility and success. All parties should focus on its immediate implementation, with its functioning coordinated by the oversight mechanism described in paragraph 7.1.2 of document A64/8. With the new Framework in place and drawing on the lessons learnt from the recent outbreaks of influenza A (H1N1 and H5N1), the world would be better prepared to respond to a future pandemic. Her Region was committed to making it a success for the good of global public health security.

Dr MHLANGA (Zimbabwe), speaking on behalf of the Member States of the African Region, paid tribute to the Co-Chairs of the Open-Ended Working Group for their tireless efforts in steering the arduous negotiations on the Pandemic Influenza Preparedness Framework to a successful conclusion, giving the international community the means for a stronger response to a future pandemic by ensuring that the roles and responsibilities of the key players were more clearly defined. It was a significant victory for public health and a milestone in the work of WHO. The outbreak and rapid spread of pandemic (H1N1) 2009 virus between June 2009 and August 2010 had made clear the challenges facing the developing countries in the African Region because they had lacked affordable

access to – and the capacity to manufacture – vaccines, as well as adequate risk assessment and surveillance systems. Since the pandemic (H1N1) 2009 virus would continue to circulate for the foreseeable future, a better-organized response was crucial. Hence the importance of implementing the Framework and institutionalizing a legal regime in order to promote a coherent global approach for making viruses available to WHO and ensuring equitable access to essential vaccines, antiviral agents, diagnostic kits and scientific information, in particular for low-income countries. He therefore requested the Director-General to work with Member States and other stakeholders such as the pharmaceutical industry, whose support for the preparedness effort at the national level had been invaluable, to ensure the swift implementation of the Framework and the development of a pan-African laboratory capacity-building programme, for example. To that end, he supported the proposal to delete the fifth preambular paragraph of the draft resolution.

Dr PÁVA (Hungary), speaking on behalf of the European Union, said that the candidate countries Turkey, Croatia, The former Yugoslav Republic of Macedonia, Montenegro, Iceland, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Serbia, as well as Ukraine, the Republic of Moldova, Armenia and Georgia aligned themselves with her statement. Welcoming the outcome of the last meeting of the Open-Ended Working Group, she commended the Co-Chairs, and all parties involved, on the commitment, flexibility and support that had made it possible, after four years of hard and challenging negotiations, to reach an agreement that clarified roles and responsibilities within the WHO system, and which had established a groundbreaking partnership with the pharmaceutical industry. It had done much to ensure that the world was better prepared for a future pandemic. The European Union endorsed the proposal to delete the preambular paragraph of the draft resolution containing language that had failed to secure a consensus. All Member States must accept the Pandemic Influenza Preparedness Framework as the instrument for governing access and benefit-sharing with respect to biological materials, and must agree to implement it accordingly. It would be a major step forward in ensuring that virus samples were made available to WHO with a view to safeguarding health security for all.

Mr JAZAÏRY (Algeria) joined previous speakers in commending the Co-Chairs and members of the Open-Ended Working Group on the quality and results of their work; in outlining the advantages of the coherent and unified approach provided by the much-needed Pandemic Influenza Preparedness Framework; and in calling on the Director-General and Secretariat to continue working closely with Member States, stakeholders and especially the pharmaceutical industry, on the implementation of the WHO global pandemic influenza action plan.

It was crucial to understand the exact nature of a virus in order to monitor the spread of disease, to establish its potential to develop into a pandemic, and to produce the necessary vaccines. Yet developing and especially least developed countries often lacked adequate access to – and the capacity to manufacture – vaccines and antiviral agents, and global supplies could be diminished by a sudden increase in demand that led to soaring and unaffordable prices. In order to prevent intellectual property rights from undermining efforts to tackle that problem, the holders should grant a non-exclusive licence to WHO, which could, in turn, grant a sublicense to those rights to interested developing countries. Member States should help to establish a multilateral system for equitable benefit-sharing, and ensure the transfer of technologies, skills and expertise required for capacity-building in terms of laboratories, surveillance and risk assessment systems, and the production of diagnostic kits and medicines. Lessons must be learnt from past experience in dealing with the pandemic (H1N1) 2009, which had exposed the inadequacy of funding provided by Member States, international organizations, development banks, the private sector and others; and WHO had come up with a number of commendable options for reliable and sustainable funding mechanisms to underpin the benefit-sharing system. He welcomed the report and draft resolution.

Mr BROU (Côte d'Ivoire) applauded the finalization of the Pandemic Influenza Preparedness Framework and called on WHO to take the necessary steps to ensure its effective implementation so as

to give African populations better access to vaccines. Particular attention should go to virus traceability.

Ms RENDÓN CARDENÁS (Mexico) said that the successful conclusion to the negotiations on the Pandemic Influenza Preparedness Framework had shown what could be achieved with diplomacy, responsibility and the political will for the benefit of humankind. The international community had become better equipped to meet the health challenges of influenza pandemics in a coherent and coordinated manner. The Framework provided a flexible system for sharing not only the viruses and biological materials required for the swift and safe production of vaccines, but also the resulting benefits. It had set a precedent for future WHO negotiations. Given the importance of adopting the draft resolution contained in document A64/8 at the present session, Mexico endorsed the amendment proposed by Australia and reaffirmed its commitment to building a safer world for one and all.

(For continuation of the discussion and approval of the draft resolution, see the summary record of the sixth meeting, section 2.)

The meeting rose at 17:30.

SIXTH MEETING

Thursday, 19 May 2011, at 09.25

Chairman: Dr H. MADZORERA (Zimbabwe)

1. SECOND REPORT OF COMMITTEE A (Document A64/54 (Draft))

Dr KULZHANOV (Kazakhstan), Rapporteur, read out the draft second report of Committee A.

The report was adopted.¹

2. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits: Item 13.1 of the Agenda (Documents A64/8, A64/8 Corr.1 and A64/8 Add.1) (continued from the fifth meeting, section 2)

Dr KIMANI (Kenya) welcomed the Pandemic Influenza Preparedness Framework and its institutionalization of a legal regime to enhance equitable access to essential vaccines, antiviral medicines and diagnostic kits, especially for lower-income countries. In the past, problems had arisen when developing countries had been unable to access vaccines developed from virus samples they had shared. He commended the commitment of the industrial sectors concerned to collaboration with the Secretariat and Member States for better pandemic influenza preparedness.

Kenya continued to be at risk of influenza and other emerging infectious diseases by virtue of its strategic location as an international travel and trade hub. As one of the first countries in Africa to have confirmed cases of pandemic influenza A (H1N1) 2009, it continued to support other countries in the African Region through laboratory testing. Sentinel surveillance sites had been established and more were planned. The International Health Regulations (2005) had been incorporated into integrated disease surveillance and response. All viral isolates were shared with the WHO Collaborating Centres in Atlanta (United States of America) and Melbourne (Australia) for quality control, quality assurance and inclusion in the viral strains bank, used for determining vaccine strains. He expressed appreciation to WHO and partners for support and asked other agencies to further support Kenya's national capacity for handling pandemic influenza.

Lack of consensus on one preambular paragraph of the draft resolution (document A64/8, Attachment 3) should not stall the adoption of the Framework for the sharing of influenza viruses and access to vaccines and other benefits, and he therefore supported its proposed deletion.

Mr SIHASAK PHUANGKETKEOW (Thailand), welcoming the consensus reached on the Pandemic Influenza Preparedness Framework after several years of negotiation, said that the Framework would provide a solid basis for scaling up international cooperation on pandemic preparedness. More predictable cooperation and partnership would result in better preparedness for future pandemics. He welcomed the establishment of a financing mechanism, based on annual

¹ See page 337.

partnership contributions, which would be crucial in enabling the Secretariat to support the strengthening of surveillance, laboratory, and vaccine development and production capacities for countries in need.

He emphasized WHO's key role in facilitating the transfer of technology. If the Framework was adopted, WHO should expeditiously conduct negotiations on the details of benefits to be provided by entities outside the WHO Global Influenza Surveillance and Response System. His country trusted the Director-General to ensure that access to essential technologies would be included in overall benefit sharing. Without access to technology, developing countries would face tremendous difficulties in expanding vaccine production capacity.

Expressing appreciation to various donors who had supported the WHO Global Pandemic Influenza Action Plan to Increase Vaccine Supply, he drew attention to the need to enhance local demand for seasonal influenza vaccines, in particular among health workers and high-risk population groups. Domestic demand would help to maintain the capacity built up for pandemic preparedness, making the system sustainable in the long term.

Pandemic preparedness was a work in progress. The Framework would be reviewed and revised as Member States continued to learn from experience. Thailand would cooperate fully and contribute to the global preparedness system.

Professor AZAD (Bangladesh) said that pandemic (H1N1) 2009 had highlighted the urgent need to finalize a mechanism for sharing viruses and other benefits, and he therefore welcomed the agreement on the Framework. He keenly awaited implementation of the WHO Global Pandemic Influenza Action Plan to increase Vaccine Supply, with its strategies to build new production facilities in developing countries and for the transfer of technology, skills and know-how.

Bangladesh had successfully managed the first wave of pandemic (H1N1) 2009 through various interventions. Stemming panic had been the highest priority. Staff had been trained and deployed throughout the country, and isolation facilities had been established at district level and below. Oseltamivir production had begun locally for domestic use and export, and Bangladesh was working with WHO to produce vaccines. Modern diagnostic facilities had also been established. Through its National Influenza Centre, Bangladesh was already examining the disease burden of seasonal influenza and would incorporate seasonal influenza vaccination into its Expanded Programme on Immunization if necessary. Its National Influenza Centre was ready, in principle, to share influenza isolates with other WHO international reference centres worldwide. He recommended that financial and technical assistance should be given to Bangladesh and other developing countries to help them to build capacity to respond to future pandemics.

Ms SILVA DO RASARIO (Sao Tome and Principe) said that there had been 65 confirmed cases of pandemic (H1N1) 2009 infection and one death in her country. Without WHO's support for training, provision of medicines and vaccines, the situation could have been much worse. Only by preparing and responding appropriately to emergencies such as pandemic influenza could death and suffering be avoided. The Framework met those needs perfectly. She expressed support for the draft resolution, but suggested that a new subparagraph be added to paragraph 4, requesting that a report should be submitted every two years to the Health Assembly on progress in the implementation of the resolution.

Mr OTAKE (Japan) supported the draft resolution as amended by the delegate of Australia. Rapid sharing of influenza virus specimens was indispensable to the response to influenza pandemics. The Framework would play a significant role in that regard, but whether it functioned properly would depend entirely on the details of its implementation, to be discussed further by the Advisory Group referred to in section 7 of the Framework, on governance and review. It was to be hoped that the Advisory Group would conduct its work transparently and fairly. At the same time, the opinions of industry, which was an interested party and a direct stakeholder, should be appropriately reflected.

Dr DAULAIRE (United States of America) said that the Framework, an historic document finalized after sometimes difficult negotiations, would improve pandemic preparedness and response, facilitate the rapid sharing of virus samples and help to increase laboratory and vaccine production capacities in developing countries. Pandemic (H1N1) 2009 had highlighted the need for rapid and transparent sharing of viruses with pandemic potential and related data, such as viral genetic sequences, as a crucial part of global preparedness and response efforts. The WHO Global Influenza Surveillance and Response System served as a vital tool for risk assessment and global response as well as for capacity building for preparedness for future epidemics and pandemics. An essential component of the Framework was preserving and enhancing cooperation and partnerships between WHO and other stakeholders, including manufacturers and civil society, to safeguard public health.

He asked the Legal Counsel whether, in paragraph 1 of the draft resolution, the phrase “in accordance with Article 23 of the Constitution” should be inserted after the word “adopts” in order to make it clear that the Health Assembly had the authority to adopt the Framework. That wording was consistent with that in previous resolutions, such as resolution WHA63.16.

He urged Member States to redouble their efforts to develop and implement short-, medium- and long-term strategies to enhance pandemic influenza preparedness and to increase influenza vaccine manufacturing capacity in developing countries. He supported the Framework and the draft resolution.

Dr HWOAL (Iraq), underlining the need to take stock following pandemic (H1N1) 2009, said that countries should have the right to conduct studies on pandemic influenza, and to obtain the necessary vaccines without being restricted to dealing with particular pharmaceutical companies, in which regard WHO had a role to play. Information on pandemic influenza and related factors should be pooled, so that it could be monitored by WHO. The pandemic situation in different regions should be monitored continuously and comparisons drawn where possible. Technical advice should be provided to take account of new developments. Countries’ capacities to study pandemic influenza should be strengthened, as should their institutional capacity, particularly with regard to vaccine production. Incidence of influenza, particularly influenza A (H1N1), should be reviewed periodically. Supplies of vaccine and laboratory staff to produce them were needed. The International Health Regulations (2005) should be implemented so that future pandemics could be tackled or even prevented, and effective partnerships should be established with all relevant stakeholders.

Mr CHANDRAMOULI (India) welcomed the Framework and expressed appreciation for the contributions of all involved and the commitments made by the pharmaceutical industry. The Framework must be implemented, and the details of such implementation should be worked out by the Director-General and the Advisory Group. Some elements should enter into force immediately, with others following in 2012. The Framework should be implemented in letter and spirit and the “equal footing” principle should guide all concerned in the discharge of their obligations. India was committed to making the Framework a success.

Dr SALEH (Egypt), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that pandemic (H1N1) 2009 had demonstrated the need for cooperation among all international organizations. The fact that the pandemic had originated in Mexico and been caused by the H1N1 strain had come as a surprise to many, as attention had previously focused on avian influenza A (H5N1), then prevalent in Asia and Europe. When the pandemic had been announced by the Director-General, the countries of the Region had made a political commitment to draw up preparedness plans, following WHO’s guidance, but various weaknesses had become apparent. Some countries had insufficient laboratory capacity to deal with the pandemic, and the Secretariat’s support to the Region, including training and assistance from diagnostic teams, had therefore been much appreciated.

Vaccine distribution in the Region should have been more equitable. Wealthier countries had secured sufficient supplies, but poorer countries had been unable to do so, in some cases receiving

vaccines only once they were no longer needed. The importance of exchanging samples had been highlighted. The availability of reagents and diagnosis capacity should be improved. Information should be pooled, through WHO collaborating centres and the WHO Global Influenza Surveillance and Response System, facilitating adequate preparation of vaccines for future pandemics so that lives could be saved and the threat to global health minimized. Information and samples from seasonal influenza outbreaks should also be pooled. It was to be hoped that adequate supplies of influenza vaccine would be available at reasonable prices in the future.

Ms EPHREM (Canada) said that the Framework, the result of four years of collaboration, was an important example of how governments, multilateral organizations and industry could find innovative ways of improving global pandemic influenza preparedness. Considerable work, diligence and governance would be required to ensure effective implementation of the Framework. It was gratifying that Member States were committed to its use as the prime instrument for access to and benefit from pandemic influenza biological materials.

Dr AL NASSER (Kuwait) emphasized prevention grounded in epidemiological surveillance and monitoring. Laboratories must be equipped; supplies of vaccines must be made available. It was important to be able to access antiviral medicines in good time and to organize national information campaigns. He called on all parties to work together to ensure that antiviral medicines and reagents were made available promptly to control future pandemics.

Dr AL HAJERI (Bahrain) said that her Government had attached priority to combating pandemic influenza, providing financial and other support for activities such as vaccine preparation. In cooperation with WHO and other partners, Bahrain had set up a laboratory equipped to diagnose pandemic influenza and other diseases; the laboratory would be brought into service shortly, allowing for isolates to be identified, examined and shared, in accordance with the Framework and WHO's principles. She welcomed the Secretariat's work on pandemic influenza preparedness, particularly virus sharing and vaccine production.

Mr LARSEN (Norway) said that the Framework represented an important and innovative agreement and a victory for public health, international solidarity and global health diplomacy under the auspices of WHO. The negotiations had highlighted the strategic link between global health and foreign policy. Pandemic (H1N1) 2009 had demonstrated the importance of WHO and the need to improve global preparedness and ensure a more coordinated response based on public health risks and needs. The Framework, which brought together governments, civil society and industry in a unique public-private partnership, provided a good basis for such efforts, and should be implemented as a matter of urgency, under the continued leadership of the Director-General. The sharing of viruses and benefits must be made to work in practice. The Framework's focus on transparency and close monitoring of implementation and compliance was particularly welcome, and the review planned for 2016 would allow for adjustment to reflect changing needs and new scientific developments.

He expressed support for the draft resolution, as amended by the delegate of Australia.

Dr SILBERSCHMIDT (Switzerland) welcomed the finalization of the Framework after four years of negotiations that had proved that WHO could move global health forward. Although Switzerland had signed the Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Utilization, it considered the Framework to be the only instrument that would apply to influenza viruses with pandemic potential, in terms of both virus and benefit sharing.

The next challenge was implementation by Member States, which should support the Secretariat in its work, and by public and private partners. Although the Framework was a major advance towards global preparedness, he recalled the message from the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009: the world was not

sufficiently prepared for the next pandemic. Vaccine would be produced too late and in too little quantity for any country. Research must therefore be promoted as a priority and thorough preparedness plans drawn up. He supported the draft resolution, subject to the deletion of the fifth preambular paragraph.

Mr MEI Yang (China) expressed appreciation for the cooperative spirit shown by all parties to negotiations on the Framework, especially on the issues of government responsibility, company contributions and benefit sharing, demonstrating international solidarity to meet a public health challenge that posed a huge threat to humanity. China supported the adoption of the Framework and would fulfil its responsibilities and obligations in that respect. Future consultations should be based on the principles of equality, fairness and transparency, and countries should shoulder common but differentiated responsibilities, according to their level of development and prevention needs, in order to generate effective implementation plans. Countries with intellectual property in the area of vaccine development should make greater commitments to intellectual property transfer to help developing countries improve vaccine research and development, so that they could lower costs and obtain affordable vaccines to protect the health of their populations.

Dr GOUYA (Islamic Republic of Iran), emphasizing the gap between global need and existing global capacity in preparing for a severe influenza pandemic or similar emergency, welcomed the Framework, which should lead to wider availability of vaccines, antiviral medicines and diagnostic kits, along with greater equity in dealing with the next pandemic. The Framework should facilitate access by developing countries to other benefits, such as knowledge sharing, transfer of technology and know-how to produce vaccines and other products. He urged all Member States and other stakeholders to give priority to and actively support the wide implementation of the Framework and to consider providing adequate resources to that end.

Dr CHISTYAKOVA (Russian Federation), acknowledging the leading role of WHO in coordinating international efforts to strengthen pandemic influenza preparedness and applauding the Director-General's work to improve monitoring, strengthen national influenza vaccination programmes and expand vaccine production capacity, welcomed the Framework. Her country fulfilled its international obligations with regard to access to vaccines and other benefits. In 2010, the Russian Federation had transferred a sublicense to WHO for the manufacture of influenza vaccine. An important part of its contribution to global pandemic preparedness efforts was cooperation with countries in eastern Europe and Central Asia for capacity building. The Russian Federation would participate actively in implementing the Framework.

Dr MANZUR (Paraguay), welcoming the Framework, reaffirmed his country's commitment to providing biological materials obtained from cases of human infection to WHO Collaborating Centres rapidly and systematically, whenever that was viable. The model standard material transfer agreements annexed to the Framework clearly set out the obligations of the parties. Materials should be accompanied by the clinical and epidemiological information necessary for risk assessment. He requested WHO to continue providing, through its collaborating centres and without charge to national influenza centres, noncommercial diagnostic reagents and test kits to identify and characterize clinical influenza samples so that reports could be submitted and appropriate measures taken. He also requested WHO to provide continued support for strengthening the capacity of laboratories serving as national influenza centres. He expressed support for the draft resolution, subject to the deletion of the fifth preambular paragraph.

Ms EKEMAN (Turkey) said that, although the experience of avian influenza A (H5N1) and pandemic (H1N1) 2009 had not been easy, it had been educational, demonstrating the need for a rapid, equitable, transparent and collective global response in the event of a pandemic. It had also made clear the need for absolute predictability. The Framework would provide the necessary structures to respond

adequately to future pandemics, and the technical agreements reached should help to mobilize public support and combat scepticism about the effectiveness of the system. The Secretariat and Member States had again demonstrated their collective political will and commitment to overcome differences of opinion and focus on the underlying issue of public health. She particularly welcomed industry's recognition of corporate social responsibility and its agreement to undertake certain tangible commitments. The open and collaborative attitude of industry had been crucial to the compromise achieved. Attention must now turn to implementing the Framework and honouring the commitments assumed, building upon the success of the negotiations. She supported the draft resolution.

Dr McMILLAN (Bahamas) expressed appreciation for efforts made to ensure vaccine availability, diagnostic capability and antiviral medicine stockpiles for use in developing countries and countries affected by pandemics at affordable prices. The coordinating mechanisms used by WHO and PAHO during pandemic (H1N1) 2009 had reduced morbidity and mortality in the Bahamas.

Regional difficulties persisted with regard to identifying novel influenza viruses and other viral etiologies; the Caribbean region relied primarily on laboratory capacity at the Caribbean Epidemiology Centre. For a region comprising many small island developing States, regional cooperation was imperative, alongside the necessary in-country capacity for rapid response. She acknowledged human resource development activities sponsored by PAHO, but noted that maintaining current knowledge and capacity levels would require further training.

She expressed support for the draft resolution, with the deletion of the fifth preambular paragraph, and requested the Director-General to continue providing support to enhance preparedness and response mechanisms and expand regional and global networks, as the movement of people and trade across borders would continue to challenge public health systems. As a recipient of the benefits of sharing viruses and other technologies, the Bahamas requested those in a position to provide support to continue to do so, to the benefit of developing Member States.

Dr NORHAYATI RUSLI (Malaysia) said that, given its commitment to share on an equal footing influenza viruses of human pandemic potential, Malaysia continued to support the WHO Global Influenza Surveillance and Response System by sending representative isolates to WHO Collaborating Centres for reference and research on influenza and for advanced antigenic and genetic analysis. Like all developing countries that contributed to the Network, Malaysia was concerned that benefits from the use of viruses should be shared fairly and equitably in support of public health. She therefore welcomed the Framework, which should provide a coherent, coordinated and unified global approach to ensuring that influenza viruses were available to the System for monitoring and developing vaccines, and for benefits such as antiviral medicines, technical knowledge and enabling developing countries to access such benefits more equitably. She supported the draft resolution, with the deletion of the fifth preambular paragraph. It was to be hoped that all concerned would implement and adhere to the Framework in order to prepare for future pandemics.

Mrs TOELUPE (Samoa) welcomed the Framework and expressed support for the draft resolution, with the deletion of the fifth preambular paragraph. She expressed appreciation for WHO's assistance in facilitating access to vaccines, improved surveillance and laboratory capacity enhancement. She further acknowledged the support received from many development partners in the area of pandemic influenza preparedness.

Mr ROSALES LOZADA (Plurinational State of Bolivia) welcomed the conclusion of the negotiations on the Framework. He did not oppose the adoption of the Framework, but reiterated his country's concerns with regard to the lack of prohibition of the patenting of the influenza biological material and parts thereof shared with entities outside the WHO Global Influenza Surveillance and Response System, as set out in document A64/8 Corr.1.

Dr AGOUDAVI (Togo), welcoming the Framework, said that pandemic (H1N1) 2009 had enabled Togo to strengthen its epidemiological surveillance system. A national steering committee had been set up to manage pandemic response and had met weekly, focusing in particular on points of entry. An influenza laboratory had been established at the National Institute of Hygiene and had identified 29 cases of pandemic influenza A (H1N1) 2009 virus infection between May 2010 and April 2011. Donations of oseltamivir, personal protective equipment and sampling equipment had been received through WHO. Vaccine donations had allowed just more than 10% of the population to be vaccinated, mainly among high-risk groups. Togo faced numerous challenges, including maintaining surveillance, especially at points of entry, and mobilizing resources to implement its national response plan, but the Framework would enable them to be tackled.

Dr JUNG Sung-hoon (Republic of Korea) expressed support for the Framework. His Government had completed construction of a vaccine production facility in early 2009 and begun production later in the year, thereby helping to control pandemic (H1N1) 2009. In order to increase influenza vaccine supply, many companies, particularly from developing countries, should be encouraged to manufacture influenza vaccine. As too many donations might deter small companies from producing vaccine, a flexible approach to donation should be adopted, in the light of companies' specific circumstances. Collaboration between Member States was crucial in responding rapidly and effectively to pandemic influenza, and the Secretariat should continue to play a leading role.

Mr SEAKGOSING (Botswana), noting that sporadic cases and seasonal outbreaks associated with pandemic (H1N1) 2009 continued to be reported, said that his Government had established a multisectoral national task force for overall coordination of pandemic influenza preparedness and response. Technical working groups had been responsible for developing and monitoring the implementation of the national preparedness and response plan, and had made progress in a range of areas. In particular, a vaccination campaign against pandemic (H1N1) 2009 had reached more than 80% of the population. No new case had been confirmed since the 32 reported to WHO during the pandemic. He expressed appreciation to WHO and other partners for their technical support and donations, including vaccines.

Supporting the draft resolution but with the deletion of the fifth preambular paragraph, he emphasized the need for immediate implementation of the Framework and urged the Director-General to develop a coordinated programme to enhance preparedness in the African Region.

Dr LEWIS FULLER (Jamaica) said that she could accept the draft resolution with the deletion of the fifth preambular paragraph, but if the paragraph were to be retained, she would prefer the opening word to be "Recognizing" rather than "Considering" and would favour retention of the word "international" before "specialized access". The text of the draft resolution placed more emphasis on the sharing of influenza viruses than on access to vaccines and other benefits. Accordingly, and in the light of the Jamaican experience during pandemic (H1N1) 2009, she proposed the insertion of a new subparagraph before existing subparagraph 4(2) to read: "to set up mechanisms to facilitate access, by countries in need, to vaccines and antiviral medicines through appropriate and adequate stockpiling and fair and affordable pricing of these products." Jamaica intended to join the international public health community in implementing the Framework.

Dr EZAATI (Uganda) endorsed the position of the Australian delegation. His country had participated in the negotiations in the Open-ended Working Group and expected the effective, fair and equitable application of the Framework, guided by the Advisory Group, in the interests of improved global preparedness and response to future influenza pandemics. He endorsed the Framework and pledged his country's cooperation in its implementation.

Dr MIYAGISHIMA (Office International des Epizooties), speaking at the invitation of the CHAIRMAN, said that, in conjunction with FAO, his organization had for several years been

operating an initiative, known as the OIE/FAO Network of expertise on animal influenza aimed at facilitating the exchange of scientific information on animal influenza viruses, including the sharing of epidemiological data and virus sequences. Pandemic (H1N1) 2009 had highlighted the importance of collaborative research on animal and human influenza. The OIE/FAO network had consequently built on its past experience to launch a new project designed to boost research on swine influenza, although the fact that swine influenza was not a notifiable animal disease in many countries posed something of a challenge. OIE welcomed WHO's ongoing participation in major meetings of the network and was committed, through that mechanism, to continue contributing useful data to WHO's vaccine composition consultations and facilitating the timely selection and production of vaccines for human use, including those against zoonotic strains of influenza virus.

Ms SHASHIKANT (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN, said that agreement on the Framework was a milestone, as it instituted terms and conditions for the sharing of influenza materials with a view to infusing equity into WHO's virus-sharing scheme. The amount of annual monetary contributions and in-kind contributions required of the industry could have been set higher. Further, the granting of non-exclusive licences at affordable royalties or royalty-free to developing countries should have been listed as a stand-alone mandatory benefit in order to facilitate sharing of the knowledge, technology and know-how needed by those countries to counter an influenza pandemic.

Nevertheless, the Framework should contribute to better pandemic preparedness. The benefit levels might at some stage be reconsidered and improved. She called on the Secretariat and Member States to ensure that both the Framework and the accompanying Standard Material Transfer Agreements were implemented in a manner that protected and promoted public health and furthered the objectives of the Convention on Biological Diversity and the Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Utilization.

Professor Shan-Chwen CHANG (Chinese Taipei) said that, in 2009, Chinese Taipei had obtained pandemic (H1N1) 2009 vaccine strains from a number of sources, including WHO Collaborating Centres. With help from Japan, the United Kingdom and the United States of America, it had been able to manufacture enough pandemic (H1N1) 2009 vaccines to launch a mass vaccination programme and successfully control the outbreak. In the light of that experience, it welcomed the Framework for the sharing of influenza viruses and access to vaccines and other benefits. It also supported the establishment of an international stockpile of vaccines for influenza A (H5N1) and other influenza viruses with human pandemic potential, and was willing to increase its contribution to the production of such vaccines. Given that influenza vaccine production capacity remained insufficient worldwide, especially in developing countries, it welcomed the consensus reached in the Open-ended Working Group on a global arrangement under which countries would share influenza virus samples in exchange for access to affordable medicines derived from those samples. Lastly, it looked forward to opportunities to participate in the global efforts to promote sharing of influenza vaccines and access to vaccines and other benefits.

Dr FUKUDA (Assistant Director-General), replying to the points raised, said that the reservations expressed by the delegate of Bolivia had been acknowledged and the Jamaican proposal noted. There appeared to be a strong consensus on the need to ensure effective implementation of the Framework through the efforts of Member States, civil society, industry and the Secretariat. The Secretariat was fully aware of the scope of the Framework and of its responsibility for its implementation, to which it would dedicate its efforts.

Mr SOLOMON (Office of the Legal Counsel), referring to the amendment proposed by the delegate of the United States to paragraph 1 of the draft resolution, said that there were several precedents, such as resolutions WHA63.16, WHA51.7 and WHA34.22, for the inclusion of a

reference to Article 23 of the WHO Constitution so as to indicate the basis of the Health Assembly's authority to make recommendations to Members.

The DIRECTOR-GENERAL expressed her thanks to all those who had contributed to the discussion. The Framework was indeed an unprecedented achievement in the field of public health and a milestone for WHO. The wisdom, flexibility and diplomacy demonstrated by Member States in the interests of public health and global solidarity had served as the catalyst for that achievement in a spirit of compromise and political commitment to strengthening pandemic influenza preparedness as a collective responsibility. Many individuals had played vital roles in steering WHO towards such an historic achievement, and she paid tribute to the Co-Chairs of the Open-ended Working Group, Ambassador Gomez-Camacho (Mexico) and Ambassador Angell-Hansen (Norway), with the support of José Ramón Lorenzo Dominguez (Mexico) and Sissel Hodne Steen (Norway), and the Chair and Vice-Chairs of the Intergovernmental Meeting on Pandemic Influenza Preparedness, as well as to Australia, Brazil and India for their important intersessional work conducted with the aim of facilitating the discussion of Member States. Those who had worked tirelessly behind the scenes in support of the Co-Chairs also deserved special recognition and her Secretariat staff was likewise to be commended for its work. The successes achieved would have been unattainable without the efforts of National Influenza Centres, WHO Collaborating Centres and Essential Regulatory Laboratories. In that connection, she stressed that, as provided for in the Framework, no laboratory in the system would seek to claim any intellectual property rights over biological materials. She looked forward to the implementation of the Framework and to working with the Advisory Group. She also looked to Member States for further advice and guidance, as well as for both human resources and financial support, with a view to satisfactory implementation of the Framework within the shortest possible time frame.

The CHAIRMAN invited the Committee to consider the draft resolution as amended.

Dr PÁVA (Hungary) requested further time to consult on the new proposals for amendment of the text.

Mr SOLOMON (Office of the Legal Counsel), responding to queries from Dr SILBERSCHMIDT (Switzerland), confirmed that the amendment proposed by the delegate of the United States had no new legal implications since the Framework constituted a recommendation under Article 23 of the Constitution and the inclusion of a reference to Article 23 would merely clarify that point. Moreover, the Standard Material Transfer Agreements would be legally binding contracts.

Dr DAULAIRE (United States of America) said that additional negotiations would be needed in order to establish mechanisms of the kind called for in the new subparagraph to paragraph 4 proposed by the delegate of Jamaica. The proposed wording did not, therefore, serve the interests of immediate approval of the text.

Dr KEINHORST (Germany), supported by Ms SEDYANINGSIH (Indonesia), asked the delegate of Jamaica to consider withdrawing the proposal since the mechanisms concerned were provided for under section 6 of the Framework.

Dr LEWIS FULLER (Jamaica) said that section 6 of the Framework set out in Attachment 2 to document A64/8 gave no precise indication of who would be responsible for ensuring the availability of vaccines and antiviral medicines at affordable prices. However, having received a personal assurance from the Director-General that she herself would assume that responsibility, she agreed to withdraw the proposed amendment.

Following explanatory remarks by Dr KEINHORST (Germany), Ms STEEN (Norway), and Mr MARQUES DE LIMA (Sao Tome and Principe) concerning the wording of the new subparagraph 4(3) proposed by the delegate of Sao Tome and Principe, Dr YOUNES (Secretary) said that the subparagraph in question would read: “to report, on a biennial basis, to the World Health Assembly, through the Executive Board, on progress in the implementation of this resolution”.

The draft resolution, as amended, was approved.¹

Global immunization vision and strategy: Item 13.5 of the Agenda (Document A64/14)

Dr HWOAL (Iraq) said that, following the experience of pandemic (H1N1) 2009, countries had to have access to the latest research on pandemic influenza, and they should be able to exchange information and advice in the light of new findings generated in particular through continual analysis of the regional status of influenza A (H1N1). The use of vaccines, especially seasonal vaccines, should likewise be based on such research and analysis, as should the provision of necessary medicines and laboratory supplies. The right to obtain vaccines was another imperative. On that score, there should be no commercial monopoly and WHO must play an effective role. Capacity building for research purposes was another fundamental requirement, together with institutional capacity building for vaccine production. He looked forward to systematic improvements in all those areas in order to strengthen implementation of the International Health Regulations (2005) and the capacity of public health systems for coping with and preventing epidemics and crises. To that end, effective partnerships must be built with all concerned parties.

Mr CHIREH (Ghana) recalled that it was as a result of the extraordinary progress in the field of immunization that no child in Ghana had died from measles since 2003. Other vaccines provided under the Expanded Programme on Immunization had also significantly contributed to the reduction in childhood morbidity and mortality, and the introduction of a pentavalent vaccine in 2002 had further improved the health status of Ghanaian children. Ghana therefore proposed to introduce the pneumococcal and rotavirus vaccines into its Expanded Programme on Immunization and a second-dose measles vaccine into its routine immunization programme. Plans were also under way to introduce the meningitis A conjugate vaccine in the northern part of the country. Those measures would put Ghana further on track towards the achievement of Millennium Development Goal 4 (Reduce child mortality). Committed as it was to the ownership and long-term sustainability of its immunization programme, Ghana would continue to contribute to the cost of vaccines with established budget lines. It appealed to donor partners, however, to step up their efforts in the fight against unnecessary deaths in developing countries from vaccine-preventable diseases.

Mrs BADJIE (Gambia) said that her country’s efforts to protect its population against vaccine-preventable diseases had been productive. Indeed, it had been awarded a certificate by the GAVI Alliance for having maintained its coverage with three doses of diphtheria-tetanus-pertussis vaccine above 90% over the past five years. It had attained poliomyelitis-free status in 2004 and had conducted five rounds of national immunization days against the disease in 2010 and a further two in 2011, attaining coverage of more than 95% in each round. Immunization against yellow fever had been routinely provided since 1979, with an administrative coverage of 92% attained in 2010; the administrative coverage for measles was also 92%. Pneumococcal conjugate vaccine had been added to its Expanded Programme on Immunization in 2009 and the rotavirus and meningitis A vaccines would be introduced under its next comprehensive multi-year plan, which had been developed with WHO’s technical and financial support. The main challenge concerned the availability of vaccines without the support of the GAVI Alliance. Gambia would nevertheless continue to ensure payment of the co-financing allocation to the GAVI Alliance.

¹ Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA64.5.

Dr OBARA (Japan) fully recognized the importance of the Global immunization vision and strategy both to improving public health worldwide and to the strengthening and monitoring of health systems. Japan therefore welcomed the strategic direction for the Decade of Vaccines outlined in the report. It actively supported vaccination not only through work with WHO and UNICEF but also through bilateral assistance, Expanded Programme on Immunization activities and vaccine donation. It was actively cooperating with international organizations to eradicate poliomyelitis and, at the national level, it was working vigorously on measures to counter vaccine-preventable diseases. One domestic result of those measures had been a decline of 96%, from 2008–2010, in cases of measles, which it was seeking to eradicate by 2012.

Dr SHONGWE (Swaziland) welcomed the Global immunization vision and strategy 2006–2015 and the work to develop a global vaccine action plan. His Government's political commitment to achieving vaccine and immunization goals was evidenced by its procurement of all vaccines. He urged WHO to increase its support to the GAVI Alliance.

Dr BIRINTANYA (Burundi), speaking on behalf of the Member States of the African Region, said that three-dose diphtheria-tetanus-pertussis vaccination coverage in the Region had increased over the past decade to 85% overall and to more than 90% in 20 countries. Measles vaccination coverage had similarly risen to 86% in 26 countries and routine vaccination against yellow fever had been introduced in 23 countries. Vaccines against hepatitis B and *Haemophilus influenzae* type b had been introduced in the past two years and the hope was that, with support from the GAVI Alliance, the pneumococcal conjugate vaccine thus far introduced in three countries would eventually be available throughout the Region. The meningococcal A conjugate vaccine had also been launched in three countries. Other measures to counter vaccine-preventable diseases included the strengthening of surveillance networks and the African Vaccination Week initiative.

Infection with wild poliovirus, measles and yellow fever had nonetheless proved persistently difficult to contain in certain countries. Lack of finance was part of the problem; local resources were often limited and international resources were unpredictable, particularly in times of economic crisis. He therefore strongly endorsed the Decade of Vaccines in the hope that it would prompt a new wave of international action in support of vaccination, which required strong political and financial commitment.

Professor LOUKOU (Côte d'Ivoire) said that measures taken in his country in the context of the Global immunization vision and strategy had resulted in an improvement in routine vaccination indicators since 2008; measles vaccination campaigns and awareness weeks had been organized; the *Haemophilus influenzae* type b and hepatitis B vaccines had been included in the Expanded Programme on Immunization to reduce child mortality; and the surveillance of invasive bacterial diseases and rotaviral diarrhoea had been strengthened through the establishment of a sentinel site network. The introduction of pneumococcal and rotavirus vaccines was also envisaged under the newly elaborated multi-year plan for 2011–2015. He supported the Decade of Vaccines and appealed for a resumption of the support that had been suspended during the country's recent crisis. Its vaccination activities could then be effectively pursued.

Mr FIFE (Norway) said that the lives of millions of children had been saved over the past decade by the accelerated introduction of new vaccines in the poorest countries and by reaching more children with immunization services. The development of a global vaccine action plan as part of the Decade of Vaccines was therefore a most welcome initiative for maintaining the necessary focus and commitment to vaccination. Norway's commitment to immunization activities was demonstrated by its high levels of official development assistance. It was one of the largest contributors to the GAVI Alliance and was working with partners with a view to fully funding the GAVI Strategy 2011–2015. Other beneficiaries of its support included the Global Polio Eradication Initiative and the Measles Initiative. The most cost-effective vaccination was that against measles and he therefore called for

continued efforts to eliminate the disease. It was also worth noting that immunization was a centrepiece of the United Nations Secretary-General's Global Strategy for Women's and Children's Health.

Norway was working closely with partners to close the financing shortfall facing the GAVI Alliance. It was imperative, however, for all stakeholder groups to contribute to that endeavour in order to secure the lowest possible vaccine prices.

Dr SOE LWIN NYEIN (Myanmar), speaking on behalf of the Member States of the South-East Asia Region, agreed with the five overarching objectives referred to in the report. It was crucially important to strengthen routine immunization and standardize expanded programmes on immunization in the Region, where pentavalent vaccine was not available in all countries owing to financial constraints. More emphasis should also be placed on cross-border vaccine-preventable diseases and response, while financial sustainability for vaccine security must be explored with regional foundations, philanthropic organizations and interested partners. The Region was striving hard to achieve good-quality immunization and high rates of routine immunization coverage. WHO's technical collaboration and financial support was needed to provide for quick reviews or sentinel surveillance for the achievement of quality immunization. Member States had greatly benefited from the regular meetings of immunization programme managers, whose reports could well yield generic information for possible inclusion in the Region's work plan for the next biennium. He suggested that information derived from reports of other WHO expert groups and workshops on immunization might also be used to develop a technical compendium that would serve as a useful reference document for Member States.

Dr MELNIKOVA (Russian Federation) said that the considerable progress achieved in tackling vaccine-preventable diseases was in large part due to the activities of WHO and UNICEF in such areas as accelerated immunization, child vaccination coverage and disease prevention. Vaccine accessibility was a particular problem in countries with underdeveloped health systems and insufficient resources to fund the high cost of vaccines. Her country therefore welcomed the Decade of Vaccines and supported the global vaccine action plan initiative which should serve to overcome the obstacles to the achievement of the aim of reducing global morbidity from vaccine-preventable diseases. Public support was essential to the success of any immunization programme. Mass immunization had enabled her country with its aim of becoming measles-free. Morbidity due to hepatitis B had also been reduced. All national strategies should incorporate the measures set forth in the Global immunization vision and strategy as a guarantee of success in the efforts to strengthen health systems and improve immunization programmes.

The meeting rose at 12:00.

SEVENTH MEETING

Thursday, 19 May 2011, at 14:40

Chairman: Dr H. MADZORERA (Zimbabwe)

TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Global immunization vision and strategy: Item 13.5 of the Agenda (Document A64/14) (continued)

Mr GONCHIGSUREN (Mongolia) said that his country had a well-established infrastructure for delivering its Expanded Programme on Immunization, which, together with a multisectoral strategy to reach every district, launched in 2011, and support from United Nations bodies and the GAVI Alliance, permitted the provision of health care and comprehensive social services to every mother and child in the country, even in remote areas.

Dr AYDINLI (Turkey) pointed out that vaccine-preventable diseases remained important causes of morbidity and mortality. Under WHO's leadership, all Member States should continue their efforts to eradicate poliomyelitis, including routine vaccination and surveillance in order to avoid the risk of re-emergence of the disease. Turkey, committed to eradicating poliomyelitis, was also giving priority to the elimination of measles in accordance with WHO's targets. Experience over the previous decade showed that the elimination and ultimate eradication of measles would require greater commitment and extensive cooperation between countries.

Dr ATTAYA LIMWATTANAYINGYONG (Thailand) said that, despite the good progress made since the adoption of the Global immunization vision and strategy by the Fifty-eighth World Health Assembly in 2005, many challenges remained. Successes in low-income countries had come from government commitment, capacity to deliver vaccines to the target population and support from WHO, UNICEF and other development partners, whose valuable contribution should be acknowledged. New vaccines could contribute to the attainment of the Millennium Development Goals, but evidence on the magnitude of the disease burden, the capacity of the cold chain and the health system needed to be used to expand activities; fiscal stability and financial sustainability were prerequisites for their introduction. The Secretariat should support Member States in the generation and use of evidence for decision-making. Structural barriers to self-reliance in low- and middle-income countries included the unaffordable cost of new vaccines, often patented by one manufacturer, with generic products becoming available only 10–15 years after introduction. The expansion of vaccine-manufacturing capacity in developing countries was a vital strategy for promoting security of affordable vaccines, as proved by the results of WHO's support for vaccine production in the recent influenza pandemic. More vaccine producers meant greater global health security. WHO and other partners should foster mechanisms to make vaccines affordable, such as public–private partnerships, differential pricing, advance market commitments, voluntary and compulsory licensing and patent pooling. WHO should not advocate new vaccines for developing countries unless they were cost-effective and affordable, with appropriate delivery services in place. Well-functioning health systems, especially primary health-care services, formed the platform for delivery of vaccines and the achievement of health equity. He welcomed the five overarching objectives of the delivery strategy for the proposed global vaccine action plan and looked forward to reviewing it in 2012.

Mr MEI Yang (China) warned that major challenges lay ahead. Some new vaccines were costly and there were technical barriers to their delivery on a large scale in many developing countries. China supported in principle the strategic direction of the Decade of Vaccines 2011–2020. Stakeholders should redouble their efforts to ensure the eradication of poliomyelitis as quickly as possible. However, prudence was called for in setting targets for the eradication of measles. Adequate and sustainable financing for monitoring and evaluation were needed in order to ensure better knowledge of disease burden and the efficacy of new vaccines. The international community must take specific measures to support developing countries in conducting appropriate research and development. The high prices of certain vaccines made it difficult for developing countries to incorporate them in their immunization programmes. Accelerated transfer of intellectual property was needed to promote local manufacture and bring down prices, and the Secretariat could play an important role in that regard.

Mrs TZIMAS (Germany) urged the Secretariat to continue its standard-setting and advisory role in the area of immunization and in the broader context of disease control and comprehensive health services. All partners should be encouraged to strive for vaccine cost reductions and cost containment in immunization services in order to ensure the long-term sustainability of affordable health systems. Immunization was complementary to other efforts to improve health, in particular multisectoral approaches to provide healthy living environments, including drinking-water and sanitation and adequate nutrition, as well as prevention activities and other needs-based health care.

Mr MARQUES DE LIMA (Sao Tome and Principe) said that the remarkable worldwide progress in the area of immunization reflected the efforts of Member States to achieve the objectives of the Global immunization vision and strategy. With support from WHO, UNICEF and the GAVI Alliance, his Government had introduced vaccines against yellow fever, hepatitis B and *Haemophilus influenzae* type b into its Expanded Programme on Immunization, and was preparing to introduce a second dose of measles-containing vaccine and the pneumococcal and rotavirus vaccines. Significant constraints remained, however, including lack of financial resources and insufficient community participation. The Decade of Vaccines and the global vaccine action plan should help to accelerate efforts to ensure that everyone benefited from immunization. Member States should share information on difficulties in their vaccination services so as to ensure that measures to overcome constraints and weak points were included in the action plan.

Dr ZAINAL (Brunei Darussalam) endorsed the strategic direction for the Decade of Vaccines 2011–2012. The report reflected the need for additional efforts to eliminate inequities in access to safe and effective vaccines. Her country's national immunization programme would be guided by the proposed vaccine delivery strategy outlined in the report, with its five overarching objectives. She also endorsed the overall goal of combating disease through the achievement of high and equitable immunization coverage and other essential health-care interventions throughout the life course. She fully supported the global vaccine action plan.

Dr BRENNEN (Bahamas) supported the implementation of a global immunization action plan. It was refreshing to note that the report acknowledged that many factors had contributed to failures in national immunization programmes, and that comprehensive approaches were needed for such programmes and for disease prevention and management as a whole. The Bahamas was raising public awareness of the importance of immunization through multimedia and personal-appearance campaigns by the Expanded Programme on Immunization team, and had participated in the recent Vaccination Week in the Americas and regional work on the documentation of the elimination of measles, rubella and congenital rubella syndrome.

Acknowledging WHO's tireless efforts to eradicate poliomyelitis, he supported the Director-General's call for continued vigilance, as pockets of disease and lapses in immunization activities left all countries at risk, especially given the fluidity of population movements.

Many developing countries were marginalized because they were ineligible for current support mechanisms and could not afford new vaccines such as the pneumococcal conjugate, rotavirus and human papillomavirus vaccines. In the Bahamas, a specific budget line for immunization had boosted public recognition of the importance of vaccines but economic difficulties threatened programmes such as the planned introduction of five new antigens into the national immunization programme within the next two years. Increased demand for vaccination placed additional strains on health systems, but the strategic response ensured that services were focused and patient-centred.

He endorsed WHO's strategies to reduce the prices of vaccines and increase availability. Pooled procurement in the Region of the Americas had been of great benefit. Further efforts were needed to ensure full participation by Member States in the Decade of Vaccines.

Dr RASAE (Yemen), speaking on behalf of the Member States of the Eastern Mediterranean Region, affirmed support for the Global immunization vision and strategy. Overall, the countries of the Region had made substantial progress in expanding coverage with the diphtheria, tetanus and pertussis vaccine, although some countries had experienced problems in delivering the third dose. Great strides had been made in controlling poliomyelitis; no case had been recorded in Yemen since 2006 but floods in Afghanistan had impeded progress. Mortality due to measles in the Region had fallen by 93% over the previous decade. Coverage with the hepatitis B vaccine was broadening. Newer vaccines had not yet been widely introduced because of cost and delivery constraints, although the pneumococcal vaccine had been introduced in Yemen. Some countries in the Region faced particular difficulties and needed further support to eliminate measles within the next two years and attain the Millennium Development Goals, especially Goal 4 (Reduce child mortality). WHO should take the lead in promoting equitable access to vaccines, especially the newer products. The start-up of vaccine manufacture in middle-income countries in the Region, including Egypt, Morocco and the United Arab Emirates, should help them to achieve vaccine self-sufficiency. Talks were under way with the GAVI Alliance on buying pneumococcal and rotavirus vaccines over the next few years, possibly from China and India.

Ms EL-HALABI (Botswana) supported the strategic direction for the Decade of Vaccines. Immunization coverage with three doses of diphtheria, tetanus and pertussis vaccine and with oral poliomyelitis vaccine in Botswana currently exceeded WHO's targets. Coverage with the pentavalent vaccine containing diphtheria, tetanus, pertussis, hepatitis B and *Haemophilus influenzae* type b antigens, introduced in 2010, was rising thanks to community mobilization during month-long campaigns to promote child health. Immunization remained a major component of the primary health care system. Introduction of new vaccines was a priority in Botswana's efforts to attain Millennium Development Goal 4 (Reduce child mortality). Constrained by a lack of funding to procure vaccines, Botswana and other countries with a high burden of mortality in children aged under five years needed additional support.

Dr KALESHA (Zambia) said that many countries had achieved high coverage with three doses of diphtheria, tetanus and pertussis vaccine, yet large numbers of children remained underimmunized. Despite the progress made in eradicating poliomyelitis in Africa, concerns remained over the threat of transmission of the wild poliovirus, which remained in circulation in some areas, and, where necessary, country emergency plans must be prepared and implemented. The re-emergence of measles was another source of concern and adequate funding had to be secured for administering a second dose of measles vaccine in supplementary immunization programmes. She commended the launch of the advance market commitment for pneumococcal vaccine (the introduction of which was expected soon in Zambia), and agreed that the introduction of such new vaccines should be set in the context of comprehensive disease control strategies. However, the prohibitive cost of new vaccines, added to already weak health systems, was denying people access to life-saving interventions. Further efforts were needed globally to reduce costs of vaccines, to redress inequities in access to them, and to accelerate the transfer of relevant technologies. Zambia supported the goals and objectives of the

Decade of Vaccines. Approaches should be country-led. Gradual movement towards self-sufficiency was the key to achieving common immunization goals, especially in low-resource settings. There should be broad consultation on the development of the global vaccine action plan. She urged donors to support the replenishment of the GAVI Alliance's funds at the pledging conference to be held in June 2011.

Dr AL NASSER (Kuwait) said that his Government attached the highest priority to immunization and had succeeded in maintaining high coverage rates across the country over recent years through an extensive range of measures, with particular emphasis on campaigns against poliomyelitis and measles. The cold chain had been improved and vaccines had been provided free of charge to all citizens, including those in remote and rural areas of the country.

Dr GWAK Jin (Republic of Korea) said that the Global immunization vision and strategy had provided a useful base for the review and strengthening of national immunization programmes by Member States and had resulted in a significant increase in global immunization coverage rates. However, too many children were still affected by vaccine-preventable diseases, and broader provision of safe and effective vaccines would have resulted in better progress towards Millennium Development Goal 4 (Reduce child mortality). His Government was therefore collaborating closely with the International Vaccine Institute, in particular on its programme to introduce the WHO-prequalified meningococcal vaccine in sub-Saharan Africa. It had also become the first Asian donor to the GAVI Alliance. Successful implementation of the Decade of Vaccines 2011–2020 would require a coordinated action plan that built on existing resources and initiatives. The consultation process for the preparation of the plan should engage important partners, and Member States should be kept fully informed of developments.

Dr GONZÁLEZ (Nicaragua) said that, despite being a low-income country, Nicaragua was developing a policy to improve social conditions. With international support, it had a strong immunization programme, although concerns existed about its long-term sustainability and the cost of new vaccines. In line with the Global immunization vision and strategy, efforts were under way to train staff and acquire the necessary technology for domestic production of vaccines. WHO should support such efforts and facilitate negotiations with the private sector to lower vaccine prices. It should also mount a worldwide campaign to tackle misinformation about vaccination.

Dr DeCOCK (United States of America) said that the Global immunization vision and strategy provided useful goals to support health ministries, international organizations and donors in establishing appropriate immunization targets. The United States recognized the Director-General's leadership role in global poliomyelitis eradication and reaffirmed its commitment to that goal through continued funding, advocacy and technical support. It encouraged other donor countries to give that goal top priority, in particular addressing the financing of oral poliomyelitis vaccine and long-term use of inactivated poliovirus vaccine.

Global efforts against measles should focus on further reduction of mortality, sustained high coverage with a second dose of measles-containing vaccine and strengthening of surveillance in order to meet the 2015 elimination goals before consideration was given to setting a target date for eradication. His Government had noted the proposed components of the action plan for the Decade of Vaccines and was collaborating with the Secretariat through its agencies in the multi-partner effort to develop the delivery strategy. It welcomed the incorporation of inputs from low- and middle-income countries, which would strengthen country ownership, but sought clarification of the practical links between the global vaccine action plan and the Global immunization vision and strategy. Improvement of data quality and surveillance should be a cross-cutting priority. There should also be a broad-based discussion of the full ramifications of the proposed objectives for the delivery strategy. New vaccines had the potential to reduce childhood mortality substantially, but their introduction should be accompanied by strengthening of the immunization system as a whole.

Given WHO's reduced Programme budget 2012–2013, difficult choices would have to be made, and WHO should endeavour to minimize the impact of cuts on routine immunization programmes, introduction of new vaccines and the sustainability of momentum in relation to the initiatives for the eradication of poliomyelitis and the elimination of measles.

Dr GOUYA (Islamic Republic of Iran) welcomed the substantial rise in global immunization coverage over the previous decade but warned that Member States would have to strengthen their commitment and make even greater efforts if the 2015 target of 90% was to be achieved. Fluctuations in immunization coverage rates must be eliminated, especially in developing countries with large birth cohorts, for example, by strengthening primary health-care systems and improving the immunization component of emergency preparedness plans. As indicated in the report, attention should be paid to subnational as well as national coverage rates, especially in border areas. His country was willing to support its neighbours and proposed that the topic should be included on the agenda of meetings in the subregion. Additional efforts should be made, for example through specific training of immunization team staff, to improve public awareness of the importance of childhood immunization, to overcome prejudice against immunization, and to vaccinate preschool children, adolescents and health-care workers. WHO, UNICEF and the GAVI Alliance should consider supporting the production of new vaccines in countries with appropriate manufacturing facilities in order to reduce the cost of new vaccines, as that cost remained a serious deterrent to their inclusion in routine immunization programmes.

Dr NORHAYATI RUSLI (Malaysia) said that attainment of the goals of the Decade of Vaccines would require sustainable implementation of immunization programmes and the availability of affordable vaccines. International regulatory bodies should share precise and impartial information on new vaccines and adjuvants with Member States in a timely manner.

Mr EL MENZHI (Morocco) said that immunization programmes provided the opportunity to deliver an integrated package of measures, including control of diarrhoeal, acute respiratory and intestinal parasitic diseases, rectification of micronutrient deficiencies, and family planning. The Decade of Vaccines was ambitious and held much promise, provided that there was optimum engagement of decision-makers in international organizations, civil society, professional bodies and other partners, and the establishment of adequate financing mechanisms, particularly in developing countries. WHO, UNICEF and the GAVI Alliance should step up their efforts to coordinate and support immunization plans, to identify weaknesses and to share information on progress in the implementation of the action plan through national and international meetings.

Ms ESCOREL DE MORAES (Brazil) said that, with the support of PAHO, Brazil, like other Latin American countries, had made significant progress towards eliminating vaccine-preventable diseases. At the 128th session of the Executive Board in January 2011, the member for Brazil had proposed introducing in the report a reference to the meeting of the Global Technical Consultation to assess the Feasibility of Measles Eradication (Washington, DC, 28–30 July 2010), which had concluded that measles could and should be eradicated globally, and activities to that end should be used as an opportunity to promote the elimination of rubella and prevention of congenital rubella syndrome.¹ As measles virus continued to circulate in many countries, countries where the disease had been eliminated remained vulnerable to importation and re-establishment of endemic transmission. Global eradication would only be possible when all regions had succeeded in interrupting transmission through the implementation of systematic activities similar to those in the Region of the Americas. Eradication strategies should become public health priorities, despite the cost. Those elements,

¹ Document EB128/2011/REC/2, summary record of the fourth meeting.

together with those set out in the report, provided a strategic direction for effective long-term global immunization efforts.

Professor HAQUE (Bangladesh) welcomed the report, noting in particular the information provided on why some countries had not yet achieved high immunization coverage rates. Bangladesh, despite being a developing country, had achieved a sustained high level of coverage. It fully supported the Decade of Vaccines initiative, which set ambitious goals. It was to be hoped that the global vaccine action plan currently under development would be approved by the Sixty-fifth World Health Assembly. He expressed particular support for the five proposed overarching objectives of the vaccine delivery strategy.

Bangladesh had been poliomyelitis-free since 2006 and had also achieved its goal for measles elimination. *Haemophilus influenzae* type b, pneumococcal conjugate and rotavirus vaccines, among others, had been recently or were due shortly to be introduced in the country, and Bangladesh was working with WHO to produce affordable vaccines to meet national needs.

Regarding the Decade of Vaccines 2011–2020, comprehensive prevention and control measures must be established and/or improved, in addition to the provision of vaccines. The gradual withdrawal of funding of the GAVI Alliance might lead some countries to seek other forms of financial and technical support in order to maintain current levels of vaccine quality and immunization coverage.

Dr AL-JALAHMA (Bahrain) said that the prevention and eradication of diseases could only be achieved through improved, safe and effective immunization programmes that were carried out in coordination with international organizations. Strengthening research and manufacturing of vaccines would also be necessary. Bahrain had made considerable progress in expanding its vaccination programmes, incorporating several new antigens. Immunization coverage at the primary health care level was universal, and routine vaccination coverage for children, with for instance *Haemophilus influenzae* type b, pneumococcal, meningococcal, tetanus, pertussis and measles vaccines, had reached 98% in 2010. Bahrain was monitoring services in both the public and private sectors to reduce the adverse effects of vaccination.

She urged support for those countries that did not currently benefit from funding from the GAVI Alliance so as to ensure universal coverage and usage of new vaccines. She welcomed the report and particularly commended the five objectives of the proposed vaccine delivery strategy.

Dr BELAYNEH (Ethiopia) welcomed the report and, in particular, its proposal for a global vaccine action plan. Ethiopia would continue to work towards achieving the objectives of the strategy, for example through lobbying donors to maintain their support. It had recently undertaken integrated supplementary immunization activities against measles, based on best practices, which had been documented and could be shared with other countries, on request. It was also working to introduce new vaccines and to enhance routine immunization. She stressed the need for all countries to support other immunization partners.

Mr NACEUR (Tunisia) informed the Committee of the positive impact of the report on national planning, noting the many objectives that had already been achieved, including a significant increase in immunization expenditure. Faced with the re-emergence of measles, Tunisia had been conducting vaccination campaigns and he asked WHO to strengthen its regional activities on raising public awareness.

If immunization was to be a human right, the availability of necessary vaccines had to be assured. Tunisia's national programme included the objectives of maintaining poliomyelitis-free status, eliminating measles and reducing the incidence of hepatitis B. The national budget provided for an action plan to monitor immunization and ensure universal coverage but it was hoped that WHO would provide financial support to provide vaccines at affordable prices. Other measures would also be needed, including joint purchasing, data collection on vaccines and the modernization of refrigeration facilities.

Dr RAMATLAPENG (Lesotho) outlined the current national health situation, noting the awareness of the need to improve certain health indicators if the country was to achieve Millennium Development Goals 4 (Reduce child mortality) and 5 (Improve maternal health). Lesotho was experiencing a steady decline in immunization coverage rates, despite having attained high levels in the context of supplementary immunization activities. The country recognized the need to undertake additional outreach activities and to encourage social mobilization and implement the recommended “Reaching Every District” strategy.

Lesotho used the pentavalent vaccine and had applied to the GAVI Alliance for support to introduce the pneumococcal and rotavirus vaccines, which were currently unaffordable. Plans had also been developed for improved nutrition and integrated management of childhood illnesses.

Her country supported the Decade of Vaccines 2011–2020 and recognized immunization as a human right; her Government was in the process of making it a legal requirement for all parents to vaccinate their children. Lesotho was also implementing the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa, but in order to attain that and other goals it would require additional financial resources. She therefore called on the donor community to replenish the GAVI Alliance’s funds and sustain support to WHO and other organizations in the United Nations system.

Dr MORALES (Bolivarian Republic of Venezuela), welcoming the report, stressed the right to free and universal access to vaccines as an essential condition of the Global immunization vision and strategy. Concerted efforts by WHO were thus required to reduce the cost of vaccines as a public good and to evaluate the epidemiological impact of new vaccines. She urged a focus on eradicating poliomyelitis and measles and eliminating maternal and neonatal tetanus.

Dr AGOUDAVI (Togo) said that, through its Expanded Programme on Immunization, Togo had had considerable success in recent years in controlling vaccine-preventable diseases, including the elimination of neonatal tetanus. Despite having been declared free of wild poliovirus in 2007, the country had had to undertake a series of synchronized vaccination campaigns between 2009 and 2011, in collaboration with neighbouring countries, following the re-importation of the virus.

Vaccination campaigns against measles had seen morbidity rates for the disease fall by 94% since 2001. Vaccines against several other diseases had been introduced since 2005 and others were due to be introduced in the two years to come with financial support from the GAVI Alliance. Togo had significantly increased routine vaccination coverage rates for all antigens through the “Reaching Every District” initiative.

Ms GAMARRA (Paraguay) said that her country had introduced several new vaccines, financed from the national budget, under a law guaranteeing the right to vaccination. As a result, Paraguay was in the process of certifying the elimination of poliomyelitis, measles and rubella.

Echoing the comments made by the delegate of Brazil, she said that a universal commitment and holistic policy were needed to eliminate measles, which still persisted in some regions. Better methods were needed to assess coverage precisely, with the support of technical committees.

Mr FOURAR (Algeria) observed that immunization programmes were much more likely to succeed if they were linked to other health interventions within a cohesive and sustainable health system. Achievements in the area of immunization were not necessarily sustainable, being susceptible to the threat of unforeseeable factors such as conflict or the lack of financial resources.

Notwithstanding the recognition of immunization as a human right and the declaration of the Decade of Vaccines 2011–2020, many children still did not have access to vaccines. Although low-income countries benefited from the GAVI Alliance, middle-income countries did not receive such support and often lacked the necessary resources to introduce new vaccines and technologies. For example, the introduction of the pneumococcal vaccine could increase immunization costs seven- or eight-fold in those countries.

Given its leadership role in the Expanded Programme on Immunization, WHO should establish innovative strategies to ensure that all children had access to all vaccines.

Dr FALL (Senegal) welcomed the report, noting that it provided a suitable framework for national programmes. He thanked WHO, UNICEF and the development partners for the continued technical and financial support provided to Senegal in interrupting the spread of wild poliovirus and controlling measles. Particular thanks were due to the GAVI Alliance, which had enabled Senegal to introduce hepatitis B and *Haemophilus influenzae* type b vaccines. It was hoped that such support for introducing new vaccines would continue.

Dr SALEH (Egypt), noting that Egypt used only vaccines recommended by WHO, including some multidose vaccines, said that the latter should be provided in liquid rather than tablet form, as it was difficult to dissolve the tablets to make several doses. Given the country's goal of maximizing immunity through high-quality services, the use of liquid vaccines was justified on both practical and financial grounds.

Professor ADITAMA (Indonesia), welcoming the report, said that Indonesia had recently initiated a comprehensive programme to promote complete immunization in areas with low coverage. The country was also maintaining quality of immunization in areas that already had higher coverage.

Indonesia considered the Global immunization vision and strategy to be of high importance and looked forward to working with other Member States and WHO to achieve the objectives of the Decade of Vaccines 2011–2020.

Dr WAMAE (Kenya) said that her country was committed to implementation of the Global immunization vision and strategy and had made remarkable progress in routine immunization in recent years, with current data showing that 82% of children were fully immunized. That and other achievements were explained by the expansion of immunization services, new regional facilities for vaccine storage and distribution, new cold-chain facilities, and enhanced outreach to under-immunized children in hard-to-reach areas.

Kenya was monitoring carefully for cases of imported poliomyelitis or acute flaccid paralysis but still faced challenges in attaining high routine coverage for the third dose of oral poliomyelitis vaccine.

Despite supplementary immunization activities, sporadic outbreaks of measles still occurred in the country, affecting children of all ages. She therefore requested further technical and financial support from WHO for the introduction of a booster dose of measles vaccine into the country's routine immunization schedule.

Other vaccines had recently been, or were due to be, introduced, including those against *Haemophilus influenzae* type b, pneumococcal infection and rotavirus. Kenya appealed to donors to contribute further funds to the GAVI Alliance so that it could continue to support developing countries in introducing new vaccines. WHO should also continue to advocate lower prices of new vaccines, for instance through fast-tracked prequalification and increased technology transfer.

Drawing attention to the high number of deaths from cervical cancer in Kenya each year, she requested urgent technical and financial support for vaccination; the high cost of the human papillomavirus vaccine placed it beyond the reach of many women.

Dr FIKRI (United Arab Emirates) said that the strategy outlined in the report would provide a useful basis for future immunization policies. High rates of coverage with three doses of diphtheria, tetanus and pertussis vaccine had been achieved in many countries, but efforts to eradicate poliomyelitis and measles needed to be accelerated. Many lives could be saved through the introduction of new vaccines. Countries should build on the successes of epidemiological surveillance networks and, to that end, ensure the provision of sustainable funding and observance of appropriate

safety and quality standards. Partnerships would need to be developed and strengthened so that the acceptance of immunization as a human right could be made a reality.

In the United Arab Emirates, children of all ages received all routine vaccinations. Medical services were accessible and provided free of charge, as were immunization services in all schools. The country aimed to enhance further its national monitoring and surveillance facilities, particularly for cases of acute flaccid paralysis but also for other vaccine-preventable diseases including those that had been eliminated or eradicated in the country, such as neonatal tetanus, measles and poliomyelitis.

Dr SOLÍS VÁSQUEZ (Peru) said that the Expanded Programme on Immunization in Peru had led to the eradication of smallpox and poliomyelitis, the elimination of neonatal tetanus and the control of other vaccine-preventable diseases. The country was in the process of certifying the elimination of measles, rubella and congenital rubella syndrome. New vaccines introduced as a result of a considerable increase in the national public health budget had benefited both children and other vulnerable population groups. Those achievements had been accompanied and sustained by a sophisticated epidemiological surveillance system, which monitored vaccine-preventable diseases and adverse events following vaccination. Obstacles to reaching all children, particularly those in indigenous tribes or living in rural areas, remained. Peru therefore attached great importance to the Decade of Vaccines 2011–2020 and to the aims of ensuring that all people lived free from the threat of vaccine-preventable diseases, and that access to safe and effective vaccines was a universal right.

Dr PADILLA (Philippines) affirmed her country's commitment to achieving the objectives of the global vaccine action plan under the Decade of Vaccines 2011–2020 and emphasized the need to ensure that the action plan was based on a demand-driven and country-led approach. In that connection, the Government's Department of Health had launched a national programme to immunize all children aged under seven years against measles and rubella.

Expanding immunization coverage would need the commitment of all stakeholders and sustainable financing. She agreed with other delegates on the need to enhance the capacity of manufacturers in low-income countries, in particular in order to facilitate self-sufficiency and reduce vaccine prices. She urged international partners to continue investing in countries such as hers in order to support the implementation of comprehensive disease prevention and control strategies.

Dr ESPINOZA (El Salvador) said that the Global immunization vision and strategy should include reference to the need to strengthen national health systems and ensure that their capacity to vaccinate and monitor adverse events after vaccination kept pace with the increase in the number of vaccines purchased by, or donated to, countries. Without such action, investment in vaccination would not be effective. Increasing costs also raised concerns about the sustainability of future immunization programmes.

El Salvador had quadrupled its immunization budget over the past two years, focusing most new expenditure on pneumococcal vaccine. However, it faced the same challenges as many other countries in terms of its ability to introduce new vaccines owing to their high cost. WHO should therefore include in its strategy ways to strengthen regional and national vaccine-manufacturing capacity and technology transfer.

Research was also needed in many developing countries on the immune response and effectiveness of vaccination in malnourished populations. The Secretariat should provide support to least-developed countries for improving immunization coverage in the short term. The inequality in coverage between regions was intolerable and posed a grave threat to humanity.

Dr BOKENGE (Democratic Republic of the Congo) said that the introduction of new vaccines and the interruption of wild poliovirus circulation in his country would require an integrated approach, with sustainable funding and a strengthened health system. His country therefore proposed the initiative of an African immunization week to promote advocacy, increase community participation and improve vaccine services.

Dr PETT (United Nations Children's Fund) said that UNICEF was proud of its contribution to implementing the Global immunization vision and strategy and achieving a 78% reduction in measles mortality worldwide, the near-eradication of poliomyelitis, and the elimination of maternal and neonatal tetanus in all but 38 countries. The key to those successes lay in effective partnerships and the power of collective action, which had led to the accelerated introduction of many new or underused vaccines and had influenced the markets to bring down the cost of vaccines.

However, many challenges still remained, such as the resurgence of measles, primarily in Africa, owing to inadequate vaccination campaigns and funding. Further action was needed from all concerned parties in order to reach and immunize all children and to ensure the safe and secure supply of affordable vaccines. UNICEF would be playing an active role throughout the Decade of Vaccines in collaboration with other key partners.

Mr GIZAW (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that the Federation was fully committed to working with partners to fulfil the ambitious goals of the Decade of Vaccines 2011–2020. However, for progress to be made towards achieving those goals, urgent attention must be paid to combating the resurgence of measles in Africa and redressing the inadequacy of routine immunization systems in some countries. The strengthening of those systems, which were the backbone of basic health care, was a particularly challenging task. Success would help to accelerate and sustain progress towards eradication and elimination of several diseases. The members of the Federation and other organizations were well placed to help to improve basic immunization and should be more broadly engaged by governments in developing strategies and prioritizing the most vulnerable and marginalized populations.

The Global Polio Eradication Initiative had made considerable progress towards its objective, but its Independent Monitoring Board had noted the need to enhance communications and social mobilization-related aspects of the programme. Stimulating community demand for vaccination against poliomyelitis would require concerted planning and resource mobilization, and he encouraged all partners to ensure that the Initiative was fully funded.

Professor Shan-Chwen CHANG (Chinese Taipei), said that it was regrettable that in a few countries so many children were not being routinely vaccinated owing to system weaknesses, low public awareness and fears or misconceptions about vaccines. Chinese Taipei had achieved high rates of coverage for all routine vaccinations, surpassing the targets of the Global immunization vision and strategy for 2010. That success could be attributed to an immunization information system, which collected and analysed vaccination data for all children and generated lists of unvaccinated children for follow-up.

Chinese Taipei was in the process of developing an enterovirus vaccine and had also amended its Communicable Disease Control Act in order to provide financial sustainability to immunization programmes and a legal basis for vaccine funding. It would seek to contribute to the 2012 goal of measles elimination set for the Western Pacific Region but was concerned that various factors could affect progress towards that goal. He therefore urged the Secretariat to promote further cooperation and collaboration in immunization programmes in the Region.

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

The meeting rose at 16:55.

EIGHTH MEETING

Friday, 20 May 2011, at 09:40

Chairman: Dr W. AMMAR (Lebanon)

1. THIRD REPORT OF COMMITTEE A (Document A64/57 (Draft))

Dr KULZHANOV (Kazakhstan), Rapporteur, read out the draft third report of Committee A.

The report was adopted.¹

2. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Global immunization vision and strategy: Item 13.5 of the Agenda (Document A64/14) (continued from the seventh meeting)

Dr SJÖLIN-FORSBERG (Council for International Organizations of Medical Sciences), speaking at the invitation of the CHAIRMAN, said that the challenge of agreeing on critical aspects of essential tools for safety supervision had led to the establishment of the CIOMS/WHO Working Group on Vaccine Pharmacovigilance. The Working Group had agreed on several possible ways to strengthen the application of pharmacovigilance standards and terminology. Its future work could include harmonizing instruments in the toolkit for vaccine risk management, strengthening pre-licensure safety monitoring in clinical trials and globally harmonizing the assessment of benefits, risks and communication of safety and efficacy studies. The continuation of its work on the harmonization of tools would save time and money, stimulate global capacity-building and be in line with the conclusions of the Secretariat's report.

Mr BERMAN (MSF International), speaking at the invitation of the CHAIRMAN, stressed the need to concentrate concurrently on introducing new vaccines in developing countries and expanding coverage with basic vaccines. Outbreaks, such as those of measles in 28 African countries, were often the result of poor vaccination coverage and were likely to continue. Countries and global partners must therefore invest in outbreak response as well as prevention efforts. He urged the GAVI Alliance, whose work was commendable, to improve its performance in countries with limited health-care infrastructure and to increase its efforts to reduce vaccine prices by stimulating competition. Furthermore, vaccine-delivery strategies should be tailored to national conditions, with more focus on community mobilization in countries with low vaccine coverage, and priority given to the cold chain and the development of new technologies that eliminated the need for needles.

Mr WRIGHT (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, reminded Member States that the United Kingdom of Great Britain and Northern Ireland was to host the pledging conference for funding for the GAVI Alliance in June 2011, and urged donor countries to increase their donations. In addition, he stressed the vital role of civil society organizations in ensuring

¹ See page 338.

transparency and accountability with regard to access to vaccines. Three principles should guide global approaches to immunization: equitable access for all, parallel work on building and strengthening health systems to ensure that qualified staff were available to administer vaccines, and the need to reduce the price of vaccines.

Mr DURISCH (Stichting Health Action International), speaking at the invitation of the CHAIRMAN and also on behalf of Health Action International, Knowledge Economy International, Third World Network, the Berne Declaration, People's Health Movement and the International Baby Food Action Network, expressed concerns about WHO's governance and management of conflict of interest issues. As a result of the complex relationship between commercial entities and WHO and other public health institutions, a clear approach and policies were needed to ensure that those with a conflict of interest were excluded from the policy or norm-setting decision-making process. The proposals for the governance of the Decade of Vaccines did not adequately address the management of conflict of interest and he urged Member States to ensure that any changes to the governance structure successfully dealt with conflict of interest and guarded against initiatives that would give the private sector a greater role in WHO's governance. He urged Member States to oppose the proposed governance of the Decade of Vaccines and the proposed reforms of WHO.

Dr AHUN (GAVI Alliance), speaking at the invitation of the CHAIRMAN, thanked those Member States that had voiced their support for the Alliance. Since the report by the Secretariat had been written, there had been continued significant progress in introducing new vaccines, such as the introduction of pneumococcal vaccines in the Democratic Republic of the Congo, Guyana, Kenya, Mali, Nicaragua, Sierra Leone and Yemen. The GAVI Alliance had committed itself to support the introduction of pneumococcal vaccine in 19 further countries by 2012, and, if sufficient support were received from donors, that number would increase to 40 countries. Welcoming the consistent support received from WHO, she reminded Member States of the pledging conference due to take place in the United Kingdom in June 2011 and expressed appreciation of the Director-General's stated intention to attend.

Dr OKWO-BELE (Immunization, Vaccines and Biologicals) thanked Member States for their comments and support. Their guidance in the preparation of the global vaccination action plan would be welcome. He applauded the success of Member States in implementing the Global immunization vision and strategy. The lessons learnt from the implementation would be used to ensure even greater coverage in future. Highlighting the success of the regional vaccination weeks that had been held in five out of six WHO regions, he looked forward to working with Member States on implementing Global Vaccination Week.

With regard to the high prices of new vaccines, additional government resources had been secured through dedicated budget line items, but in most cases that had not sufficed to reduce costs. That issue was also being addressed through various mechanisms, including full procurement, such as the PAHO Revolving Fund for Vaccine Procurement, and the establishment of advance market commitments and other forms of innovative financing. Discussion of other possible methods was also vital, with UNICEF playing a leading role, for example by providing support for work towards the GAVI Alliance's goal of shaping vaccine markets. He acknowledged the positive comments on the Secretariat's approach to technology transfer, and observed that several candidate vaccines from manufacturers in developing countries were in clinical trials. The Secretariat provided support for technology transfer initiatives at all stages, including the strengthening of national regulatory authorities to ensure the safety and efficacy of vaccines.

The aim of the global vaccination action plan was to expand the framework of the Global immunization vision and strategy, notably by extending the time frame from 2016 to 2020. A further aim was to foster engagement with additional stakeholders in order to reach the goal of equitable access to vaccines for all. A clear balance had to be struck between accelerated disease-control initiatives, introduction of new vaccines and routine vaccination, and that should form the basis for the

development of the global vaccination action plan. With regard to measles, the Strategic Advisory Group of Experts on immunization had confirmed the view of the Ad-Hoc Expert Working Group on Measles that the disease could be eradicated. The target date for the eradication of measles should be brought forward in view of the progress that had already been made towards the goal set by the Health Assembly in May 2010 for reduction of measles mortality.¹

The Committee noted the report.

Health system strengthening: Item 13.4 of the Agenda (Documents A64/12, A64/13 and EB128/2011/REC/1, resolutions EB128.R8, EB128.R9, EB128.R10, EB128.11 and EB128.R12) (continued from the fifth meeting, section 2)

The CHAIRMAN drew attention to a revised version of the draft resolution in resolution EB128.R8, on sustainable health financing structures and universal coverage, which incorporated amendments made during the discussions of the informal working group and read:

The Sixty-fourth World Health Assembly,

PP1 Having considered the reports on health system strengthening;²

PP2 Having considered *The world health report 2010*,³ which received strong support from the Ministerial Conference on Health Systems Financing – Key to Universal Coverage (Berlin, November 2010);

PP3 Recalling resolution WHA58.33 on sustainable health financing, universal coverage and social health insurance;

PP4 Recalling Article 25.1 of the Universal Declaration of Human Rights, which states that everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control;

PP5 Recognizing that effective health systems delivering comprehensive health services, including preventive services, are of utmost importance for health, economic development and well-being and that these systems need to be based on equitable and sustainable financing as mentioned in the Tallinn Charter: Health Systems for Health and Wealth (2008);

PP6 Underlining the valuable contribution made by fair and sustainable financing structures towards achieving health-related Millennium Development Goal 4 (Reduce child mortality); Goal 5 (Improve maternal health); and Goal 6 (Combat HIV/AIDS, malaria and other diseases); as well as Goal 1 (Eradicate extreme poverty and hunger);

PP7 Having considered *The world health report 2008*⁴ and resolution WHA62.12, that highlighted universal coverage as one of the four key pillars of primary health care and services through patient-centred care, inclusive leadership and health in all policies;

PP8 Noting that health-financing structures in many countries need to be further developed and supported in order to expand access to necessary health care and services for all while preventing and providing protection against disastrous financial risks;

PP9 Accepting that, irrespective of the source of financing for the health system selected, equitable prepayment and pooling at population level, and the avoidance, at the point

¹ See document A63/18 paragraph 29.

² Documents A64/12 and A64/13.

³ *The world health report 2010. Health systems financing: the path to universal coverage*. Geneva, World Health Organization, 2010.

⁴ *The world health report 2008. Primary health care: now more than ever*. Geneva, World Health Organization, 2008.

of delivery, of direct payments that result in financial catastrophe and impoverishment, are basic principles for achieving universal health coverage;

PP10 Considering that the choice of a health-financing system should be made within the particular context of each country, and that it is important to regulate and maintain the core functions of risk pooling, purchasing, and delivery of basic services;

PP11 Acknowledging that a number of Member States are pursuing health-financing reforms that may involve a mix of public and private approaches, and a financing mix of contribution-based and tax-financed inputs;

PP12 Recognizing the important role of State legislative and executive bodies, with the support of civil society, in further reform of health-financing systems with a view to achieving universal coverage,

1. URGES Member States:¹

(1) to consider proposing an agenda item on universal health coverage to be discussed by the forthcoming United Nations General Assembly; [Thailand]

(2) to ensure that health-financing systems evolve so as to avoid significant direct payments at the point of delivery and include a method for prepayment of financial contributions for health care and services as well as a mechanism to pool risks among the population in order to avoid catastrophic health-care expenditure and impoverishment of individuals as a result of seeking the care needed;

(3) to aim for affordable universal coverage and access for all citizens on the basis of equity and solidarity, so as to provide an adequate scope of health care and services and level of costs covered, as well as comprehensive and affordable preventive services through strengthening of equitable and sustainable financial resource budgeting;

(4) to continue, as appropriate, to invest in and strengthen the health-delivery systems, in particular primary health care and services, and adequate human resources for health and health information systems, in order to ensure that all citizens have equitable access to health care and services;

(5) to ensure that external funds for specific health interventions do not distort the attention given to health priorities in the country, that they increasingly ~~comply with~~ **implement [USA] the principles of aid effectiveness, and that they contribute in a predictable way to the sustainability of financing;**

(6) to plan the transition of their health systems to universal coverage, while continuing to safeguard the quality of services and to meet the needs of the population in order to reduce poverty and to attain internationally agreed development goals, including the Millennium Development Goals;

(7) to recognize that, when managing the transition of the health system to universal coverage, each option will need to be developed within the particular epidemiological, macroeconomic, sociocultural and political context of each country;

(8) to take advantage, where appropriate, of opportunities that exist for collaboration between public and private providers and health-financing organizations, under strong overall government-inclusive stewardship;

(9) to promote the efficiency, transparency and accountability of health-financing governing systems;

(10) to ensure that overall resource allocation strikes an appropriate balance between health promotion, disease prevention, rehabilitation and health-care provision;

(11) to share experiences and important lessons learnt at the international level for encouraging country efforts, supporting decision-makers, and boosting reform processes;

¹ And, where applicable, regional economic integration organizations.

(12) to establish and strengthen institutional capacity in order to generate country-level evidence and effective, evidence-based policy decision-making on the design of universal health coverage systems, **including tracking the flows of health expenditures through the application of standard accounting frameworks; [Thailand]**

2. REQUESTS the Director-General:

(1) **to communicate with the United Nations Secretary-General in order to insert an agenda item on universal health coverage to be discussed by the forthcoming United Nations General Assembly; [Thailand]**

(2) to provide a report on measures taken and progress made in the implementation of resolution WHA58.33, especially in regard to equitable and sustainable health financing and social protection of health in Member States;

(3) to work closely with other United Nations organizations, international development partners, foundations, academia and civil society organizations, in fostering efforts towards achieving universal coverage;

(4) to prepare a plan of action for WHO to support Member States in realizing universal coverage as envisaged by resolution WHA62.12 and *The world health report 2010*;¹

(5) to prepare an estimate of the number of people covered by a basic health insurance that provides access to basic health care and services, that estimate being broken down by country and WHO region;

(6) to provide, in response to requests from Member States, technical support for strengthening capacities and expertise in the development of health-financing systems, particularly equitable prepayment schemes, with a view to achieving universal coverage by providing comprehensive health care and services for all, **including strengthening capacity in tracking resource flows through the application of standard accounting frameworks; [Thailand]**

(7) to facilitate within existing forums the continuous sharing of experiences and lessons learnt on social health protection and universal coverage;

(8) to report to the Sixty-fifth World Health Assembly and thereafter every three years, through the Executive Board, on the implementation of this resolution, including on outstanding issues raised by Member States during the Sixty-fourth World Health Assembly.

The financial and administrative implications of the adoption of the resolution for the Secretariat were unchanged from those provided to the Board at its 128th session.²

Ms WISEMAN (Canada) asked for clarification on the objectives and expected outcomes of the proposed discussion by the United Nations General Assembly on universal health coverage. WHO was the more appropriate venue for discussion of global health issues and challenges, including that of universal health coverage.

Dr JADEJ THAMMATACHAREE (Thailand) explained that, with regard to universal health coverage, increased awareness was needed of the issues and initiatives taken by different entities within the governments of the Member States and other parties, as the issue would affect departments such as the ministries of finance, labour and development, as well as trade unions and the private sector.

¹ *The world health report 2010. Health systems financing: the path to universal coverage*. Geneva, World Health Organization, 2010.

² See document EB128/2011/REC/1, Annex 4.

Dr PÁVA (Hungary), speaking on behalf of the European Union, proposed that the word “forthcoming” should be removed from subparagraph 1(1), as the current proposed agenda for the next meeting of the United Nations General Assembly was already full and adding universal health coverage to the debate risked detracting from the discussion on noncommunicable diseases.

With regard to subparagraph 2(1), it was premature to request the Director-General to act immediately; asking the Director-General to propose the inclusion of the agenda item would both weaken the request contained in subparagraph 1(1) and deprive Member States of their role in proposing agenda items for discussion at the General Assembly. She therefore proposed that subparagraph 2(1) be deleted.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) agreed with the proposed change to subparagraph 1(1). He suggested that in subparagraph 2(1) the word “insert” should be replaced by “propose” and the phrase “in the context of social protection” be inserted after “universal health coverage”.

Mr HOHMAN (United States of America) said that he was not in a position to accept either subparagraph 1(1) or 2(1) as proposed by the delegate of Thailand; both subparagraphs should be deleted.

Ms BENNETT (Australia) supported the statement made by the delegate of Hungary.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) expressed concern at the proposal by the delegate of the United States of America and asked why deleting the two subparagraphs would be necessary.

The DIRECTOR-GENERAL thanked Member States for their views and suggested that subparagraph 1(1) should be retained, subject to amendment on the wording. With regard to subparagraph 2(1), she agreed that the authority of Member States should not be usurped by the Director-General; therefore, if the language in subparagraph 1(1) could be amended acceptably to incorporate some of the aspects of subparagraph 2(1), it would make the latter redundant, so allowing its deletion.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) argued that, if one subparagraph were to be deleted, it should be subparagraph 1(1) not subparagraph 2(1). He agreed that it was the prerogative of Member States to propose agenda items for the United Nations General Assembly, and therefore accepted that subparagraph 1(1) was too strongly worded. However, advocacy of universal health coverage at the global level would serve to increase awareness of the issue. Therefore, it would be more productive for the Health Assembly to request the Director-General to communicate to the United Nations Secretary-General the wish for a discussion of the subject at the General Assembly. Noncommunicable diseases were already on the agenda for discussion by that body, meaning that there would be no chance that universal health coverage might detract from discussion of that issue.

Mr HOHMAN (United States of America) affirmed the prerogative of Member States to propose items for discussion at the General Assembly, and welcomed Thailand’s receptivity to the deletion of subparagraph 1(1). However, he voiced concern at the willingness of the Health Assembly to adopt such language at that point, as well as at the continued efforts to move the discussion of important health issues to the United Nations.

Ms WISEMAN (Canada), supporting the comments by the previous speaker, stressed that any message communicated by the Director-General to the United Nations Secretary-General would be for information purposes only, as items for discussion could be proposed only by Member States.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) disagreed with the view that health issues, particularly universal health coverage, should not be discussed at the United Nations General Assembly, as that crucial measure required input from numerous sectors and thus warranted discussion by the General Assembly.

The DIRECTOR-GENERAL, thanking the delegate from Thailand for his comments, said that, although there was agreement about the Member States' prerogative to propose items for discussion at both the Health Assembly and the United Nations General Assembly, it was unclear whether Member States collectively wished to request her to communicate a message to the United Nations Secretary-General. Even if she did so, that would not guarantee the inclusion of the issue on the provisional agenda of the General Assembly. She emphasized the importance of providing health care for all and acknowledged the challenges faced by Member States. Although debate of the issue at the General Assembly might not cause substantive changes, it would serve to bring the issue to the attention of important ministries and, most importantly, Heads of State.

Dr VIROJ TANGCHAROENSATHIEN (Thailand), seconded by Mr BUSS (Brazil), proposed that discussion of the draft resolution be temporarily suspended to permit informal discussions between the interested delegations.

It was so agreed.

(For approval of the draft resolution, see the summary record of the ninth meeting.)

The CHAIRMAN drew attention to a revised version of the draft resolution in resolution EB128.R9 on health workforce strengthening, which incorporated amendments made during the discussions of the informal working group and read:

The Sixty-fourth World Health Assembly,

PP1 Having considered the reports on health system strengthening;¹

PP2 Recalling resolution WHA57.19 on challenges posed by the international migration of health personnel, which, inter alia, urged Member States to develop strategies to mitigate the adverse effects of migration of health personnel and minimize its negative impact on health systems, and to frame and implement policies that could enhance effective retention of health personnel;

PP3 Recalling also resolution WHA59.23 on rapid scaling up of health workforce production, which, inter alia, recognized that shortages of health workers are interfering with efforts to achieve the internationally agreed health-related development goals, including those contained in the Millennium Declaration, and those of WHO's priority programmes;

PP4 Taking note of the WHO Global Code of Practice on the International Recruitment of Health Personnel,² which, inter alia, recognized that an adequate and accessible health workforce is fundamental to an integrated and effective health system and for the provision of health services, and that Member States should take measures to meet their own health personnel needs, i.e. take measures to educate, retain and sustain a health workforce that is appropriate for the specific conditions of each country;

PP5 Acknowledging the ongoing development of the WHO policy guidelines on transformative scale-up of health professional education, which is related to the increase in quantity, quality and relevance of the skill-mix of the health workforce in an equitable and efficient manner;

¹ Documents A64/12 and A64/13.

² Adopted in resolution WHA63.16.

PP5bis Recognizing that, for the transformative scaling up of faculty members in health professional training institutions, quantity, quality and attitude are prerequisites for sustainable transformative scaling up of health professionals; [Thailand]

PP6 Recognizing that recruiters and employers are key stakeholders who may contribute to success in the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel;

PP7 Noting with approval recent international calls to action regarding the importance of ensuring scale-up and an equitable distribution of the health workforce globally, regionally and within countries;¹

PP8 Recognizing the centrality of human resources for health for the effective operation of health systems as highlighted in *The world health report 2006*,² and that the health workforce shortages and inefficiencies are also seriously hampering effective implementation of primary health care, as stated in *The world health report 2008*,³ and expansion of health service coverage, as described in *The world health report 2010*;⁴

PP9 Deeply concerned that shortages and inadequate distribution of appropriately trained and motivated health workers, and inefficiencies in the ways in which the health workforce is managed and utilized, remain major impediments to the effective functioning of health systems and constitute one of the main bottlenecks to achieving the health-related Millennium Development Goals;

PP10 Realizing that increased production and improved retention of health workers, in particular in rural areas, is reliant on various factors including a sufficient and sustainable health financing system, which is to some extent determined by decisions made outside the confines of the health sector, including in international organizations;

PP11 Observing that insufficient evidence of the effectiveness of health workforce policies and a lack of comprehensive, reliable and up-to-date data, including analytical tools, constitute significant challenges for Member States trying to achieve or maintain a sufficient, sustainable and effective health workforce;

PP12 Concerned that many Member States, particularly those with critical shortages or imbalances of health workers, also lack the governance, technical and managerial capacity to design and implement efficient and effective policy interventions related to scaling up and retaining the health workforce;

PP13 Realizing that a sufficient, efficient and sustainable health workforce is at the heart of robust health systems and a prerequisite for sustainable health improvement;

PP14 Recognizing the division of health responsibilities between national and subnational levels of government that is unique to federated states,

1. URGES Member States:⁵
 - (1) to implement the voluntary WHO Global Code of Practice on the International Recruitment of Health Personnel in order that both source and destination countries may derive benefits from the international migration of health personnel and in order to

¹ Including, but not limited to, the *Kampala Declaration and Agenda for Global Action of March 2008*, the G8 Communiqué of July 2008; *Closing the gap in a generation: health equity through action on the social determinants of health: Final Report of the Commission on Social Determinants of Health*. Geneva, World Health Organization, 2008; the High-level Taskforce on Innovative International Financing for Health Systems, 2009; and the *Venice concluding statement on maximizing positive synergies between health systems and global health initiatives*, 2009.

² *The world health report 2006 – working together for health*. Geneva, World Health Organization, 2006.

³ *The world health report 2008. Primary health care: now more than ever*. Geneva, World Health Organization, 2008.

⁴ *The world health report 2010. Health systems financing: the path to universal coverage*. Geneva, World Health Organization, 2010.

⁵ And, where applicable, regional economic integration organizations.

mitigate the negative effects of health worker migration on health systems, particularly in countries with critical health worker shortages;

(2) to prioritize, in the context of global economic conditions, public sector spending on health, as appropriate, to ensure that sufficient financial resources are available for the implementation of policies and strategies to scale-up and retain the health workforce, particularly in developing countries, and to recognize it as an investment in the health of the population that contributes to social and economic development;

(3) to consider developing or maintaining a national health workforce plan as an integral part of a validated national health plan, in accordance with national and subnational responsibilities with increased efforts towards effective implementation and monitoring, as appropriate in the national context;

(4) to use and implement evidence-based findings and strategies, including those from the Global Health Workforce Alliance Taskforce on Scaling Up Education and Training, for the successful scaling-up of health worker education and training;

(5) to participate actively in the ongoing work on the WHO policy guidelines on transformative scale-up of health professional education in order to increase the workforce numbers and relevant skill-mix in response to country health needs and health systems context;

(5)bis to expand, strengthen and reorient the faculty members of health professional training institutions, in terms of quantity, quality, skill-mix and attitudes relevant to the implementation of the transformative scaling up of health professionals; [Thailand]

(6) to develop strategies and policies to increase the availability of motivated and skilled health workers in remote and rural areas, with reference to WHO global policy recommendations on increasing access to health workers in remote and rural areas through improved retention of the health workforce;

(7) to implement the relevant recommendations for increased retention of health workers in rural areas, including: improved living conditions; safe and supportive working environment; outreach support; career development and advancement programmes; supporting professional networks; and social recognition of dedicated health personnel;

(8) to develop or strengthen in-country capacity for health workforce information systems in order to guide, accelerate and improve country action including the collection, processing and disseminating of information on their health workforce, covering, but not limited to, stock, education and training capacity, distribution, migration and expenditures;

(9) to work with other sectors to generate evidence and introduce effective policy interventions in order to address other factors that affect the availability of health workers in rural or remote areas, such as socioeconomic deprivation, geographical barriers and distance, transport and the acceptability of services;

2. URGES nongovernmental organizations, international organizations, international donor agencies, financial and development institutions and other relevant organizations working in developing countries:

(1) to align and harmonize, in line with the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, their education, training, recruitment and employment practices with those of the countries in which they are based, in particular national health plans, where available, in order to create ~~synergies~~ **coherence and coordination [USA]** and support Member States' efforts in building a sustainable health workforce, strengthening health systems and improving health outcomes;

- (2) to support national long-term strategies and interventions to build and sustain a sufficient and efficient health workforce, including investment in the future health workforce;
3. REQUESTS the Director-General:
- (1) to continue the implementation of the Global Code of Practice on the International Recruitment of Health Personnel, including, upon request, provision of technical support to Member States in implementing the Global Code;
 - (2) to provide leadership at global and regional levels by generating evidence and recommending effective interventions to address factors that hinder access to health workers; to work closely with partner agencies in the multilateral system on appropriate measures to support Member States' efforts to maintain or achieve a sufficient, sustainable and effective workforce; and to advocate for this topic to be placed high on global development and research agendas;
 - (3) to provide technical support to Member States, upon request, for their efforts to scale-up education and training and improve the retention of the health workforce; including identifying efficient and effective health workforce policies and developing and implementing national health workforce plans;
 - (4) to support Member States, upon request, in strengthening their capacity for coordination on health workforce issues between ministries of health, other ministries and other relevant stakeholders;
 - (5) to encourage and support Member States in developing and maintaining a framework for health workforce information systems, in order to accommodate the collection, processing and dissemination of information on their health workforce, including stock, migration, education and training capacity, skill mix, distribution, expenditures, positions and determinants of change;
 - (6) to encourage Member States to support the ongoing development of the WHO policy guidelines on transformative scale-up of health professional education in order to increase the quantity, quality and relevance of the health workforce, and towards addressing shortages in human resources for health in an equitable and efficient manner;
 - (7) to promote research relevant for both developing and developed countries on efficient and effective policies and interventions to improve scale-up and retention of the health workforce, with the aim of establishing and maintaining an accessible global evidence base for best practice, and efficient and effective health workforce policies and interventions, including supporting the strengthening of knowledge centres with the purpose of accommodating translation of evidence and best practice into context-specific policy solutions;
 - (8) to strengthen capacity within the Secretariat with the purpose of giving sufficient priority to relevant tasks related to the Organization's wider efforts in addressing the global health workforce crisis;
 - (9) to report on progress in implementing this resolution to the World Health Assembly through the Executive Board, in a manner integrated with the reporting on resolution WHA63.16 on the WHO Global Code of Practice on the International Recruitment of Health Personnel.

The financial and administrative implications of the adoption of the resolution for the Secretariat were unchanged from those provided to the Board at its 128th session.¹

¹ See document EB128/2011/REC/1, Annex 4.

Dr PÁVA (Hungary), speaking on behalf of the European Union, disagreed with the introduction of the fifth preambular paragraph bis, as the potential implications of the amendment on the education and training of health workers in the scope of national education systems were unclear. In addition, she did not support the inclusion of the word “attitude” in that preambular paragraph and questioned the meaning of “faculty members” in both the fifth preambular paragraph bis and in subparagraph 1(5)bis.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) explained that the term “faculty members” referred to teachers and professors; it could be replaced by “teachers” in both the fifth preambular paragraph bis and subparagraph 1(5)bis. The reason for including the word “attitude” in the relevant paragraphs was that, in order change education systems and scale up health professionals, it was necessary to change attitudes.

Mr PRAZ (Switzerland) shared the concern about inclusion of the word “attitude”. He suggested that, as the language in subparagraph 1(5)bis was fairly strong, the phrase “according to needs” or “when appropriate” be inserted after “health professionals”.

Mr HOHMAN (United States of America) observed that the amendments proposed by the delegate of Thailand were aimed at solving an important issue, as increasing the quality and quantity of medical school teachers was a vital tool for strengthening of the health workforce. He echoed the concerns expressed about the use of the word “attitude”; the problems with the two outstanding paragraphs were perhaps simply linguistic ones. It might be possible to amend the fifth preambular paragraph to incorporate the provisions of the fifth preambular paragraph bis.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) proposed that in both the fifth preambular paragraph bis and subparagraph 1(5)bis the words “and attitudes” be deleted.

Dr PÁVA (Hungary) and Mr PRAZ (Switzerland) accepted the amendments proposed by the delegate of Thailand.

Mr HOHMAN (United States of America) commented that the discussions were moving in the right direction. However, he had further concerns about the reference to reorienting teachers of health professionals in subparagraph 1(5)bis.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) explained that the term “reorient” referred to the reorientation of the curriculum and training activities in order to be explicit that, in future, it would be the prerogative of Member States to intervene and reorient the curriculum.

Mr HOHMAN (United States of America) pointed out that subparagraph 1(5)bis referred to reorienting teachers rather than the curriculum. The language should be either amended or deleted.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) said that the term “reorient” was vital and should be retained. He noted the United States’ President’s Emergency Plan for AIDS Relief was currently working with the Secretariat on the reorientation of the medical education system. He proposed that the first line of subparagraph 1(5)bis be amended to read: “to expand, strengthen and reorient curricula, training methods and teachers ...”. He urged Member States and the Secretariat not to allow a linguistic issue to thwart the wish of a Member State to convey a strong intention for the work of WHO.

Dr DOLEA (Assistant Secretary) read out the proposed text of the first line of subparagraph 1(5)bis, which took account of the amendments proposed by the delegate of Thailand:

“to reorient curricula and training methods, and to expand and strengthen teachers of health professional institutions ...”.

Ms BENNETT (Australia) expressed concern at the use of the word “expand” in conjunction with “teachers”. She proposed that the first line of subparagraph 1(5)bis be amended to read: “to expand, strengthen and reorient, as appropriate, health professional training, in terms of ...”.

Dr ISSA MOUSSA (Niger) said that the proposed wording read out by the Secretary did not link well with subparagraph 1(5), which referred to health professional education-related human resources and the rationale behind subparagraph 1(5)bis was to strengthen that first paragraph. The word “involve” should be used in place of “reorient” in order to facilitate having a critical mass of human resources involved in health-related activities.

Dr DOLEA (Assistant Secretary) said that another possible formulation could read: “to reorient curricula and training methods and to scale up and strengthen teachers of health professional training institutions ...”.

Mr HOHMAN (United States of America) proposed an alternative formulation, which read: “to expand, strengthen and orient health professional training institutions, in terms of quantity, quality and skill-mix to the implementation of the transformative scaling up of health professionals”.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) accepted the proposal by the delegate from the United States of America, but requested that “relevant” be reinserted after “skill-mix”.

Dr DOLEA (Assistant Secretary) read out the revised version of subparagraph 1(5)bis: “to expand, strengthen and orient health professional training institutions, in terms of quantity, quality and skill-mix relevant to the implementation of the transformative scaling up of health professionals”.

Mr HOHMAN (United States of America) proposed that “to be” should be inserted before “relevant to”.

The CHAIRMAN took it that the Committee agreed to all those proposed amendments and that it wished to approve the draft resolution as amended.

The draft resolution, as amended, was approved.¹

The CHAIRMAN drew attention to a revised version of the draft resolution in resolution EB128.R10 on strengthening national health emergency and disaster management capacities and resilience of health systems, which incorporated amendments made during the discussions of the informal working group and read:

The Sixty-fourth World Health Assembly,

PP1 Recalling resolutions WHA58.1 on health action in relation to crises and disasters, and WHA59.22 on emergency preparedness and response, resolution WHA61.19 on climate change and health, and other World Health Assembly and Regional Committee resolutions and action plans, inter alia, on health security and the International Health Regulations (2005), as well as on pandemic preparedness, safe hospitals and other matters related to emergencies and disasters at local, subnational and national levels;

¹ Transmitted to the Health Assembly in the Committee’s fourth report and adopted as resolution WHA64.6.

PP2 Recalling United Nations' General Assembly resolution 60/195, which endorsed the Hyogo Declaration and the Hyogo Framework for Action 2005–2015: Building the Resilience of Nations and Communities to Disasters, as well as resolutions 61/198, 62/192, 63/216, 64/200 and 64/251, which, inter alia, called upon Member States to increase efforts to implement the Hyogo Framework, to strengthen risk-reduction and emergency preparedness measures at all levels, and to encourage the international community and relevant United Nations' entities to support national efforts aimed at strengthening capacity to prepare for and respond to disasters;

PP3 Reaffirming that countries **should ensure the protection of** ~~have responsibility for ensuring the protection of [USA]~~ the health, safety and welfare of their people and ~~for ensuring~~ **should ensure [USA]** the resilience and self-reliance of the health system, which is critical for minimizing health hazards and vulnerabilities and delivering effective response and recovery in emergencies and disasters;

PP4 Regretting the tragic and enormous loss of life, injuries, disease and disabilities resulting from emergencies, disasters and crises of all descriptions;

PP5 Mindful that emergencies and disasters also result in damage and destruction of hospitals and other health infrastructure, weakened ability of health systems to deliver health services; and setbacks for health development and the achievement of the Millennium Development Goals;

PP6 Expressing deep concern that continuing poverty, increasing urbanization and climate change are expected to increase the health risks and impacts of emergencies and disasters on many countries and communities;

PP7 Acknowledging that most actions to manage the risks to health from natural, biological, technological and societal hazards, including the immediate emergency response, are provided by local- and country-level actors across all health disciplines, including mass casualty management, mental health and noncommunicable diseases, communicable diseases, environmental health, maternal and newborn health, reproductive health, and nutrition and other cross-cutting health issues;

PP8 Recognizing the contribution of other sectors and disciplines to the health and well-being of people at risk from emergencies and disasters, including local government, planners, architects, engineers, emergency services and civil protection, and academia;

PP9 Concerned that country and community capacities to manage major emergencies and disasters are often overwhelmed, and that coordination, communications and logistics are often revealed as the weakest aspects of health emergency management;

PP10 Appreciating that some countries, including those with low-income or emerging country development status, have reduced mortality and morbidity in disaster situations through their investment in emergency and disaster risk-reduction measures, with the support of local, regional and global partners;

PP11 Recognizing that WHO plays an important role as a member of the International Strategy for Disaster Reduction system and as the health cluster lead in the framework of humanitarian reform, and works closely with other members of the international community, such as the United Nations Secretariat of the International Strategy for Disaster Reduction, UNDP, UNICEF, the United Nations Office for the Coordination of Humanitarian Affairs, the International Red Cross and Red Crescent Movement, and other nongovernmental organizations, on supporting country capacity development and developing institutional capacities for multisectoral emergency and disaster risk-management, which includes disaster risk-reduction;

PP12 Building on the International Strategy for Disaster Reduction, the 2008–2009 World Disaster Reduction Campaign on Hospitals Safe from Disasters, the 2010–2011 Campaign on Disaster Resilient Cities, World Health Day 2008 on Climate Change and Health, World Health Day 2009 on Hospitals Safe in Emergencies, and World Health Day 2010 on

Urban Health Matters, which have resulted in local, subnational, national and global actions on reducing risks to health from emergencies and disasters;

PP13 Recognizing that improved health outcomes from emergencies and disasters require urgent additional action at country, regional and global levels to ensure that the local, subnational and national health risk-reduction and overall response in emergencies and disasters are timely and effective and that health services remain operational when they are most needed, in this respect bearing in mind that emergencies and disasters affect men and women differently,

1. URGES Member States:¹

(1) to strengthen all-hazards health emergency and disaster risk-management programmes (including disaster risk-reduction, emergency preparedness and response)² as part of national and subnational health systems, supported by, **and with effective enforcement of, [Thailand]** legislation, regulations and other measures, to improve health outcomes, reduce mortality and morbidity, protect investment in **[Thailand]** health infrastructure and strengthen the resilience of the health system and society at large, and mainstream a gender perspective into all phases of these programmes;

(2) to integrate all-hazards health emergency and disaster risk-management programmes (including disaster risk-reduction) into national or subnational health plans and institutionalize capacities for coordinated health and multisectoral action to assess risks, proactively reduce risks, and prepare for, respond to, and recover from, emergencies, disasters and other crises;

(2bis) to establish inventories of types and quantities of chemical hazards at sites and in transportation, and to make this information accessible to concerned government and other related agencies, and to stakeholders in order to support effective health emergency and disaster risk-management for chemical hazards; [Thailand]

(3) to develop programmes on safe and prepared hospitals that ensure: that new hospitals and health facilities are located and built safely so as to withstand local hazards; that the safety of existing facilities is assessed and remedial action is taken; and that all health facilities are prepared to respond to internal and external emergencies;

(4) to **establish, [Thailand]** promote **and foster [Thailand]** regional and subregional collaboration, **not limited to WHO regional structures, [Thailand]** including sharing of experience and expertise for capacity development, in risk-reduction, response and recovery;

(5) to strengthen the role of the local health workforce in the health emergency management system, ~~in order~~ **[Thailand]** to provide local leadership and health services, through enhanced planning, training; **for all health-care workers, [Thailand]** and access to other resources;

~~3-2.~~ **[Thailand]** CALLS UPON Member States, donors and development cooperation partners to allocate sufficient resources for health emergency and disaster risk-management programmes and partners through international cooperation for development, humanitarian appeals, and support for WHO's role in ~~all international health-related matters.~~ **health emergency and disaster risk-management matters; [Thailand]**

~~2-3.~~ **[Thailand]** REQUESTS the Director-General:

(1) to ensure that WHO at all levels has enhanced capacity and resources, and optimizes its expertise across all disciplines in the Organization, in order to provide the

¹ And, where applicable, regional economic integration organizations.

² Health emergency and disaster risk-management includes all measures to assess risks, proactively reduce risks, prepare for, respond to, and recover from, emergencies, disasters and other crises.

necessary technical guidance and support to Member States and partners for developing health emergency and disaster risk-management programmes at national, subnational and local levels;

(2) to strengthen collaboration with and ensure coherence and complementarity of actions with those of relevant entities, including those in the public, private, nongovernmental and academic sectors, in order to support country and community health emergency and disaster risk-management, which includes disaster risk-reduction, as well as ongoing efforts by Member States to implement the International Health Regulations (2005);

(3) to strengthen the evidence base for health emergency and disaster risk-management including operational research and economic assessments;

(4) to support national and subnational assessments of risks and capacities for health emergency and disaster risk-management, as a basis for catalysing action and strengthening national and subnational health emergency and disaster risk-management capacities, including disaster risk-reduction;

(5) to report to the Sixty-sixth World Health Assembly through the Executive Board at its 132nd session, on progress made in implementing this resolution;

(5bis) to support regional and subregional networks, including those outside the WHO regional structures, in order to strengthen their collaboration on health emergency and disaster risk management. [Thailand]

The financial and administrative implications of the adoption of the resolution for the Secretariat were unchanged from those provided to the Board at its 128th session.¹

Dr PÁVA (Hungary), speaking on behalf of the European Union, did not support the insertion of a new subparagraph 1(2)bis which related more to preparations to comply with the International Health Regulations (2005). Moreover, there was no information available on the potential financial implications for Member States. In addition, she expressed a reservation about the reference to making information available “to concerned government and other related agencies, and to stakeholders”, which could have security implications. She could not support the proposed amendments to subparagraphs 1(4) and 3(5)bis; the proposed support outside WHO’s regional structures was too broad and vague. It needed further clarification of whether engagement was meant instead of support.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) stated that there was no link to the International Health Regulations (2005) in the proposed subparagraph 1(2)bis. Information was badly needed on the type and quantity of chemical hazards in order to allow timely and appropriate responses to, and management of, chemical hazards by emergency management and disaster management teams. Creating an inventory had no significant cost implications for Member States. With regard to subparagraph 3(5)bis, “including those outside the” could be replaced by “not limited to”.

Dr PÁVA (Hungary) reiterated her concern about the insertion of the proposed subparagraph 1(2)bis and proposed that it be deleted.

The DIRECTOR-GENERAL suggested that the discussion of the draft resolution should be suspended to permit further informal discussion by interested parties and to allow time to understand the rationale behind the proposed amendment.

It was so agreed.

¹ See document EB128/2011/REC/1, Annex 4.

The CHAIRMAN drew attention to a revised version of the draft resolution in resolution EB128.R11 on strengthening nursing and midwifery, which incorporated amendments made during the discussions of the informal working group and read:

The Sixty-fourth World Health Assembly,

PP1 Having considered the reports on health system strengthening;¹

PP2 Recognizing the need to build sustainable national health systems and to strengthen national capacities to achieve the goal of reduced health inequities;

PP3 Recognizing the crucial contribution of the nursing and midwifery professions to strengthening health systems, to increasing access to comprehensive health services for the people they serve, and to the efforts to achieve the internationally agreed health-related development goals, including the Millennium Development Goals and those of the World Health Organization's programmes;

PP4 Concerned at the continuing shortage and maldistribution of nurses and midwives in many countries and the impact of this on health care and more widely;

PP5 Acknowledging resolution WHA62.12 on primary health care, including health system strengthening, which called, inter alia, for the renewal and strengthening of primary health care, as well as urging Member States to train and retain adequate numbers of health workers, with appropriate skill mix, including primary care nurses and midwives, in order to redress current shortages of health workers to respond effectively to people's health needs;

PP6 Acknowledging the ongoing WHO initiatives on the scaling up of transformative health professional education and training in order to increase the workforce numbers and the relevant skill-mix in response to the country health needs and health systems context;

PP7 Recognizing the global policy recommendations by WHO on increasing access to health workers in remote and rural areas through improved retention² as an evidence platform for developing effective country policies for rural retention of nursing and midwifery personnel;

PP8 Taking note of the WHO Global Code of Practice on the International Recruitment of Health Personnel;³

PP9 Reaffirming the call for governments and civil society to strengthen capacity to address the urgent need for skilled health workers, particularly midwives, made in the WHO UNFPA UNICEF World Bank Joint Statement on Maternal and Newborn Health;

PP10 Noting the importance of multidisciplinary involvement, including that of nurses and midwives, in high-quality research that grounds health and health systems policy in the best scientific knowledge and evidence, as elaborated in WHO's strategy on research for health, endorsed in resolution WHA63.21;

PP11 Noting that nurses and midwives form the majority of the workforce in many countries' health systems, and recognizing that the provision of knowledge-based and skilled health services maximizes the physical, psychological, emotional and social well-being of individuals, families and societies;

PP12 Recognizing the fragmentation of health systems, the shortage of human resources for health and the need to improve collaboration in education and practice, and primary health care services;

PP13 Having considered the reports on progress in the implementation of resolution WHA59.27 on strengthening nursing and midwifery;⁴

¹ Documents A64/12 and A64/13.

² *Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations*. Geneva, World Health Organization, 2010.

³ Adopted in resolution WHA63.16.

⁴ See documents A61/17 and A63/27.

PP14 Mindful of previous resolutions to strengthen nursing and midwifery (WHA42.27, WHA45.5, WHA47.9, WHA48.8, WHA49.1, WHA54.12 and WHA59.27) and the new strategic directions for nursing and midwifery services in place for the period 2011–2015;¹

PP15 Recognizing the need to improve the education of nurses and midwives,

1. URGES Member States: ~~demonstrate their commitment to strengthening nursing and midwifery by:~~ **[Thailand]**

(1) ~~to developing~~ targets and action plans for the development of nursing and midwifery, as an integral part of national or subnational health plans, that are reviewed regularly in order to respond to population-health needs and health system priorities as appropriate;

(2) ~~to forgeing~~ strong, interdisciplinary health teams to address health and health system priorities, recognizing the distinct contribution of nursing and midwifery knowledge and expertise;

(3) ~~to participateing~~ in the ongoing work of WHO's initiatives on scaling up transformative education and training in nursing and midwifery in order to increase the workforce numbers and the mix of skills that respond to the country's health needs and are appropriate to the health system context;

(4) ~~to collaborateing~~ within their regions and with the nursing and midwifery professions in the strengthening of national or subnational legislation and regulatory processes that govern those professions, including the development of ~~entry-level~~ **[Zimbabwe]** competencies for the educational and technical preparation of nurses and midwives, **and systems for sustaining those competencies [Thailand]; and** consideration ~~must~~ **should** **[USA]** be given to the development of the continuum of education that is necessary for attaining the required level of expertise of nurse and midwifery researchers, **educators and administrators; [Thailand]**

(5) ~~to harnessing~~ the knowledge and expertise of nursing and midwifery researchers in order to contribute evidence for health system innovation and effectiveness;

(6) ~~to engage~~ actively ~~engaging~~ the expertise of nurses and midwives in the planning, development, implementation and evaluation of health and health system policy and programming;

(7) ~~to implementing~~ strategies for enhancement of interprofessional education and collaborative practice including community health nursing services as part of people-centred care;

(8) ~~to includeing~~ nurses and midwives in the development and planning of human resource programmes that support incentives for recruitment, retention and strategies for improving workforce issues, such as remuneration, conditions of employment, **career development and advancement, [Thailand]** and development of positive work environments;

(9) ~~introduceing~~ **to establish national mechanism in order to develop an infrastructure that supports [Thailand]** the effective interventions proposed in the global policy recommendations on increasing access to health workers in remote and rural areas through improved retention;²

(10) ~~to implementing~~ the WHO Global Code of Practice on the International Recruitment of Health Personnel, given the national impact of the loss of trained nursing staff, **and to implement effective rural retention policies and interventions; [Thailand]**

¹ Document WHO/HRH/HPN/10.1.

² *Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations*. Geneva, World Health Organization, 2010.

2. REQUESTS the Director-General:
- (1) to strengthen WHO's capacity for development and implementation of effective nursing and midwifery policies and programmes through continued investment and appointment of professional nurses and midwives to specialist posts in the Secretariat both at headquarters and in regions;
 - (2) to engage actively the knowledge and expertise of the Global Advisory Group on Nursing and Midwifery in key policies and programmes that pertain to health systems, the social determinants of health, human resources for health and the Millennium Development Goals;
 - (3) to provide technical support and evidence for the development and implementation of policies, strategies and programmes on interprofessional education and collaborative practice, and on community health nursing services;
 - (4) to provide support to Member States in optimizing the contributions of nursing and midwifery to implementing national health policies and achieving the internationally agreed health-related development goals, including those contained in the Millennium Declaration;
 - (5) to encourage the involvement of nurses and midwives in the integrated planning of human resources for health, particularly with respect to strategies for maintaining adequate numbers of competent nurses and midwives;
- (5bis) to strengthen the dataset on nurses and midwives as an integral part of the national health workforce information systems and maximize use of this information for evidence-based policy decisions; [Thailand]**
- (6) to report on progress in implementing this resolution to the Sixty-fifth and Sixty-seventh World Health Assemblies **and thereafter every three years, [Zimbabwe]** through the Executive Board.

The financial and administrative implications of the adoption of the resolution for the Secretariat were unchanged from those provided to the Board at its 128th session.¹

Dr PÁVA (Hungary), speaking on behalf of the European Union, questioned the wisdom of deleting the phrase “demonstrate their commitment to strengthening nursing and midwifery by:” from the introductory text of paragraph 1. In addition, in subparagraph 1(9) she suggested replacing the verb “establish” by “promote”. The proposed amendment to subparagraph 1(10) was acceptable, provided that the following text were added at the end: “as appropriate at national and local levels”. The proposed insertion of subparagraph 2(5)bis was redundant, as resolution WHA63.16 on the WHO Global Code of Practice on the International Recruitment of Health Personnel had contained a similar provision. In subparagraph 2(6) she proposed that the same wording from subparagraph 3(9) of WHA64.6 should be used.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) explained that the deletion of “demonstrate their commitment to strengthening nursing and midwifery by:” had been proposed as it was considered that the phrase weakened the subparagraphs contained in paragraph 1. Member States should be urged to take action rather than merely to demonstrate their commitment, which did not guarantee action.

Ms WISEMAN (Canada), referring to subparagraph 1(9), proposed the insertion of “and subnational” after “national” and the deletion of “infrastructure”, in order to reflect the division of responsibility that existed within federated states. In addition, the proposed amendment to subparagraph 1(10) should be deleted as there was no clear link between rural retention policies and international migration and, furthermore, subparagraph 1(9) already called for efforts to increase

¹ See document EB128/2011/REC/1, Annex 4.

“access to health workers in remote and rural areas through improved retention”. The text of the proposed subparagraph 2(5)bis should be moved to become subparagraph 1(4)bis, as the collection of national and subnational data was the responsibility of Member States. In addition, in the same paragraph, she proposed the insertion of “and subnational” after the word “national”. She welcomed proposal by the delegate of Hungary to amend subparagraph 2(6), as reporting requirements clearly needed streamlining.

Ms BENNETT (Australia) expressed support for the amendments to subparagraph 1(9) proposed by the delegates of Hungary and Canada. The proposed subparagraph 2(5)bis should, she agreed, be moved to paragraph 1, as the activities mentioned were aimed at the Member States. She supported the comments by the delegate of Canada regarding the proposed amendments to subparagraph 1(10).

Dr VIROJ TANGCHAROENSATHIEN (Thailand) would accept changes to subparagraph 1(9) if the text were to read: “to promote establishment of national and subnational mechanisms in order to develop and support ...”. With regard to subparagraph 1(10), he concurred with the comments of the delegates of Australia and Canada; he stressed that the WHO Global Code of Practice was a comprehensive instrument that covered rural retention but agreed that, because of the mention of health workers in remote and rural areas in subparagraph 1(9), the proposed amendment could be deleted. He welcomed Canada’s proposed amendments to subparagraph 2(5)bis but did not agree with the delegate of Hungary that the subparagraph was redundant.

Ms CHASOKELA (Zimbabwe) endorsed the proposals of the delegates of Hungary and Australia to retain the reporting process and format.

Dr DOLEA (Assistant Secretary) read out the amended texts. Operative paragraph 1 would read: “URGES Member States to translate into action their commitment to strengthen nursing and midwifery by ...”. Subparagraph 1(9) would read: “to promote the establishment of national and subnational mechanisms in order to develop and support the effective interventions proposed ...”. Subparagraph 1(10) would read: “to implement the WHO Global Code of Practice on the International Recruitment of Health Personnel, given the national impact of the loss of trained nursing staff as appropriate at national and local levels”. Subparagraph 2(5)bis would read: “to strengthen the dataset on nurses and midwives as an integral part of the national and subnational health workforce information systems ...” and the paragraph would be moved to operative paragraph 1, to become subparagraph 1(4)bis. Subparagraph 2(6) should be replaced with the following text: “to report on progress in implementing this resolution to the World Health Assembly through the Executive Board in a manner integrated with the reporting on resolution WHA63.16 on the WHO Global Code of Practice on the International Recruitment of Health Personnel.”

The draft resolution, as amended, was approved.¹

The CHAIRMAN drew attention to the revised version of the draft resolution contained in resolution EB128.R12 on strengthening national policy dialogue to build more robust health policies, strategies and plans, which incorporated proposed amendments and read:

The Sixty-fourth World Health Assembly,

PP1 Having considered the report on health system strengthening: improving support to policy dialogue around national health policies, strategies and plans;²

¹ Transmitted to the Health Assembly in the Committee’s fourth report and adopted as resolution WHA64.7.

² Document A64/12.

PP2 Having considered the importance of policy directions suggested by the world health reports for 2008 and 2010;¹ resolution WHA62.12 on primary health care, including health system strengthening; resolutions EUR/RC60/R5 on addressing key public health and health policy challenges in Europe: moving forwards in the quest for better health in the WHO European Region; WPR/RC61.R2 on the Western Pacific Regional Strategy for health systems based on the values of primary health care; AFR/RC60/R1 on a strategy for addressing key determinants of health in the African Region and documents AFR/RC60/7 on health systems strengthening: improving district health service delivery, and community ownership and participation and SEA/RC63/9 on the development of national health plans and strategies;

PP3 Recognizing that robust and realistic national health policies, strategies and plans are essential for strengthening health systems based on primary health care;

PP4 Underlining the importance of coherent and balanced policies, strategies and plans under ministries of health with respect to efforts to achieve the Millennium Development Goals;

PP5 Acknowledging that many Member States have made efforts to ensure that their national health policies, strategies and plans respond better to growing expectations for improved health and better services;

PP6 Noting that an inclusive policy dialogue with a comprehensive range of stakeholders, within and beyond government, **including civil society organizations, the private sector, and health professionals and academics, [Thailand]** within the health and other sectors, is critical to increasing the likelihood that national policies, strategies and plans will be appropriately designed and implemented and will yield the expected results,

1. URGES Member States:²

(1) to show effective leadership and ownership of the process of establishing robust national or subnational health policies and strategies, basing that process on broad and continuous consultation and engagement of all relevant stakeholders;

(2) to base their national or subnational health policies, strategies and plans on the overarching goals of universal coverage, people-centred primary care and health in all policies, as well as on a comprehensive, balanced and evidence-based assessment of the country's health and its health system challenges;

(3) to ensure that national or subnational health policies, strategies and plans are ambitious but realistic with respect to available resources and the capacities of staff and institutions, and that they address the entire health sector, public as well as private, and the social determinants of health;

(4) to ensure that national health policies, strategies and plans are integrated with subnational operational plans, disease or life-cycle programmes, and are linked to the country's overall development and political agenda;

(5) to regularly monitor, review and adjust their national or subnational health policies, strategies and plans with a view to ~~adjusting them to respond to~~ **developing evidence-based responses to [Thailand]** evolving challenges and opportunities, and to involve all relevant stakeholders;

(6) to strengthen their institutional capacity, as appropriate, in harmonizing and aligning donor programmes with the national policies, strategies, priorities and plans;

(6bis) to empower civil society and communities, the private sector, health professionals and academics, to participate actively and efficiently in policy dialogue

¹ *The world health report 2008. Primary health care (now more than ever)*. Geneva, World Health Organization, 2008. *The world health report 2010. Health systems financing: the path to universal coverage*. Geneva, World Health Organization, 2010.

² And, where applicable, regional economic integration organizations.

and the evaluation and monitoring process, as well as to be actively involved in reviewing the performance of national policies, strategies and plans; [Thailand]

2. CALLS upon development agencies and other partners to strengthen adherence to the principles of the Paris Declaration on Aid Effectiveness, of ownership, harmonization, alignment, **managing for [Thailand]** results, and mutual accountability, encouraging efforts through mechanisms such as the International Health Partnership;
3. REQUESTS the Director-General:
 - (1) to renew the Organization's role at country level as a facilitator of inclusive policy dialogue around national health policies, strategies and plans, to reflect this across the Organization's workplans and operations, and to provide technical inputs for conducting the planning process, as appropriate;
 - (2) to promote the principles of the Paris Declaration on Aid Effectiveness, of ownership, harmonization, alignment, results, and mutual accountability, based on priorities set out in the national health policies, strategies and plans;
 - (3) to support Member States in their efforts to ensure the ownership, quality and coordination of the technical support they receive, and to foster cross-country and regional learning and cooperation;
 - (4) to strengthen the Organization's capacity at all levels for enhanced and integrated support to national policy dialogue around national health policies, strategies and plans;
 - (5) to report to the Sixty-fifth World Health Assembly, through the Executive Board, on progress made, obstacles faced and results obtained in enhancing support provided to Member States for national policy dialogue around national health policies, strategies and plans.

The financial and administrative implications of the adoption of the resolution for the Secretariat were unchanged from those provided to the Board at its 128th session.¹

Dr PÁVA (Hungary), speaking on behalf of the European Union, proposed that, in order to give more flexibility to Member States, in subparagraph 1(6)bis the following new text should be added: "URGES Member States to promote engagement and empowerment for all stakeholders including civil society and communities, the private sector, health professionals and academics to participate actively and efficiently in policy dialogue concerning the performance of national policies, strategies and plans".

Dr VIROJ TANGCHAROENSATHIEN (Thailand) expressed support for the amendments.

The CHAIRMAN took it that the Committee wished to approve the draft resolution as amended.

The draft resolution, as amended, was approved.²

Draft WHO HIV/AIDS strategy 2011–2015: Item 13.6 of the Agenda (Document A64/15)

The CHAIRMAN drew attention to a draft resolution proposed by the delegations of Angola, Argentina, Brazil, Cape Verde, Panama, Paraguay, Timor-Leste and United States of America, which read:

¹ See document EB128/2011/REC/1, Annex 4.

² Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA64.8.

The Sixty-fourth World Health Assembly,

Recalling resolution WHA63.19 which requested the Director-General inter alia to develop a WHO HIV/AIDS strategy for 2011–2015 that builds on previous WHO HIV/AIDS strategies and plans endorsed by several Health Assemblies, including resolutions WHA53.14, WHA56.30, WHA59.12 and WHA59.19;

Having considered the draft WHO HIV/AIDS strategy 2011–2015,¹

1. ENDORSES the global health sector strategy on HIV/AIDS, 2011–2015;
2. AFFIRMS the vision and strategic directions of the global health sector strategy on HIV/AIDS, 2011–2015 and that the global strategy aims to guide the health sector's response to HIV/AIDS, including recommended actions at country and global levels as well as contributions to be made by WHO;
3. WELCOMES the alignment of the global health sector strategy on HIV/AIDS, 2011–2015 with other strategies addressing related public health issues, including the UNAIDS strategy for 2011–2015;²
4. URGES Member States:
 - (1) to adopt and implement the global health sector strategy on HIV/AIDS, 2011–2015;
 - (2) ~~to adapt~~ **to implement according to the national context** the strategy, on the basis of the most current strategic information on the nature of the HIV/AIDS epidemic and the preparedness of the health system and community systems to respond, and to reach those populations most vulnerable to, and at risk of, HIV/AIDS infection;
5. REQUESTS the Director-General:
 - (1) to give adequate support to implementation of the global health sector strategy on HIV/AIDS, 2011–2015, including provision of support to Member States for country implementation and annual reporting on progress on the health sector response to HIV/AIDS;
 - (2) to monitor progress in implementing the global health sector strategy on HIV/AIDS, 2011–2015 and to report progress, through the Executive Board, to the Sixty-sixth World Health Assembly and every two years thereafter.

The financial and administrative implications for the Secretariat of the adoption of the resolution were as follows:

¹ Document A64/15.

² *Getting to zero: UNAIDS strategy 2011–2015*. Geneva, UNAIDS, 2010.

1. Resolution Draft global health sector strategy on HIV, 2011–2015	
2. Linkage to programme budget	
Strategic objective:	Organization-wide expected result:
2. To combat HIV/AIDS, tuberculosis and malaria.	All expected results.
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals.	All expected results.
The HIV strategy also links with strategic objectives 6, 7 and 11.	
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
The goals of the strategy are consistent with the UNAIDS Strategy 2011–2015 and reaffirm existing internationally agreed goals:	
<ul style="list-style-type: none"> • to achieve universal access to comprehensive HIV prevention, treatment and care • to contribute to achieving Millennium Development Goal 6 (Combat HIV/AIDS, malaria and other diseases) and other health-related Goals (3, 4, 5 and 8) and associated targets. 	
The HIV strategy's four targets for 2015 build on the indicators and targets of the Medium-term strategic plan 2008–2013. The targets are as follows:	
<ul style="list-style-type: none"> • reduce new infections: reduce by 50% the percentage of young people aged 15–24 years who are infected (compared with a 2009 baseline) • eliminate new HIV infections in children: reduce new HIV infections in children by 90% (compared with a 2009 baseline) • reduce HIV-related mortality: reduce HIV-related deaths by 25% (compared with a 2009 baseline) • reduce tuberculosis-related mortality: reduce tuberculosis deaths by 50% (compared with a 2004 baseline). 	
3. Budgetary implications	
(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).	
US\$ 515 million for the five-year period 2011–2015.	
(b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)	
US\$ 73 million, of which more than two thirds is expected to be incurred at regional and country levels.	
(c) Is the estimated cost noted in (b) included within the existing approved Programme budget for the biennium 2010–2011?	
Yes.	

<p>4. Financial implications</p> <p>How will the estimated cost noted in 3 (b) be financed (indicate potential sources of funds)?</p> <p>Funding sources include: assessed contributions; core voluntary contributions; core funding of the UNAIDS Unified Budget, Results and Accountability Framework; and direct voluntary contributions from Member States and foundations.</p>
<p>5. Administrative implications</p> <p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant).</p> <p>The Secretariat will provide support to implementation of the strategy at all levels of the Organization and in all regions. A detailed draft operational plan for the next biennium has been developed, indicating specific outputs at each organizational level and for each region. Particular attention will be given to ensuring that the Organization has adequate capacity at country level to support strategy implementation.</p> <p>(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.</p> <p>WHO's HIV programme is currently undergoing a realignment process that aims to identify the necessary competencies, skills and staffing structure for implementing the strategy. The realignment is focusing on improving efficiencies within the programme throughout the Secretariat, including defining a clear division of labour across the three levels of the Organization. The outcome of the realignment process should be implemented by July 2011 and it is anticipated that the staffing levels will be sufficient to support implementation of the strategy. It is anticipated that there may need to be some adjustments in staffing over the five-year period to meet changing demands.</p>
<p>(c) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile).</p> <p>Not applicable.</p>
<p>(c) Time frames (indicate broad time frames for implementation of activities)</p> <p>The strategy will be implemented over a five-year time period. Detailed operational plans will be developed for each biennium.</p>

Dr TAKEI (Japan) fully supported the new draft strategy, which had been based on extensive consultations and maintained consistency with the existing guidelines and technical framework. In particular, he welcomed the following improvements to the version submitted to the Executive Board in January: the clearer and more specific description of monitoring; the broadening of the strategy, in response to the expectations from Member States and recognition of the need for health systems strengthening, to target all the health-related Millennium Development Goals; greater consistency and coherence with existing policy documents such as the UNAIDS strategy; and the consideration of WHO's complementary role and collaboration with other organizations in the United Nations system.

In cooperation with international organizations and the Global Fund to Fight AIDS, Tuberculosis and Malaria, Japan would continue to provide assistance globally in order to have an impact on HIV/AIDS.

Ms ESCOREL DE MORAES (Brazil), speaking on behalf of the sponsors of the draft resolution, said that much had changed since the adoption in 2006 of the WHO HIV/AIDS Universal Access Plan 2006–2010, which had been based on the target adopted in 2006 by the United Nations of universal access to HIV prevention, treatment and care. There had been an increased recognition of the importance of integrating HIV into the broader public health and development agendas and of putting human rights at the centre of the response. Evidence had demonstrated that linking the HIV response

to the attainment of the Millennium Development Goals and to the renewed primary health care agenda was the most effective overall approach to strengthening health systems.

WHO needed a new strategy to guide its work towards the targets of the 2015 Millennium Development Goal. She commended the Secretariat's wide and transparent consultative process for drafting a strategy for 2011–2015 that was in line with the broader United Nations and UNAIDS frameworks.

She further proposed two amendments to the draft resolution. In subparagraph 4(2), the text should begin: "to implement the strategy according to their epidemic situation ..." and in subparagraph 5(1) the word "annual" should be deleted.

Dr HWOAL (Iraq) said that, even though the incidence of HIV infection was not high in Iraq, the Government had been working to keep the prevalence low since starting an HIV/AIDS programme in 1982. Partnerships with all stakeholders, from intergovernmental organizations to civil society, were needed in order to build capacity for diagnosis, treatment and prevention and to raise awareness about HIV/AIDS. In general, knowledge and health education needed to be strengthened through the media and better school health education programmes. Social and medical support was provided to people living with HIV. Couples should be tested for HIV before marriage. HIV services and programmes needed to be integrated into all primary health care and it was important to ensure screening programmes in all provinces of the country, including blood testing in regions where there was a high prevalence of HIV. World AIDS Day provided an incentive to take stock of the situation in order to review implementation indicators.

Strong partnerships were also needed to counter malaria and tuberculosis, with engagement of all stakeholders and follow-up.

Dr NORHAYATI RUSLI (Malaysia) applauded the draft global health sector strategy on HIV, 2011–2015 and endorsed its recommendations. She welcomed its alignment with the UNAIDS strategy 2011–2015 and its focus on priority areas. Malaysia had prepared a national strategic plan on HIV/AIDS 2011–2015, which was in line with the WHO and UNAIDS strategies and the Millennium Development Goal targets.

Dr KAPATA (Zambia) expressed satisfaction with the revised draft strategy and thanked the Secretariat for ensuring that Member States' comments had been incorporated. Zambia had participated in the consultation process for developing the strategy with key stakeholders, including representatives of government institutions, donors, civil society, nongovernmental organizations, universities, media, bilateral and multilateral agencies and experts in HIV and related programmes. The strategy developed was expected to build on WHO's "3 by 5" initiative and the WHO HIV/AIDS Universal Access Plan and guide countries like Zambia in strategically prioritizing HIV in the context of global commitments and targets.

Like many countries in sub-Saharan Africa, Zambia had a heavy burden of HIV/AIDS and related illnesses such as tuberculosis and he asked the Secretariat to continue its support through guidance in adapting strategies to suit countries' individual scenarios. He appealed to all interested partners and stakeholders to support the implementation of the strategy fully.

Professor AHMED (Bangladesh) said that Bangladesh wished to build on the achievements and experiences of the "3 by 5" initiative and the five strategic directions of the WHO HIV/AIDS Universal Access Plan 2006–2010. He urged WHO to provide guidance to countries on how to prioritize their HIV and health investments.

As Bangladesh had a low prevalence of HIV (less than 1% seropositivity rate), it needed relevant indicators and activities. He asked the Secretariat to provide a framework for concerted action at the global, regional and country levels and within the Organization.

Dr PÁVA (Hungary) speaking on behalf of the European Union, said that the candidate countries Turkey, Croatia, The former Yugoslav Republic of Macedonia, Montenegro, Iceland, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Serbia, Republic of Moldova, Armenia and Georgia aligned themselves with her statement. The European Union welcomed the simplified structure of the revised strategy and the stronger focus on the need to tailor interventions to each country and key populations, in which civil society's participation was crucial. It recognized the need to monitor and evaluate the strategy on a regular basis. The Secretariat should ensure coordination with other international organizations and existing HIV/AIDS reporting mechanisms and she strongly recommended streamlining the monitoring activities of other agencies and choosing validated indicators. Responses would benefit from focus on regionally relevant issues.

The strategy was ambitious, but financing was limited. Was the estimated US\$ 221 million for 2012–2013 covered by the budget and how did the Secretariat allocate the respective resources?

She urged a clear division of labour at the three levels of the Organization and within UNAIDS for the effective implementation of the strategy. WHO should concentrate on normative work, in particular on models of integrated, decentralized service delivery; strategic technical support; collaboration with all national stakeholders; and, collaboration – in Europe – with the relevant institutions of the European Union, and with UNAIDS, especially during and after the United Nations General Assembly High-Level Meeting on AIDS (New York, 8–10 June 2011).

The European Union would continue to support WHO's role and activities. She supported the draft resolution and endorsement of the global health sector strategy.

Mr PRAZ (Switzerland) endorsed the draft strategy. He welcomed the special consideration of gender and HIV-related stigmatization and discrimination in accessing services as well as the health systems approach in national HIV interventions recommendations. He had two specific comments on strategic direction 1, Optimize HIV prevention, diagnostic, treatment and care. First, in paragraphs 35, 44 and 50, the word "counselling" should appear before "testing" and the strategy should not encourage general screening but should focus on prevention and counselling. Secondly, he strongly supported paragraph 60, Ensure access to comprehensive services for sex workers, men having sex with men and transgendered people, and paragraph 61, Provide harm reduction services for people who use drugs. The French version of harm reduction should be rendered "*reduction des risques*".

The division of labour between WHO headquarters and field offices was welcome and he supported the close collaboration with national partners to strengthen local capacities in defining and implementing the HIV/AIDS response. He also supported a periodic monitoring review that was based on the burden of disease in each region and country. An indicator could be added under strategic direction 1 for a greater link to other sexually transmitted infections and sexual and reproductive health prevention programmes.

Dr TAAL (Gambia) recalled that the draft strategy had been circulated in July 2010 to Member States in the African Region for comment and suggestions together with a support document to guide them in the consultative meeting with stakeholders. At the end of the review process, 31 (68%) of the 46 countries in the African Region had organized country consultations using the guidelines provided. The major challenge had been the limited time offered to Member States for organizing in-country consultations and providing feedback. There had been competing demands, among which were the preparation of proposals for Round 10 of applications to the Global Fund to Fight AIDS, Tuberculosis and Malaria; preparations and negotiations for projects and reviews under the United States' President's Emergency Plan for AIDS Relief; and revision of national HIV/AIDS strategic plans.

Aligning WHO's strategic guidance to the overall national strategic planning or the health sector strategic planning for HIV/AIDS for countries in the mid-term planning cycle could be problematic or cause delays in the adaptation and implementation of the new global strategy by Member States. Nevertheless, he recommended that the strategy be endorsed.

Mr CHANDRAMOULI (India) noted the revised draft strategy with appreciation. WHO should take the lead on HIV treatment and care and on HIV/tuberculosis coinfection and share responsibility with UNICEF, UNAIDS and other organizations in the United Nations system for the prevention of mother-to-child transmission of HIV. It should collaborate with other UNAIDS cosponsors in supporting actions in all other priority areas.

In order to control the spread of HIV/AIDS, his Government was implementing the National AIDS Control Programme as a 100% centrally-sponsored scheme. The scheme had been launched in July 2007 and phase 3 of the programme, 2007–2012, had planned to halt and reverse the epidemic over a five-year period by integrating programmes for prevention, care, support and treatment.

According to recent estimates, since the launch of the scheme, the number of newly detected cases of HIV had more than halved. His country would take into account WHO's proposed strategy when drafting phase 4 of its national AIDS control programme.

Professor TJANDRA YOGA ADITAMA (Indonesia) supported the draft HIV/AIDS strategy 2011–2015 including the four strategic directions. Her country intended to expand its HIV/AIDS programme with health education programmes in collaboration with health professionals, community and religious leaders. It also planned to increase the number of hospitals and clinics that could provide care, support and treatment to patients and implement the integrated tuberculosis and HIV/AIDS programme in several provinces. She called for a patient-oriented approach rather than a disease-oriented approach to combat HIV/AIDS.

Dr GOUYA (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that, to be effective in reaching universal access, a combination of increased and predictable funding and an effective response to diverse and evolving epidemics in a changing environment was needed. The Member States recommended endorsement of the global health sector strategy for HIV. In order to implement the strategy effectively, they recommended that the Secretariat should provide country-level support in various ways. National HIV prevention and control strategies should be reviewed and revised in order to prioritize interventions in line with global and regional strategies, according to the local epidemic context; the capacity of government institutions and civil society organizations should be built; HIV surveillance systems should be set up with special attention to adolescents and adults engaging in high-risk sexual activity and injecting drugs; investment should be made in programme monitoring and evaluation so as to enable responsive HIV programme management; and costed operational plans for health sector response to HIV should be drafted with an adequate proportion of spending on health allocated to the implementation of those plans.

Dr HUYA RIMVALTANGUGUYON (Thailand) said that she could not accept the new indicators tabulated in the draft strategy. There was no need to establish a new set of indicators which would lead to an unnecessary administrative burden on countries. WHO should and must apply the existing indicators contained in the United Nations General Assembly's Declaration of Commitment on HIV/AIDS, with which Member States were already familiar.

The Secretariat should support Member States in improving the quality, reliability and comparability of datasets at the country level and support evidence-based policy decisions. Also, it seemed that an increasing proportion of resources went to treatment, at the expense of prevention, although prevention of new HIV cases was more important than treatment. The new CD4⁺ count-based guideline for early initiation of antiretroviral treatment should be carefully implemented in line with countries' health systems and policies. Priority should be given to early enrolment of patients in therapy programmes.

She proposed the following amendments to the draft resolution: subparagraphs 4(1) and 4(2) should be deleted and replaced with a new subparagraph that read: "to adapt, apply and implement, according to the national context, the global health sector strategy on HIV/AIDS 2011–2015 according to the status of the HIV epidemic, the readiness of health and community systems in response to and

reaching the most at risk populations”. A new subparagraph 4(2)bis should be inserted, to read: “to strengthen primary health care with an adequate number and skill-mix of health workforces, supply of diagnostics, medicines and other essential medical supplies as a platform for the effective implementation of the strategy”. In subparagraph 5(1), the word “annual” should be changed to “biennial”, as annual reporting would be an ambitious undertaking.

In view of the biennial report required by the United Nations General Assembly special session on AIDS, it would be unnecessary to report to the Health Assembly every two years after the Sixty-sixth World Health Assembly. She proposed reporting in 2014 at the same time as the report to the General Assembly. Subparagraph 5(2) should therefore read: “to evaluate the outcomes and challenges in implementing the global health sector strategy on HIV, 2011–2015 and formulate the next phase of strategy through the Executive Board to the Sixty-seventh World Health Assembly in 2014”.

Ms NYANDORO (Zimbabwe) welcomed the draft strategy, and called on the Director-General to allocate adequate finance, human resources and technical assistance to Member States for the effective implementation of the strategy. Such allocation of resources should be guided by the greatest needs at regional and country levels. HIV/AIDS remained a major health challenge for Africa, especially southern Africa; WHO and the Global Fund to Fight AIDS, Tuberculosis and Malaria should provide the resources with a focus on women, children and adolescents, but she expressed concern at the reduction in the budget for HIV/AIDS at both the headquarters and regional levels. WHO had a leadership role to play in the fight against AIDS and could not afford to abrogate its responsibilities to other partners.

The strategy should be revised to identify more specifically those at risk and key populations, and the definitions should be linked to the circumstances pertaining to countries and regions.

Dr FENG Yong (China) supported the draft strategy. WHO should not only provide technical support but also play a coordinating role and provide specific tactics, such as: allocation of resources for prevention; coordination with pharmaceutical companies in various countries to lower the costs of antiviral medicines; testing of reagents; and exploring and promoting effective means of prevention and control to help countries to solve their problems with regard to prevention and treatment. His Government would refer to the draft strategy in formulating its prevention and treatment objectives and plans and work with international communities to stop the global spread of disease.

He proposed two amendments to the draft resolution. Paragraph 4 duplicated information in its two subparagraphs; he proposed removing “and implement” in subparagraph 4(1), leaving reference only to “adopt”. He endorsed the proposal by the delegate of Brazil for subparagraph 4(2), which should begin: “to implement the strategy, according to the epidemic situation and national context, ...”.

Dr ZAINAL (Brunei Darussalam) fully supported the revised draft strategy. He greatly appreciated its approach, which incorporated existing good practices, valuable evidence on the effectiveness of HIV-related approaches, interventions in the health sector, and the broad consultative process to its development. He welcomed the efforts made in aligning the draft strategy with the UNAIDS strategy for 2011–2015. The four strategic directions and core elements were tightly focused and would be of great value in guiding country level actions and in monitoring progress.

Mrs GŁAŻEWSKA (Poland) said that Poland, as Vice-Chair of the UNAIDS Programme Coordinating Board, welcomed the revised draft strategy and supported WHO’s efforts to align its strategy with that of UNAIDS. There was a need to strengthen interventions that focused on regions especially affected by the HIV/AIDS epidemic and where the number of HIV infections was on the increase, particularly eastern Europe, which was the only region where the prevalence had tripled in the past decade. She emphasized her country’s support for the participation of civil society in the fight against HIV/AIDS.

Dr CHISTYAKOVA (Russian Federation) noted that the revised draft strategy was clear and comprehensive, with defined goals, objectives and directions. In particular, she noted the attention given to the rational use of existing financial and human resources, and to increasing the effectiveness of procurement and supply. Given that so far progress had been fragile and uneven, it was important to analyse in more detail the deficiencies in the implementation of previous initiatives, especially the “3 by 5” initiative and expanding access to care. Her Government was fulfilling the obligations it took on in the Declaration of Commitment on HIV/AIDS adopted by the United Nations General Assembly and, in line with WHO recommendations and its national programmes, was expanding screening, prevention and access to care.

Some elements of the draft strategy would need further analysis and amendment, in the light of differences in culture, religion and national practices. In particular, the recommended country action on harm-reduction services (paragraph 61 of the draft strategy) should be revised to read: “A package of services should be provided that includes a complex of measures on prevention, treatment and care of people with HIV”.

She supported the draft resolution as amended by the delegates of Thailand and China.

Ms CADGE (United Kingdom of Great Britain and Northern Ireland) welcomed the revised draft strategy, emphasizing that work on HIV should continue to be grounded in evidence, for which WHO’s technical leadership was crucial. It was gratifying that, in its revision, the draft strategy had been aligned with the UNAIDS strategy for 2011–2015 and that that was reflected in the draft resolution, which she supported.

Dr DLAMINI (South Africa) congratulated the Director-General on the revised draft strategy. Her country’s HIV counselling and testing campaign had to date reached 11.9 million out of the targeted 15 million and had resulted in 1.5 million people receiving antiretroviral treatment. The Government’s budget allowed for increasing treatment coverage to two million people, reflecting the fact that the prices of antiretroviral medicines had more than halved. Further price reduction would enable even greater coverage. She supported Treatment 2.0 as the next phase towards universal access, but agreement had to be reached on the CD4⁺-cell count threshold for initiating treatment. WHO should support countries with implementation and increasing responsiveness of the health system.

The draft resolution should reflect the setting of realistic targets that were measurable. She agreed with the delegate of Thailand that the texts in paragraph 4 should be merged and reflect the national context, and with the delegate of China regarding the financial implications. A footnote should be added to subparagraph 4(2) to define vulnerable populations, while recognizing that HIV/AIDS remained a generalized heterosexual epidemic in high-burden countries. Reporting requirements (subparagraph 5(2)) should be aligned across the organizations in the United Nations system.

Ms MÅRENG (Norway) congratulated the Secretariat on its work to revise and elaborate the draft strategy, with its clear links to and complementarity with the UNAIDS strategy and definition of WHO’s specific roles and tasks. It was important for WHO to ensure sufficient capacity and resources to implement and monitor the bold and ambitious strategy. She highlighted the areas of gender and harm-reduction, stressing that WHO needed courage with regard to the latter to promote what was best for health. Norway had positive experiences with harm-reduction measures: needle-exchange programmes and low-threshold health services had resulted in only limited spread of HIV among injecting drug users. She endorsed the draft resolution as amended.

Ms KHUMALO (Swaziland) said that Swaziland had the highest HIV prevalence in the world, with 26% of the adult population infected. The pandemic was generalized in the population and not confined to certain population groups.

She urged the Secretariat to continue its leadership, giving HIV/AIDS the highest priority and ensuring allocation of adequate resources, even in times of austerity. The African Region had the highest burden and must receive support. She supported the draft resolution as amended.

Dr JUNG Sung-hoon (Republic of Korea) acknowledged the contributions of all parties that had led to the success of the “3 by 5” initiative and the 2006–2010 WHO HIV/AIDS Universal Access Plan. He welcomed the revision of the draft strategy for 2011–2015, which was clearer; it also better defined national and Secretariat actions. It was to be hoped that the strategy would produce synergy in work towards achieving both the UNAIDS strategy and the Millennium Development Goals.

His Government’s three proposed strategic directions for HIV/AIDS response were: strengthening prevention among high-risk groups; enhancing early diagnosis and compliance with antiretroviral therapy; and preventing prejudice and discrimination. It would continue to support WHO’s strategy on the response to HIV.

Dr KABUAYI (Democratic Republic of the Congo) supported the objective of WHO’s global health sector strategy on HIV, 2011–2015, namely universal access to HIV prevention, treatment and care. He thanked WHO for the consultative process and for taking into account his country’s recommendations for improving the draft text. In particular, he welcomed the strategies proposed for the effective integration of HIV/AIDS control and WHO’s commitment to mobilize further resources for implementation of the strategy.

He urged the inclusion of an indicator for the third strategic direction on building strong and sustainable systems in terms of a percentage of teaching and health-personnel training institutions that included HIV in their curricula, as his country had called for during the consultation process.

Dr DeCOCK (United States of America) commended WHO’s leadership in the response to HIV/AIDS. His Government had been pleased to have collaborated with WHO through the President’s Emergency Plan for AIDS Relief. The revised draft strategy rightly continued to emphasize the Secretariat’s role in supporting countries and reaffirmed internationally agreed commitments on HIV and alignment with the UNAIDS Strategy for 2011–2015. His Government supported its global goals and strategic directions. WHO should work closely with UNAIDS to estimate the investment needed to achieve those goals, through development and use of tools to cost national plans and work with development partners to increase efficiency in the application of development assistance funds. Costs should be based on country-specific empirical costing and cost-effectiveness data and should take into account coverage rates of current programmes.

Recognizing the pressure of budgetary constraints, he called on the Secretariat to continue to work closely with Member States and other partners in implementing the strategy so as to ensure that activities were prioritized and scarce resources used effectively. The relative strengths of different parties for implementing aspects of the strategy should be identified; WHO’s strength in HIV/AIDS lay in its convening authority, normative work and policy guidance. In view of recent scientific advances, a priority for WHO should be the provision of guidance on how best to use antiretroviral medicines for prevention as well as treatment. With regard to human rights, WHO should recognize that UNAIDS and other cosponsors were more experienced in advocacy, and better resourced for it. Efforts must be made to avoid duplication.

The draft strategy made several references to the need to foster an open competitive market for antiretroviral medicines in order to contain costs, and to the importance of voluntary mechanisms to promote access to medicines, such as voluntary licences and patent pools. The licence from the United States National Institutes of Health within the Medicines Patent Pool was an important first step but it was crucial to provide more rights holders with incentives to voluntarily explore such mechanisms on agreed terms and conditions. Meaningful and transparent engagement among all relevant stakeholders, including owners of intellectual property rights, to address public health challenges while maintaining an incentive system that promoted investment, research and innovation was critical for much-needed new HIV treatments.

He asked to see the proposed amendments in writing, and agreed on the need for achieving clarity in subparagraph 5(2) with regard to harmonizing the reporting requirements and their conclusion – possibly at the Seventieth World Health Assembly.

The meeting rose at 13:05.

NINTH MEETING

Friday, 20 May 2011, at 14:45

Chairman: Dr W. AMMAR (Lebanon)

TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Draft WHO HIV/AIDS strategy 2011–2015: Item 13.6 of the Agenda (Document A64/15) (continued)

Dr KASSEM (Jordan) said that, although HIV prevalence in his country was relatively low, Jordan contributed to international initiatives to combat HIV/AIDS. Its national HIV/AIDS plan for 2010–2015 was in line with the draft strategy, including the recommendations for at-risk populations in paragraphs 60 and 62. Efforts were also under way to prevent mother-to-child transmission of HIV. The focus of the previous five-year national plan had been to combat stigmatization of persons living with HIV/AIDS, by, for example, creating a voluntary organization to assist and educate such persons.

Professor DOKEKIAS (Congo) said that partner support had helped to reduce HIV infection rates in Africa, but more remained to be done. Having carefully examined the strategic directions set out in the draft strategy, he argued that particular emphasis needed to be placed on preventing mother-to-child transmission of HIV, and he supported the goal of eliminating that route of transmission by 2015. Efforts were needed to strengthen countries' capacity to manage long-term antiretroviral therapy through, *inter alia*, monitoring and management of drug resistance and increased access to affordable medicines, including second- and third-line therapies. He supported the draft resolution and the draft strategy, and would use both to strengthen its national plan in accordance with the country's needs and available resources.

Professor LOUKOU (Côte d'Ivoire) said that his Government had begun to implement national strategies drawn up to guide the health sector response to HIV/AIDS in 2011–2015 and which were consistent with WHO's draft strategy. His country would require continuing support from WHO in order to strengthen the capacity of its health ministry and ensure the sustainability of HIV/AIDS prevention and control activities. Expressing support for the adoption of the draft strategy, he said that the comments made by Member States during the 128th session of the Executive Board and those made by health ministers from the African Region during the present Health Assembly should be taken into account.

Mrs REITENBACH (Germany), referring to the target established in the draft strategy for reduction of tuberculosis-related mortality, said that the baseline for comparison should be 2004, not 1990, as 2004 was the year referred to in the United Nations Secretary-General's March 2011 report on the implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS.¹

¹ Uniting for universal access: towards zero new HIV infections, zero discrimination and zero AIDS-related deaths: report of the Secretary-General. United Nations, New York, 2011 (A/65/797).

Ms PATTERSON (Australia), expressing support for the draft strategy, said that her Government was especially concerned about the impact of HIV in developing countries, especially in the Asia-Pacific region. She welcomed the strategy's recognition of the need to focus on key populations who faced a higher risk of HIV transmission than the general population, endorsed the strategic directions set out in the draft strategy and applauded the integrated approach that built on HIV-specific interventions in health system strengthening. With regard to the draft resolution, she supported the amendments proposed in the previous meeting by the delegates of Brazil and the United States of America.

Dr VAN-DÚNEM (Angola), speaking on behalf of the Member States of the African Region, welcomed the draft strategy. Although the number of new HIV infections had decreased globally by 19%, the African Region still faced significant challenges in combating HIV. Sub-Saharan Africa accounted for 68% of the global prevalence of HIV infection, and women made up 60% of people living with HIV/AIDS in the subregion. The high prevalence among women was probably related to persistent gender inequalities, harmful social norms and lack of information. Of further concern was the fact that 35% of tuberculosis patients in the Region were also infected with HIV. Access to antiretroviral treatment in low- and middle-income countries had increased from 2003 to 2009, but only 35% of those in need were being treated, and alternative therapies were still not available. The implementation of the draft strategy's strategic directions, with their emphasis on universal access to prevention measures, would be a challenge.

Nevertheless, he supported the four strategic directions and requested WHO's technical support for their implementation, including support to increase domestic resources through innovative financing mechanisms. Strategic directions 2 and 3 and their respective core elements were the key to the success of the draft strategy. In the light of rising demand for and limited availability of antiretroviral agents, the strategy should advocate more forcefully lower prices for first-line medicines. Full use should be made of the flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights in order to stimulate the manufacture of generic medicines through a strong and consistent alliance between the public and private sectors. In order to achieve the draft strategy's goal of universal access to HIV prevention, treatment and care by 2015, he encouraged the Secretariat to develop a joint health system strategy for disease control to support country-led efforts in that regard.

In order to fulfil the monitoring and evaluation requirements outlined in the draft strategy, health information systems needed to be more efficient and effective, and should include a pharmacovigilance system. In view of the growing number of HIV-positive adolescents, indicators should include the percentage of youth aged 15–24 years testing positive for HIV in the previous 12 months; percentage of countries with a policy to ensure access for children to HIV prevention, care and support; adherence to treatment; and first-line and second-line HIV drug resistance. All organizations in the United Nations system should align their indicators in order to avoid burdening countries with multiple reporting requirements.

The draft strategy should reflect attainable targets, and he therefore proposed amending the reference in the draft strategy to “zero new infections, zero AIDS-related deaths and zero discrimination” to read “elimination of new infections and AIDS-related deaths” and replacing the reference in paragraph 18 to “Getting to Zero” with “Working towards Elimination”.

Mr MENESES GONZÁLEZ (Mexico) noted that the draft strategy, like other United Nations documents on the subject, continued to promote the integration of HIV/AIDS programmes and services with programmes on sexual health, reproductive health and neonatal and maternal health, among others. In countries with generalized epidemics, the integration of programmes and services might be useful, but in countries with concentrated epidemics and countries with health systems similar to his country's system, such integration might not be appropriate. Coordinating or linking HIV/AIDS strategies and programmes with other services, on the other hand, was highly advisable and was the approach that his Government favoured. He therefore suggested that references to integration in the draft strategy should be revised. For example, in paragraph 77, “support the integration of HIV

services with ...” might be changed to read “support the coordination and linkage of HIV services with ...”. He would submit a list of proposed changes.

Strategic direction 4 still contained no mention of homophobia, despite repeated requests by his Government for its inclusion. Homophobia was one of the primary forms of discrimination affecting access to HIV/AIDS services, prevention and care and as such should be mentioned explicitly. References in the Spanish version of the strategy to “people infected with HIV” should be replaced with “people living with HIV”, in line with the terminology recommended by UNAIDS, and the term “*antirretrovirico*” (antiretroviral) should be replaced with “*antirretroviral*”, which was the term most commonly used in Latin America. With regard to the draft resolution, he requested that all proposed amendments be provided in writing.

Dr SAIDE (Mozambique), expressing support for the draft resolution and strategy, said that his country had a heavy burden of HIV/AIDS, and the provision of comprehensive and integrated services through a primary health care approach was crucial to increasing the availability of and access to quality services. He asked the Secretariat to strengthen its technical support and resource mobilization for that purpose.

Mr NACEUR (Tunisia) welcomed the revised draft strategy, which would contribute to the attainment of the Millennium Development Goals. Cooperation among organizations in the United Nations system, in particular those working on AIDS, should be strengthened so as to enhance support to countries and thus ensure the success of the draft strategy. It was important to reinforce partnerships in order to improve screening for HIV and other sexually transmitted infections. Voluntary HIV screening programmes should be expanded, and screening methods should be evaluated in the light of countries’ differing needs. Poorer countries should receive support to enable them to develop and access funding for HIV/AIDS and malaria projects.

Dr COPELAND (Jamaica) said that the draft strategy demonstrated WHO’s commitment to addressing HIV/AIDS and achieving the related Millennium Development Goals.

She thanked all partners and donors that had supported her country in strengthening its health system and sustaining progress in the prevention and control of HIV/AIDS and other sexually transmitted infections. A recent evaluation of the health system response to HIV/AIDS had shown mixed results. The number of new HIV infections in infants resulting from mother-to-child transmission had decreased, coverage of antiretroviral medicines had increased and HIV/AIDS mortality had declined. The national HIV/AIDS programme had been strengthened through, inter alia, linkages with primary health care, recruitment of human resources, expansion of service delivery through a network of strategically distributed centres and strengthening of laboratory services. On the other hand, 43% of those requiring antiretroviral treatment were not receiving it, and people living with HIV/AIDS suffered discrimination. Furthermore, the uncertainty of donor funding threatened the efficiency and sustainability of the national HIV/AIDS programme. Jamaica’s classification as a middle-income country had meant a reduction in external funding, and her Government urged that the practice of withdrawing funding from countries on the basis of their development classification be reviewed. She endorsed the draft strategy, which was comprehensive and provided clear technical guidance on expanding HIV response.

Mr CONSTANT (Trinidad and Tobago) welcomed the draft strategy, which, thanks to the consultative process through which it had been formulated, would ensure a coherent global approach. It called for co-accountability between the Secretariat and Member States and recognized the need to tailor responses to national contexts. The strategy’s emphasis on national development and human rights was consonant with his Government’s holistic approach to the HIV epidemic, which took into account not only biomedical aspects but also social determinants of health, environmental factors and obstacles to progress in the fight against HIV/AIDS. The four strategic directions gave clear guidance, and the analysis of the global situation identified structural barriers, health system weaknesses and

social vulnerabilities that needed to be addressed in his country and others. He endorsed, in particular, strategic directions 3 and 4, with their focus on building effective, efficient and comprehensive health systems and on eliminating gender-based health inequalities and protecting the rights of people living with HIV and members of key populations. He supported the draft resolution.

Dr DEHNE (UNAIDS) said that the draft strategy, which had been developed in close consultation with UNAIDS, was tailored to regional and country needs; covered all activities required to achieve universal access to HIV/AIDS prevention, treatment and care; and was fully aligned with the UNAIDS Strategy 2011–2015, including the vision of zero new infections, zero deaths due to AIDS and zero stigmatization and discrimination, and he encouraged Member States to adopt and implement it. WHO's strong contribution was crucial to an effective global response to HIV, and he therefore called on Member States and the Secretariat to provide the necessary support, including resources, to enable WHO to play its mandated roles with regard to prevention, treatment and care; including implementing the Treatment 2.0 Initiative and working to eliminate infections in children, reduce HIV/tuberculosis coinfection, strengthening links between HIV programmes and other health programmes and with national health plans, and strengthening health systems. UNAIDS would support the implementation of the strategy through the new UNAIDS Unified Budget, Results and Accountability Framework.

Mr GIZAW (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, expressed firm support for the draft strategy, which underscored the need for stronger partnership, focused on reaching key populations and described a set of concrete actions to be taken by countries with WHO's support. Since the start of the HIV pandemic, the International Federation had been implementing comprehensive HIV programmes at community and household levels, seeking to empower people by providing information on prevention; providing home-based care and support; promoting adherence to antiretroviral and tuberculosis treatment regimes; implementing harm-reduction programmes for injecting drug users; reducing stigmatization and discrimination; providing psychosocial support to children orphaned by AIDS and promoting the human rights of those affected by HIV. It would continue to support governments in implementing comprehensive HIV programmes in the context of the strategy.

Dr LHOTSKA (Consumers International), speaking at the invitation of the CHAIRMAN, expressed gratitude that the importance of nutrition had received greater recognition in the revised draft strategy. However, the role of infant feeding as a key child survival strategy was still not adequately acknowledged, and the WHO Guidelines on HIV and infant feeding¹ were mentioned only in passing and not referenced in the bibliography. That oversight should be rectified. Infants should be identified in the strategy as a vulnerable risk population, and WHO should provide support to strengthen capacity at country level for skilled infant feeding counselling as an essential pre- and post-natal service. The latter would also promote breastfeeding in general populations and thus contribute significantly to the achievement of Millennium Development Goal 4.

The draft strategy highlighted WHO's role in bringing together different stakeholders and promoting the participation of industry, but did not mention its role in identifying and managing conflicts of interest. The draft strategy should offer guidance on how the Secretariat would support Member States to ensure that efforts to reduce transmission to infants in countries that opted for replacement feeding strategies would not be seized as a marketing opportunity by the baby food industry.

¹ *Guidelines on HIV and infant feeding 2010: principles and recommendations for infant feeding in the context of HIV and a summary of evidence*. Geneva, World Health Organization, 2010.

Ms N'YAMBE (Stichting Global Network of People Living with HIV), speaking at the invitation of the CHAIRMAN, encouraged Member States and the Secretariat to commit themselves to strengthening the capacity and meeting the needs of people living with HIV and to ensuring that they had universal access to HIV prevention, treatment, care and support by 2015. She welcomed the focus on human rights and equity in strategic direction 4 and the commitment to revolutionize HIV prevention in strategic direction 1. In that regard, she noted the reported evidence of benefit in the randomized trial (HPTN 052) to prevent sexual transmission of HIV in serodiscordant couples, and called on WHO to review those results and work with others to issue appropriate and timely recommendations for country action. The benefits of treatment and other health interventions could not be realized in an environment of stigmatization and marginalization. People living with HIV must be supported and helped to be active partners in their own care and the care of others. As part of its efforts to build strong and sustainable health systems, WHO should promote zero tolerance of discrimination and stigmatization and work with other organizations to eliminate HIV-related human rights violations in health care and community settings.

Ms ATHERSUCH (MSF International), speaking at the invitation of the CHAIRMAN, said that WHO had shown strong leadership in recommending earlier treatment with better medicines for people living with HIV. Scientific evidence had shown that early treatment could reduce the spread of the virus by lowering the level of virus in people's blood. Initiation of treatment at the threshold of 350 CD4⁺ cells/μl should be the norm everywhere.

At the 2011 high-level meeting of the United Nations General Assembly special session on AIDS, countries would be asked to sign a declaration of commitment for the next decade of the global AIDS response. The United Nations Secretary-General had asked governments to support a treatment target of at least 13 million people by 2015. However, some governments had refused to support a target, and the target in the latest draft declaration remained blank. Her organization believed that an ambitious treatment target was important if a credible global response was to be mounted and called for a target of 15 million.

Ever greater protection and enforcement of intellectual property rights significantly limited the availability of affordable medicines, particularly for newer treatments. Full use should be made of the flexibilities in the Agreement on Trade-related Aspects of Intellectual Property Rights in order to encourage the production of generic medicines, and mechanisms designed to reduce the price of patented medicines, such as the Medicines Patent Pool, should be supported. She called on pharmaceutical companies to enter into negotiations with the Pool. Countries should explore innovative sources of financing, in particular a financial transaction tax, in order to generate sustainable and predictable revenue to support HIV programmes.

Dr Chin-Hui YANG (Chinese Taipei) said that Chinese Taipei was carrying out many of the activities recommended under the four strategic directions outlined in the strategy. Free antiretroviral therapy had been available since 1997; harm-reduction programmes had been under way since 2005, and had halted the increase in HIV infection among injecting drug users; and free HIV screening was offered to all pregnant women, which, in combination with other measures to prevent mother-to-child transmission of HIV, was expected to eliminate paediatric HIV infection by 2015. The prevention of HIV infection, in particular through sexual transmission, remained a challenge. More effective and sustainable prevention strategies, such as the development of a vaccine, were needed, and she therefore welcomed WHO's efforts to promote the development of new prevention interventions. The implementation of effective treatment programmes in Chinese Taipei had increased the number of people living with HIV, and thus also increased treatment costs. She encouraged WHO to work with pharmaceutical companies to lower prices and improve access of HIV medicines with a view to ensuring free comprehensive treatment and high-quality care.

Dr NAKATANI (Assistant Director-General) said that the Secretariat would apply delegates' suggestions for further improvement of the draft strategy during its implementation. Responding to the comments by the delegate of Angola, he said that the vision of zero new HIV infections, zero AIDS-related deaths and zero discrimination was identical to that contained in the UNAIDS strategy, which was the HIV/AIDS strategy for the entire United Nations system. The draft WHO strategy laid out the health sector's contribution to that strategy and its vision and goals therefore needed to be the same. However, the targets and indicators for the work to be undertaken by WHO would be health-specific. Regarding the concerns expressed by the delegates of Hungary and Thailand, he affirmed that WHO was working with key partners, including UNAIDS, to harmonize and simplify indicators, and thus minimize reporting requirements for countries. The list of indicators included in the draft strategy were suggestions that countries' might or might not embrace, although most had already been agreed as indicators for the Millennium Development Goals and the Declaration of Commitment on HIV/AIDS adopted in 2001 at the special session of the General Assembly on HIV/AIDS. The baseline indicator for tuberculosis mortality would be corrected as indicated by the delegate of Germany.

Several delegates had raised concerns about the Secretariat's ability to implement the draft strategy in the current budget environment. The amount required for implementation during the biennium 2012–2013, about US\$ 221 million, could be covered by the Proposed programme budget appropriation for strategic objective 2 and other relevant objectives, and the draft strategy could be fully implemented, provided that the budget was fully funded, particularly in Africa. The Secretariat trusted that generous voluntary contributions from Member States would make that possible, and pledged to align its activities both internally among programmes and externally with those of other partners in order to make the best use of the resources.

Regarding the questions raised by the delegates of South Africa and Zimbabwe on the definition of "vulnerable populations" and "key populations", the terminology used in the draft strategy was consistent with that used by UNAIDS. Key populations included the populations considered most vulnerable and most at-risk. That broad definition allowed Member States' flexibility in identifying the most affected populations in their respective national contexts.

The CHAIRMAN suggested that an informal working group should be formed to reach consensus on the wording of the proposed amendments to the draft resolution.

It was so agreed.

Dr PÁVA (Hungary), speaking on behalf of the Member States of the European Union, supported by Dr DAULAIRE (United States of America), pointed out that the Executive Board and its various drafting groups had made an extraordinary effort to prepare the draft resolutions for consideration at the Health Assembly. Delegates should, whenever possible, refrain from reopening debate on draft resolutions on which the Board had already reached consensus, as doing so undermined the Board's authority and hindered the work of the Health Assembly. If the plan to reform WHO and strengthen its governing bodies was to succeed, Member States must take a more disciplined approach to the tabling and amendment of resolutions. If new actions were added to a draft resolution, an updated report on financial and administrative implications should be issued.

(For approval of the draft resolution, see the summary record of the eleventh meeting, section 2.)

Health system strengthening: Item 13.4 of the Agenda (Documents A64/12, A64/13 and EB128/2011/REC/1, resolutions EB128.R8, EB128.R9, EB128.R10, EB128.R11 and EB128.R12) (continued from the eighth meeting, section 2)

The CHAIRMAN invited the Committee to consider the revised draft resolution on sustainable health financing structures and universal health coverage.¹

Dr DOLEA (Assistant Secretary) said that, following informal consultations, subparagraph 1(1) had been deleted, and subparagraph 2(1) had been amended to read “to convey to the United Nations Secretary-General the importance of universal health coverage for discussion by a forthcoming session of the United Nations General Assembly”.

The draft resolution, as amended, was approved.²

Dr DOLEA (Assistant Secretary) said that, following information consultations, the draft resolution on strengthening national health emergency and disaster management capacities and resilience of health systems¹ had been amended as follows:

Subparagraph 1(2)bis should read “to facilitate access by concerned governments and other related agencies to information on types and quantities of hazardous materials stored, used or transported, in order to support effective health emergency and other disaster risk management”.

Subparagraph 1(4) should read “to establish, promote and foster regional and subregional collaboration, as well as interregional cooperation within WHO, including sharing of experience and expertise for capacity development, in risk-reduction, response and recovery”.

Subparagraph 3(5)bis should read “to consider providing, as appropriate, support to regional and subregional networks, as well as interregional cooperation within WHO, in order to strengthen their collaboration on health emergency and disaster risk management.”

The draft resolution, as amended, was approved.³

Health-related Millennium Development Goals: WHO’s role in the follow-up to the high-level plenary meeting of the sixty-fifth session of the United Nations General Assembly on the review of the Millennium Development Goals (September 2010): Item 13.3 of the Agenda (Documents A64/11, A64/11 Add.1 and EB128/2011/REC/1, resolution EB128.R1)

The CHAIRMAN drew attention to a draft resolution proposed by the delegations of Argentina, Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Plurinational State of Bolivia and Uruguay on working towards the reduction of neonatal mortality, which read:

The Sixty-fourth World Health Assembly,

PP1 Recalling Resolution WHA58.31 advocating universal coverage of maternal, newborn and child health interventions;

PP2 Recalling the launch of the **Millennium Development Goals**, with their targets for health care and human development to be met by 2015, the fourth of which commits the international community to reduce by two thirds the mortality rate among children under five between 1990 and 2015, while the fifth is to reduce maternal mortality by three quarters over the same period;

¹ See the summary record of the eighth meeting of Committee A, section 2.

² Transmitted to the Health Assembly in the Committee’s fourth report and adopted as resolution WHA64.9.

³ Transmitted to the Health Assembly in the Committee’s fourth report and adopted as resolution WHA64.10.

PP3 Recognizing the importance of the Global Strategy for Woman's and Children's Health launched in September 2010 by the Secretary-General of the United Nations and acknowledging the report of the Commission on Information and Accountability for Women's and Children's Health;

PP4 Recalling the **Partnership for Maternal, Newborn and Child Health**, which reflects the growing international interest in and attention to this issue, and whose objective is to coordinate and intensify national, regional and global activities along the continuum of care for maternal and child health to achieve the Millennium Development Goals;

PP5 Taking into account the request by Member States to implement the WHO Regional Strategies;

PP6 Aware that WHO Member States have undertaken a number of actions and programmes to reduce neonatal morbidity and mortality and meet the targets set out by the MDGs, developing their respective *National Plans for the Accelerated Reduction of Maternal and Child Mortality*, to improve access, timeliness, continuity and quality of health care for women of childbearing age and newborns;

PP7 Noting the conclusion of the World Health Assembly that there has been insufficient progress towards achieving MDG 5, and that, while MDG 4 has progressed in the reduction of post-neonatal mortality, it has stagnated in relation to the reduction of neonatal mortality;

PP8 Concerned by the limited resources for disease prevention and treatment of newborns in developing countries, which contribute to high neonatal mortality rates;

PP9 Recognizing that neonatal mortality is a significant social and economic burden that seriously affects countries and in particular developing countries, that rates should be reduced both by preventing the most common problems such as prematurity, sepsis and respiratory conditions, and also by implementing basic, high-impact and low-cost interventions founded on solid scientific evidence;

PP10 Aware that meeting the targets of MDG 4 and 5 will require intense efforts,

1. URGES Member States:

(1) to ensure that health authorities in countries with high neonatal mortality rates use their stewardship and leadership to involve other institutions and sectors, to strengthen capacity to achieve a greater reduction in avoidable neonatal and perinatal mortality in the context of improving the continuum of maternal and child health;

(2) to further promote political will to apply existing regional and/or global plans and implement evidence-based strategies and interventions to improve neonatal health;

(3) to advance neonatal care as a priority and develop, as appropriate, plans based on effective interventions, including information and awareness raising;

(4) to strengthen the neonatal mortality surveillance system including data and vital statistics collection as well as monitoring and reporting;

2. REQUESTS the Director-General:

(1) to continue to raise awareness within the international community about the global burden of neonatal mortality and promote, based on current best practices, targeted plans to increase access to high quality and safe health services to prevent and treat neonatal conditions within an integrated mother and child health package;

(2) to strengthen regional and country level institutional capacity and human resources (including skilled birth attendance and essential newborn care) to identify innovative solutions, and promote research to address the main causes of neonatal mortality such as prematurity, sepsis, respiratory conditions and infections, in particular of nosocomial origin;

(3) to support coordination of actions with WHO bodies and other stakeholders and strengthen or build partnerships to promote intra and interregional collaboration in order to enhance effectiveness of action in this specific area;

(4) to provide Member States with the necessary assistance and technical advice to develop and implement national policies, plans and strategies for the prevention and reduction of perinatal and neonatal mortality, and related maternal morbidity and mortality.

The financial and administrative implications for the Secretariat of the adoption of the resolution were as follows:

1. Resolution Working towards the reduction of neonatal mortality	
2. Linkage to programme budget	
Strategic objective: 4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals.	Organization-wide expected result: 4.1 Support provided to Member States to formulate a comprehensive policy, plan and strategy for scaling up towards universal access to effective interventions in collaboration with other programmes, paying attention to reducing gender inequality and health inequities, providing a continuum of care throughout the life course, integrating service delivery across different levels of the health system and strengthening coordination with civil society and the private sector. 4.3 Guidelines, approaches and tools for improving maternal care applied at the country level, including technical support provided to Member States for intensified action to ensure skilled care for every pregnant woman and every newborn, through childbirth and the postpartum and postnatal periods, particularly for poor and disadvantaged populations, with progress monitored. 4.4 Guidelines, approaches and tools for improving neonatal survival and health applied at country level, with technical support provided to Member States for intensified action towards universal coverage, effective interventions and monitoring of progress.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
The resolution links with indicators 4.1.1, 4.3.1 and 4.4.1; the targets for those indicators will measure progress in the implementation of the resolution.	
3. Budgetary implications	
(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).	
It is estimated that implementation of the resolution will cover the five-year period 2011–2015. The estimated cost of implementation over this period at headquarters and in regional and country offices is US\$ 95.1 million.	

(b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).

The estimated cost for the Secretariat at all levels during the remainder of the biennium would be US\$ 9 510 000.

(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?

Yes.

4. Financial implications

How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?

Existing extrabudgetary sources are not sufficient to support all these costs. It is estimated that US\$ 500 000 of additional funds will be needed. The Secretariat will seek to identify sufficient additional sources of funding to ensure that the resolution can be implemented.

5. Administrative implications

(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant).

Implementation in all regions and countries.

(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.

No.

(c) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile).

Seven additional full-time equivalent staff members will be required – one at grade P.5 at headquarters and one at grade P.4 in each of the regions – to ensure the support for the implementation of the resolution in the regions.

(d) Time frames (indicate broad time frames for implementation of activities).

2011–2015.

The CHAIRMAN said that Algeria, Angola, Bangladesh, Costa Rica, Cuba, Democratic Republic of the Congo, El Salvador, Ghana, Guatemala, Honduras, Mexico, Mozambique, Nicaragua, Panama, Senegal and Trinidad and Tobago wished to sponsor the draft resolution.

Dr KÖKÉNY (representative of the Executive Board), introducing the item, said that the Executive Board had considered an earlier version of the report on the health-related Millennium Development Goals during its 128th session, and had noted that serious effort was needed if Millennium Development Goals 4, 5 and 6 were to be achieved by 2015.¹ The Board had welcomed the United Nations Secretary-General's Global Strategy for Women's and Children's Health and the establishment of the Commission on Information and Accountability for Women's and Children's Health, and had noted the request to WHO by the United Nations Secretary-General to lead the process of determining the most effective institutional arrangements for global reporting, oversight and accountability on women's and children's health. The Board had adopted resolution EB128.R1, which recommended that the Health Assembly adopt a resolution requesting the Director-General to

¹ See document EB128/2011/REC/2, summary record of the third meeting.

ensure the effective engagement of all key stakeholders in the work of the Commission, and to report to the current Health Assembly on the progress of the Commission's work in relation to the Millennium Development Goals.

Dr FRANCO GAME (Ecuador), introducing the draft resolution on working towards the reduction of neonatal mortality, said that it had been drafted by the health ministers of the member countries of the Union of South American Nations and endorsed by the Group of the Americas. She noted that, although infant mortality had decreased significantly, death rates among neonates remained relatively high. Neonatal mortality had a significant impact in countries all over the world and created a heavy social and economic burden. Action was needed to reduce it quickly through low-cost, high-impact evidence-based interventions. The draft resolution aimed to draw attention to the need to take such action immediately, and to ensure a global commitment to reduce neonatal mortality.

Dr GOPEE (Mauritius), speaking on behalf of the Member States of the African Region, said that most of the countries had made insufficient progress towards the Millennium Development Goals, owing to conflict, poor governance, humanitarian and economic crises and lack of resources. Well-structured comprehensive and affordable community-based primary health care services were still not universally accessible. Women's health remained a critical concern, essential medicines and technologies were not yet affordable to the poor and significant health inequalities, which were masked by regional and national averages, persisted. In addition, many countries were grappling with a double burden of communicable and noncommunicable diseases.

In order to attain the Millennium Development Goals, several challenges needed to be addressed. Resources were not always well used, and external resources were often unpredictable, unsustainable and not aligned with national priorities. Health systems remained weak, and access to quality health services was limited. Human resources for health were insufficient. Health remained a low priority in many national economic and development policies, and multisectoral action aimed at achieving the Millennium Development Goals was not common.

With only four years left to attain those Goals, action was urgently needed to promote research so as to learn from the success and failure of national interventions; to improve coordination of national health strategies, policies and plans; and to undertake interventions that would enhance growth and prosperity, including ensuring access to potable water, boosting agricultural production, investing in health and education and expanding opportunities for women and girls. Concerning the latter, he called on Member States to implement the recommendations of the Commission on Information and Accountability for Women's and Children's Health in order to make further progress towards Goals 4 and 5. In addition, structures and mechanisms for sustainable, effective and efficient mobilization and utilization of internal and external resources should be strengthened, and donor pledges must be fulfilled. Member States should consider increasing their total health budgets, in line with the recommendations of the Abuja Declaration of 2001. Furthermore, the emphasis on noncommunicable diseases, though justified, should not detract attention from achieving the Goals. It would be important to prioritize areas where progress had been limited, in particular maternal health and action to address social and economic determinants of health. Health ministries should strengthen their leadership and institutional capacity, especially in strategic planning and evidence-based policy formulation. Finally, international partnerships should be enhanced in order to sustain past gains and prevent setbacks.

Dr BELAYNEH (Ethiopia) welcomed WHO's role in respect of the Commission on Information and Accountability for Women's and Children's Health and suggested that the work and report of the Commission should include monitoring of health system performance, as maternal and child health depended on a well-functioning health system. It should also take account of gender issues. She supported the draft resolution.

Mr QUINTANILLA (Cuba) said that much remained to be done in order to achieve the health-related Millennium Development Goals by 2015. Many Latin American countries had made significant progress as a result of far-reaching social policies and political commitment. Those successes however, could not be attributed to international support from developed countries, which had been almost non-existent, or to changes in the global economic order, which continued to favour rich countries. The international community must acknowledge the current global reality. A new international economic and political order – one based on the principles of solidarity, social justice, equality and respect for human rights – was needed in order to ensure human survival.

His country had succeeded in achieving nearly all the Millennium Development Goals, thanks to policies that had prioritized well-being, equality and social justice. Those successes had been achieved despite the long-standing economic, trade and financial embargo imposed on the Cuban people by the United States of America, one recent effect of which had been the freezing of funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria for three projects in Cuba. His country was one of a few in Latin America that had managed to decrease rates of low weight-for-age in children under the age of five years. Its infant mortality rate was 4.5 per 1000 live births; 99.9% of live births occurred in health centres and were attended by skilled health personnel; and the maternal mortality ratio was 46.5 per 100 000 live births, one of the lowest in Latin America. Since 2004, 95.6% of the population had had access to safe drinking-water, and 95% had solid waste services.

He welcomed WHO's participation in the preparation of and follow-up to the United Nations High-Level Plenary Meeting on the Millennium Development Goals, and he supported the draft resolution on neonatal mortality.

Dr AYDINLI (Turkey) said that strong political commitment and multisectoral cooperation were crucial to securing the economic and financial stability and the sustainability needed to achieve the health-related Millennium Development Goals. Turkey had made significant reductions in maternal and child mortality as a result of structural reforms carried out under its Health Transformation Programme, which demonstrated that rapid progress could be made by implementing a systematic reform programme with strong institutional commitment and which could serve as a model to others in the global health community.

Dr MUKONKA (Zambia) said that achieving the health-related Millennium Development Goals was essential in order to improve the lives of people in the African Region, where morbidity and mortality rates were especially high. Zambia had significantly reduced maternal and child mortality, as well as stunting in children under the age of five years. It had also made great progress in combating malaria, tuberculosis and, as a result of extensive antiretroviral therapy and prevention of mother-to-child transmission programmes, HIV/AIDS. But much more must be done to overcome the obstacles to achieving Goals 4 and 5. It was to be hoped that the commitments made within the framework of the United Nations Secretary-General's Global Strategy for Women's and Children's Health to target the 25 lowest-income countries with a heavy burden of mortality would yield tangible results. The importance of ensuring accountability for resource commitments and for results could not be overemphasized.

He supported the draft resolution contained in resolution EB128.R1. With respect to the draft resolution on neonatal mortality, the issue would be best tackled within the broader framework of a continuum-of-care approach and he suggested that the draft resolution should be recast accordingly.

Ms NYANDORO (Zimbabwe) said that Zimbabwe needed greater technical and financial support from WHO and other United Nations bodies if it were to sustain its modest progress towards the health-related Millennium Development Goal targets. The 5.5% annual decline in maternal mortality, for example, would not be met without addressing the challenges in the area of sexual and reproductive health, including increasing access to quality care, strengthening the health workforce, especially midwifery services, and reducing the unmet need for family planning within integrated reproductive health services.

Dr ABHE (Côte d'Ivoire) noted the findings presented in document A64/11, especially the global trends in the areas of undernutrition in children under the age of five years, child mortality, measles immunization coverage, maternal mortality, and malaria cases and deaths. Her delegation welcomed the Global Strategy for Women's and Children's Health and the establishment of the Commission on Information and Accountability for Women's and Children's Health and supported the adoption of the draft resolution contained in resolution EB128.R1.

Dr AL-NAMANI (Yemen), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that natural and man-made disasters had had a major impact on health and development, especially in low-income countries. The recent popular uprisings in the Region had also had health repercussions. Appropriate decision-making was crucial to strengthening democracy and achieving the equity and social justice that would pave the way for attainment of the Millennium Development Goals. Several countries in the Region had achieved notable progress in reducing child mortality, thanks, inter alia, to major initiatives to expand measles vaccination coverage. Yet maternal and newborn mortality in remote areas remained high, largely because of inequitable access to health care services.

More must be done in the Region to prevent and control malaria, which, despite a decline in new cases, remained endemic; to reduce HIV infection, especially in children, through the use of antiretroviral therapy; and to reduce the tuberculosis disease burden. WHO should redouble its efforts to improve the health of poor populations and ensure a more equitable distribution of resources in order to support countries in attaining the health-related Millennium Development Goals. To that end, measures were needed to strengthen primary health care and vaccination programmes; to bring national policies into line with the Goals; to improve information systems; and to promote gender equality and protect the human rights of women so as to increase the chances of achieving social development. The success of such efforts depended on the participation of civil society and the mobilization of both domestic resources and support from international partners. The countries of the Region stood ready to continue working with other Member States to accelerate progress towards the health-related Millennium Development Goals.

Dr LASKAR (Bangladesh) noted that the international community had acknowledged his country's efforts to achieve Goal 4 by presenting Bangladesh with a 2010 Millennium Development Goals Award. The importance that his Government attached to that Goal was reflected in its sponsorship of the draft resolution on neonatal mortality. Greater attention must be paid to the prevention of childhood diseases, especially pneumonia; to mobilizing resources for women's and children's health; to innovative mechanisms and interventions for the treatment of neglected diseases; and to improving record-keeping, disease surveillance, information exchange and health intelligence from multiple sources, including the private sector.

Mr BLAIS (Canada) stressed the importance that his country attached to the Commission on Information and Accountability for Women's and Children's Health. It had been co-chaired by the Prime Minister of Canada and its mandate had formed the core of the G8 Muskoka (Canada) Initiative on maternal, newborn and child health. In view of the fact that the Commission had already completed its work before the resolution contained in resolution EB128.R1 had been drafted, he maintained that some amendments were in order.

First, a new paragraph should be inserted at the end of the preamble, reading: "Welcoming the final report of the Commission and its set of recommendations for strengthening accountability for resources and results in women and children's health". That should be followed by a new operative paragraph 1, reading: "REQUESTS the Executive Board to hold a discussion at its 130th session in January 2012 on the implementation of the recommendations of the Commission". Furthermore, the words "follow-up to" should be inserted into existing subparagraph 1(1), after "stakeholders in the"; and the first line of subparagraph 1(2) should be amended to read: "to report to the Sixty-fifth World Health Assembly on progress achieved in ...". Those proposed amendments had already been

submitted in writing to the various regional groups and had thus far received the support of the Member States of the Region of the Americas, as well as Lebanon and South Africa.

The Commission had decided that the word “accountability” should be translated into French as “*redevabilité*” as opposed to “*responsabilisation*”, and he asked the Secretariat to make the necessary changes to the French version of the draft resolution, and to ensure that that decision was reflected in the translation of any subsequent texts on the subject.

Ms MÅRENG (Norway) said that her Government had redoubled its efforts to improve women’s and children’s health through the United Nations General-Secretary’s Global Strategy for Women’s and Children’s Health. Norway welcomed WHO’s leadership in the Commission on Information and Accountability for Women’s and Children’s Health, and pledged financial support for the implementation of its recommendations, which it encouraged other Member States also to support. WHO had a crucial role to play in ensuring that countries fulfilled their commitments, and its partnership with other relevant bodies in the United Nations system and partners would help to advance matters. She strongly supported the draft resolution contained in resolution EB128.R1, as amended by the delegate of Canada.

Dr DAULAIRE (United States of America) said that his Government regarded the Millennium Development Goals as a global commitment to promoting global development, eradicating poverty and extending opportunity to all, and that it was committed to maintaining and accelerating momentum in order to meet the targets. He welcomed the reported encouraging progress in many developing countries in areas such as undernutrition and child mortality, but several large barriers remained, notably that of mobilizing sufficient funding. His Government had allocated US\$ 8000 million to support work on the Goals – particularly in the area of health system strengthening – and urged other Member States to step up their support.

He shared the concern expressed by the delegate of Ecuador about the failure globally to reduce maternal and neonatal mortality, and continued to support a comprehensive women-centred approach of the kind advocated under the Global Strategy for Women’s and Children’s Health. He endorsed the draft resolution on neonatal health and was encouraged by WHO’s activities to reduce child mortality through the expansion of programmes for children under five years of age in developing countries and by the large number of Member States introducing pneumococcal conjugate vaccines and implementing more extensive interventions for the control of pneumonia and diarrhoeal diseases.

Turning to the draft resolution recommended in resolution EB128.R1, he endorsed the amendments proposed by the delegate of Canada and suggested inserting the words “regarding health” after “international development cooperation” in the fourth preambular paragraph; adding the words “in addressing health issues” to the end of the seventh preambular paragraph; and changing the word “aspects” to “concerns” in the tenth preambular paragraph.

He expressed regret at the unfounded accusation by the delegate of Cuba that his Government had blocked its funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria. His country was a major contributor to the Fund and had never blocked any grant approved by the Fund. It was unfortunate when a delegate of a Member State made false statements for purely political reasons.

Ms ZHANG Xiaobo (China) supported the draft resolution contained in resolution EB128.R1. The report revealed that progress towards the health-related Millennium Development Goals had been variable and pointed to the need for increased support from the international community to enable developing countries to achieve the Goals. China called on the Secretariat to formulate targeted programmes to provide such countries with greater financial and technical support for health system strengthening. In view of the report’s finding that pneumonia was a leading cause of child mortality, the Secretariat should do more to encourage the pharmaceutical companies holding intellectual property rights to pneumococcal vaccines to transfer those rights and vaccine-production technologies in order to reduce the price of the vaccine – something that must occur before countries could consider introducing the pneumococcal vaccine into national immunization programmes.

WHO should assume a lead role in promoting the implementation of the Global Strategy for Women's and Children's Health. During the High-level Plenary Meeting of the General Assembly on the Millennium Development Goals some US\$ 40 000 million had been pledged for implementation of the Strategy. She urged the donor countries to honour those commitments, which would go a long way towards bridging the financial gap preventing developing countries from achieving the Goals. WHO should also consider what should be done and what institutions should be put in place to promote the sustainable development of global health beyond the 2015 target date.

Endorsing the draft resolution on neonatal mortality, she suggested inserting the words "including the Baby-friendly Hospital Initiative" after "interventions" in subparagraph 1(2), and the words "and the Baby-friendly Hospital Initiative" after "newborn care" in subparagraph 2(2).

Dr CHISTYAKOVA (Russian Federation) noted the positive trends highlighted in the report with respect to reductions in maternal and child mortality, which had been the result of international initiatives to strengthen health systems, especially in developing countries. Progress in maternal and child health, however, remained slow in resource-constrained countries. All countries should continue working to strengthen and improve their health systems in order to accelerate progress towards the Millennium Development Goals. The Russian Federation was participating in international cooperation to implement the G8 Muskoka Initiative on maternal, newborn and child health by providing training at Russian paediatric clinics for health workers from countries where mortality rates were high and helping to promote telemedicine and other electronic means for promoting consultation and methodological support. More than 30 measures were covered in a five-year plan, which would start later in 2011 with a forum in Moscow. Her Government would continue to support international efforts to achieve the health-related Goals and supported the draft resolution contained in resolution EB128.R1, but needed time for further consideration in the light of the proposed amendments.

Dr HWOAL (Iraq) stressed the importance of social development in order to achieve the Millennium Development Goals. Their attainment called for partnership and accountability among all concerned, intra- and inter-regional exchange mechanisms, quality of governance, the participation of civil society, and health system strengthening, with a particular emphasis on primary and family health care services. Efforts to achieve the Goals must also take into account the everyday lives of the population and must involve every level of government. It was also important to address the problem of noncommunicable diseases, which was crucial to reducing morbidity and mortality. As part of his Government's pursuit of the Millennium Development Goals, it had added another goal at the national level, namely that of protecting human rights and promoting human security, without which the other Goals could not be achieved.

Dr PÁVA (Hungary) spoke on behalf of the European Union. The candidate countries Turkey, Croatia, The former Yugoslav Republic of Macedonia, Montenegro, Iceland, the countries of the Stabilisation and Association Process and potential candidate Serbia, as well as Ukraine, the Republic of Moldova and Armenia aligned themselves with her statement. The European Union noted with satisfaction the work of the Secretariat since assuming its crucial role in monitoring progress towards the health-related Millennium Development Goals pursuant to resolution WHA61.18; that work should include a comprehensive annual review of successes and gaps. With just four years remaining before 2015, greater efforts were needed to achieve some of the targets, especially those relating to maternal and child mortality. Commitment and collaboration among global stakeholders was vital.

Support must continue for health system strengthening with a view to ensuring universal coverage and the delivery of basic quality care through a holistic, human rights-based approach, as set out in the European Commission's statement on the European Union's role in global health.¹ The European Union was committed to providing sufficient financial and political support for that and

¹ COM(2010)128, http://ec.europa.eu/development/icenter/repository/COMM_PDF_COM_2010_0128_EN.PDF.

other goals – including meeting its commitment to reach the official development assistance target of 0.7% of gross national income by 2015 – in line with the Paris Declaration on Aid Effectiveness, the Accra Agenda for Action and the International Health Partnership and related initiatives. Nevertheless, the Millennium Development Goals would only be achieved if developed and developing countries genuinely worked together and in close cooperation with all stakeholders.

Welcoming the report and recommendations of the Commission on Information and Accountability for Women's and Children's Health, she expressed support for the draft resolution contained in resolution EB128.R1 and endorsed the amendments proposed by the delegate of Canada. As for the draft resolution on neonatal mortality, she requested time for further consideration.

Dr AL-JALAHMA (Bahrain) said that the report was a good indicator of progress towards the health-related Millennium Development Goals but did not cover the main challenges, namely the increasing burden of noncommunicable diseases and environmental, demographic and behavioural changes that were undermining progress towards the Goals and which must be addressed in order to reduce poverty substantially. Health systems had to be able to respond to those changes, and they therefore needed to be strengthened and universal access to primary health care ensured.

Bahrain had made good progress towards achieving the health-related Millennium Development Goals, with significant reductions in neonatal and under-five child mortality and in the prevalence of tuberculosis and HIV/AIDS. Malaria had been eradicated for some time.

She supported the draft resolution contained in resolution EB128.R1.

Dr TAKEI (Japan) supported the United Nations Secretary-General's Global Strategy for Women's and Children's Health and the draft resolution in resolution EB128.R1, as amended by the delegate of Canada. He was keenly aware of the need to monitor resources and results during implementation of the Global Strategy. It furthermore endorsed the final report of the Commission on Information and Accountability for Women's and Children's Health, and stressed the importance of the accountability framework. Japan's global health policy included a clear goal to reduce maternal, neonatal and child mortality by ensuring sustainable health system strengthening in cooperation with other development partners. Future action to accelerate progress towards achieving the Millennium Development Goals would be discussed with partners and international organizations at a ministerial-level meeting to be hosted by his Government in June 2011.

Dr JUMA (United Republic of Tanzania) supported the draft resolution contained in resolution EB128.R1, with the amendments proposed by the delegate of Canada, and welcomed the final report and recommendations of the Commission on Information and Accountability for Women's and Children's Health. Their implementation would help to accelerate progress towards Millennium Development Goals 4 and 5, and he requested that the Executive Board further discuss the matter.

Dr AL HAMAD (Kuwait) endorsed the amendments proposed by the delegate of China to the draft resolution contained in EB128.R1.

Mr DA CRUZ (Luxembourg), noting the findings presented in the report in relation to maternal and child mortality, said that success in meeting the health-related Millennium Development Goals by 2015 would hinge on progress in meeting the other Goals, such as improving access to safe drinking-water and reducing poverty and hunger. Yet the number of people in the world suffering from hunger and malnutrition had actually grown, and the situation looked set to worsen as a result of continuing food crises. He therefore welcomed the pledges of US\$ 40 000 million made at the United Nations High-level Plenary Meeting on the Millennium Development Goals. The Health Assembly must continue examining progress towards the Goals each year, in accordance with resolution WHA63.15, and the reports prepared by the Secretariat for that purpose should include information on the extent to which financial commitments had been honoured.

Dr WALAIPORN PATCHARANARUMOL (Thailand) supported the draft resolution contained in resolution EB128.R1 as amended by the delegate of Canada. She suggested deleting the ninth preambular paragraph as there was no need to reiterate the objectives of the Commission on Information and Accountability for Women's and Children's Health. She furthermore suggested adding a new paragraph 1, reading: "URGES Member States to implement the recommendations provided by the Commission on Information and Accountability for Women's and Children's Health to improve the accountability of results and resources".

Concerning the draft resolution on neonatal mortality, the seventh preambular paragraph should be amended to read: "... that there has been insufficient and uneven progress towards achieving MDG 5 and an increase in the maternal mortality ratio in a number of countries, and that, while MDG 4 ..."; a new paragraph should be added after the ninth preambular paragraph, reading: "Recognizing that universal access to cost-effective neonatal survival interventions, through the application of outreach, family-community and facility-based clinical services, averts a huge proportion of neonatal deaths worldwide"; and the tenth preambular paragraph should be amended to read: "... will require intense health and intersectoral efforts with a high level of political commitments". Subparagraph 1(2) should be amended to read: "to further promote political commitment for effective implementation of the existing regional and/or global plans with the application of evidence-based strategies ..."; and the words "based on effective" in subparagraph 1(3) should be deleted and replaced with "for universal access to cost-effective".

Dr BRENNEN (Bahamas), expressing support for the draft resolution contained in resolution EB128.R1, said that his country had managed to reduce maternal and child mortality and undernutrition in children under the age of five years; at the same time, however, the numbers of young children who were overweight or obese had increased considerably, which was cause for concern. Fewer children were dying from vaccine-preventable illnesses thanks to an extensive immunization programme, but pneumonia and diarrhoeal diseases remained significant causes of morbidity and mortality. The Bahamas hoped to reduce mortality from respiratory diseases in under-five-year-old children through the introduction of the pneumococcal conjugate vaccine. There was an urgent need to improve vaccine availability to countries eligible for support from the GAVI Alliance and to support developing countries that were not eligible and could not afford to vaccinate their populations.

Technological advances had helped to reduce the number of premature births and to increase newborn survival rates, yet respiratory and other conditions associated with the perinatal period continued to account for a good share of mortality in children under one year of age. All high-risk births in the Bahamas were attended by skilled health workers, as a result of which maternal mortality had declined to fewer than five deaths per year. The Governments of countries in the Caribbean had concerns about the method used to calculate the maternal mortality ratio, in particular the use of a denominator of 100 000 live births, which was too large given the small size of their populations and tended to yield overestimates of maternal mortality, making comparison with larger countries difficult. Small countries could often report actual numbers, which might reflect the situation more accurately.

His Government, with the cooperation of international partners, had fulfilled its commitment to provide all pregnant women, infants and children with antiretroviral therapy for the prevention of mother-to-child transmission of HIV, thereby decreasing HIV infections in children under five years of age and increasing the survival rate among those already infected. Access to drinking-water had been improved. Although malaria was not a significant problem in the Bahamas, it was endemic in other Caribbean countries and continued vigilance was needed in order to prevent its introduction or reintroduction in malaria-free areas. New cases of tuberculosis continued to decrease annually, thanks largely to the work of the national tuberculosis control programme, which worked in partnership with the HIV/AIDS programme and was an example of the progress that could be achieved through such partnerships in increasing access for marginalized populations and identifying at-risk populations.

The Bahamas supported the objectives of the Commission on Information and Accountability for Women's and Children's Health and applauded attempts to minimize reporting burdens while acknowledging the challenges of data generation and sharing in many countries.

Mr DESIRAJU (India) supported the draft resolution contained in resolution EB128.R1 and endorsed the amendments proposed by the delegates of Canada and Thailand. He also supported the draft resolution on neonatal mortality, with the amendments proposed by the delegates of China and Thailand. Regarding the latter resolution, he suggested adding a new paragraph after the eighth preambular paragraph, reading: "Recognizing the evidence that early and exclusive breastfeeding significantly prevents neonatal mortality".

Ms TOLSTOÏ (France) said that her country regarded maternal and child health as a global health priority. Progress had been made in many parts of the world but much remained to be done. At the G8 summit in Muskoka (Canada), France had pledged € 500 million in bilateral and multilateral aid for the period 2011–2015 in order to accelerate progress towards Millennium Development Goals 4 and 5. The main beneficiaries would be the least developed countries of sub-Saharan Africa, Afghanistan and Haiti. France would, within the framework of its presidency of the G8, attach great importance to following up on the commitments made by the G8 countries.

Efforts to improve maternal health called for action on several fronts, such as reproductive health and family planning, the training of skilled health workers, health system strengthening, and promoting respect for women's rights. Experience in the fight against HIV/AIDS had shown what could be achieved with sufficient political will. It was to be hoped that Member States would give women and children the attention they deserved in their national health programmes.

Ms CADGE (United Kingdom of Great Britain and Northern Ireland) welcomed the amendments proposed by the delegate of Canada to the draft resolution in resolution EB128.R1. The United Kingdom strongly supported the work of the Commission on Information and Accountability for Women's and Children's Health, whose recommendations in its final report could provide a strong framework for accelerating and monitoring action on Millennium Development Goals 4 and 5. Welcoming the draft resolution on neonatal mortality, which was in keeping with the United Kingdom's recently launched framework for promoting reproductive, maternal and newborn health, she suggested inserting the word "equitable" after "improve" at the beginning of the fourth line of the sixth preambular paragraph. In subparagraph 1(2), the word "national" should be inserted after "existing", and "and increase access to quality maternal, newborn and child health services" should be added after "neonatal health" at the end of that subparagraph. The phrase "skilled birth attendance, early postnatal care and early and exclusive breastfeeding" should be added at the end of subparagraph 1(3); the word "mechanisms" should be added at the end of subparagraph 1(4); and "United Nations agencies and" should be inserted before "stakeholders" in subparagraph 2(3).

Dr WAMAE (Kenya) said that, although Kenya had made significant progress in controlling HIV/AIDS, malaria and tuberculosis and in reducing child mortality, maternal and neonatal mortality rates had continued to rise, and the country was not on track to meet Millennium Development Goals 4 and 5. Nearly all pregnant women received some antenatal care, but less than half all births were attended by skilled health workers and the unmet need for family planning remained high. The country's success in tuberculosis control was threatened by an increase in cases of multidrug-resistant and extensively drug-resistant tuberculosis. It currently lacked the funding needed to provide all patients with drug-resistant tuberculosis with the highly expensive treatment, and she urged WHO to continue pressing for a reduction in the price. Kenya's efforts to achieve the health-related Millennium Development Goals were hindered by weak health systems and a lack of financial resources, and she therefore appealed to WHO and other partners to support her country's efforts to rectify the situation. She supported the draft resolution contained in resolution EB128.R1.

Dr ISSA MOUSSA (Niger) proposed three amendments to the draft resolution on neonatal mortality: “reduction of post-neonatal mortality” in the seventh preambular paragraph should be replaced with “reduction of mortality during the neonatal period” as the resolution concerned the neonatal period, not the post-neonatal period; the words “awareness raising” in subparagraph 1(3) should be replaced with “communication”; and, in order to reflect the fact that the United Nations had yet to adopt the report of the Commission on Information and Accountability for Women’s and Children’s Health, a new subparagraph 2(5) should be inserted, to read: “to ensure a successful outcome for the report of the Commission on Information and Accountability for Women’s and Children’s Health and the implementation of the recommendations contained therein”.

The report (document A64/11) should have contained specific data on infant mortality in addition to the information on child mortality contained in paragraph 4 and greater emphasis should have been placed on the need to do much more in order to meet Goal 4, particularly in developing countries. It should have dwelt more on the problem of diarrhoeal diseases and the introduction by numerous countries of the rotavirus vaccine. He indicated that Niger should be added to the list of countries preparing to introduce the 13-valent pneumococcal vaccine in 2011 with support from the GAVI Alliance.

Dr LEWIS FULLER (Jamaica) said that, although not all targets were being met, the Millennium Development Goals had nevertheless provided a catalyst for action to improve the health of populations. The global recession had had a negative impact on her country’s efforts to achieve the Millennium Development Goals, and although undernutrition and mortality among children under five years of age had declined, the rate of decline fell short of the targets, and there had been no significant reduction in maternal mortality. The high cost of vaccines such as the pneumococcal vaccine was also hindering Jamaica’s efforts to meet the child mortality target.

Prematurity accounted for a large proportion of neonatal deaths in Jamaica. Technological advances might make it possible to save some premature infants, but if they survived into childhood many would have disabilities and poor quality of life. It was therefore vital to focus on prevention. Accordingly, she proposed the addition of a new paragraph after the third preambular paragraph of the draft resolution on neonatal mortality, which would read: “Recognizing that adequate antenatal care reduces the risks of maternal mortality, prematurity and other poor related outcomes that will increase the challenges of taking care of very young neonates”.

Mr MANDABA (Central African Republic) said that, since 2000, his country had, with the support of its development partners, made sustained efforts to implement the programmes needed in order to achieve the Millennium Development Goals, in spite of its difficult circumstances. Infant and maternal mortality had fallen, and the prevalence of HIV/AIDS and tuberculosis had decreased substantially in recent years. However, the country still faced enormous challenges, notably technical weaknesses and shortages of human resources. It would continue to need support from WHO and other partners if it were to achieve the Goals by 2015.

Dr FRANCO GAME (Ecuador) proposed amending the second preambular paragraph of the draft resolution on neonatal mortality to read: “Recalling Millennium Development Goals 4 and 5, with their targets to reduce, between 1990 and 2015, under-five mortality by two-thirds and maternal mortality by three-quarters”.

Mr QUINTANILLA (Cuba), speaking in exercise of the right of reply in accordance with Rule 57 of the Rules of Procedure of the World Health Assembly, said that he rejected the claim by the delegate of the United States of America that his Government had not frozen the funding that the Global Fund to Fight AIDS, Tuberculosis and Malaria had approved for projects in Cuba. It was a fact that the three projects had not been implemented because the United States had frozen the funds, and had only agreed to release them after intensive negotiations involving the Global Fund itself. Cuba had

raised the issue during the most recent meeting of the Board of the Global Fund and could document its claim.

His earlier comments had not been politically motivated; they had been intended to call attention to the rights of the Cuban people, and particularly their right to health, which was seriously undermined by the embargo. The United States should lift the embargo immediately, and it should also guarantee the right to health of more than 40 million of its own citizens who lacked health insurance and therefore lacked access to health care.

Dr DAULAIRE (United States of America), speaking in exercise of the right of reply, and observing that the Health Assembly was not the place for such polemics, said that he wished to confirm that, as a member of the Board of the Global Fund, his Government had voted to approve the grants for Cuba.

Mr QUINTANILLA (Cuba), speaking again in exercise of the right of reply, reiterated that he rejected the claims of the delegate of the United States of America. The United States Government had only released the funds for the three projects approved by the Global Fund a few days earlier, and only after intensive negotiations. There was no guarantee that the same situation would not occur again in the future. His delegation would, in the strongest terms, reject any other allegations made by a delegate of the United States.

Dr VIROJ TANGCHAROENSATHIEN (Thailand), referring to the earlier comments made by the delegate of Hungary regarding the tabling of resolutions and amendments, said that the Health Assembly should indeed conduct its business more efficiently, and delegates should limit their comments to the matter in hand. However, the draft resolutions recommended by the Executive Board were not always perfect, and Member States should be free to amend and improve them as they saw fit. The views of all Member States should be heard and respected in a spirit of goodwill and mutual trust.

Dr GAMARRA (Paraguay) said that ensuring the availability of accurate statistics was essential in order to monitor progress towards the Millennium Development Goals. Coordination between countries and international agencies and between statistical institutes and health ministries was often inadequate. A common method was needed for monitoring indicators and aligning data requests from international agencies with national statistical systems. The Inter-Agency and Expert Group on MDG Indicators should provide such a method, along with alternative and proxy indicators, and should foster cooperation between developing countries in order to take advantage of the considerable statistical expertise of some of the countries of Latin America. Indicator calculation methods should be collected at country level, reporting methods improved and national databases created. Ideally, adjusted or estimated statistics should not be used, but, if they were, countries should be notified that their data had been adjusted and informed of the adjustment methods used. She called for greater coordination between national authorities and the international organizations which handled their data in order to reflect the real progress towards achievement of the Millennium Development Goals.

Mrs ARENDT (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN and also on behalf of Consumers International, said that recent scientific publications and high-level analyses and studies presented to United Nations bodies had shown the importance of early and exclusive breastfeeding and continued breastfeeding with complementary feeding for achieving the Millennium Development Goals, in particular Goals 4 and 5. Breastfeeding information and education should be provided during antenatal visits. She urged WHO to promote the inclusion of breastfeeding data among the indicators of progress towards the Goals. The United Nations agencies and donor countries had a responsibility to increase their financial and technical support for training health workers and supporting and promoting breastfeeding.

Ms CHAVEZ (International Council of Nurses), speaking at the invitation of the CHAIRMAN and also on behalf of the World Health Professions Alliance, welcomed the progress made towards achieving the health-related Millennium Development Goals, in particular with regard to child and maternal mortality, HIV/AIDS and tuberculosis and praised WHO's efforts to encourage prevention and treatment of pneumonia as part of the strategy to reduce child mortality. She expressed concern, however, at the slow rate of progress on some of the indicators and called on the Secretariat and governments to increase investment in tested interventions.

The health-related Millennium Development Goals could not be achieved without simultaneous progress towards the achievement of the other Goals and without attention to problems that were weakening health systems, such as migration and shortages of health professionals. Welcoming the mobilization of partnerships and resources to achieve the Millennium Development Goals, she called on WHO to make human resources for health a priority.

Mr WRIGHT (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, welcomed WHO's initiatives relating to women's and children's health, including the proposed accountability framework developed by the Commission on Information and Accountability for Women's and Children's Health. A comprehensive approach was required in order to improve women's and children's health, including strengthening of health systems, addressing health workforce shortages and developing equitable health financing systems. It was also necessary to address poverty and other social determinants of health. Civil society and service users, including children, should be included in the list of key stakeholders to engage in the further development and implementation of the accountability framework.

The Secretariat should provide Member States and other stakeholders technical support to meet their current commitments and make new commitments under the United Nations Secretary-General's Global Strategy for Women's and Children's Health. Member States should fulfil all their commitments, support the Commission's recommendations and establish national accountability mechanisms. The Secretariat should be provided with sufficient resources to enable it to host the Expert Review Group secretariat.

Dr Guey-Ing DAY (Chinese Taipei) welcomed the establishment of the Commission on Information and Accountability for Women's and Children's Health, which would accelerate progress on the Global Strategy for Women's and Children's Health. Universal access to primary health care played a crucial role in achieving the Millennium Development Goals, which required more commitment from the international community. WHO should place more emphasis on health education, above all at the primary and community levels, as it was a cost-effective way of bringing about lasting change in attitudes towards health. Chinese Taipei was willing to share its extensive experience in the fields of maternal and child health and to support developing countries in building high-quality, affordable public health systems with universal coverage.

Dr KIENY (Assistant Director-General) commended the efforts made by Member States to monitor progress towards achieving the health-related Millennium Development Goals. She noted the lack of recent data from some countries on maternal mortality in particular, often as a result of inadequate vital statistics systems. Accurate information was essential for accountability and she looked forward to the positive impact of the recommendations of the Commission on Information and Accountability for Women's and Children's Health on the quality of health-related information in all countries.

Following a discussion between Dr VIROJ TANGCHAROENSATHIEN (Thailand), Dr PÁVA (Hungary), Dr REN Minghui (China), Mr BLAIS (Canada) and the DIRECTOR-GENERAL, the CHAIRMAN suggested that the Secretariat prepare a revised text of both draft resolutions, taking account of the amendments proposed, for consideration at a later meeting.

It was so agreed.

(For continuation of the discussion and approval of the draft resolution, see the summary record of the tenth meeting, section 2.)

The meeting rose at 18:40.

TENTH MEETING

Saturday, 21 May 2011, at 09:30

Chairman: Dr W. AMMAR (Lebanon)

1. **FOURTH REPORT OF COMMITTEE A** (Document A64/59 (Draft))

Dr KULZHANOV (Kazakhstan), Rapporteur, read out the draft fourth report of Committee A.

The report was adopted.¹

2. **TECHNICAL AND HEALTH MATTERS:** Item 13 of the Agenda (continued)

Prevention and control of noncommunicable diseases: WHO's role in the preparation, implementation and follow-up to the high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases (September 2011): Item 13.12 of the Agenda (Documents A64/21 and A64/21 Add.1) (continued from the fourth meeting, section 3)

The CHAIRMAN drew attention to the following draft resolution on preparations for the high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases, following the Moscow Conference, proposed by Argentina, Australia, Bahrain, Barbados, Bolivarian Republic of Venezuela, Brazil, Canada, Chile, China, Colombia, Côte d'Ivoire, Ecuador, Ghana, Hungary on behalf of the Member States of the European Union, Iraq, Kuwait, Mexico, Monaco, Norway, Oman, Paraguay, Peru, Plurinational State of Bolivia, Qatar, Republic of Moldova, Russian Federation, Saudi Arabia, Switzerland, Trinidad and Tobago, Uganda, United Arab Emirates, United Republic of Tanzania, United States of America, Uruguay, and Yemen:

The Sixty-fourth World Health Assembly,

PP1 Having considered the report on WHO's role in the preparation, implementation and follow-up to the high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases² (high-level meeting);

PP2 Deeply concerned that the global burden and threat of noncommunicable diseases continues to grow, in particular in developing countries, and convinced that global action is necessary and urgent response is needed, including by effectively addressing the key risk factors for noncommunicable diseases;

PP3 Reaffirming its commitment to the aim of the global strategy for the prevention and control of noncommunicable diseases to reduce premature mortality and improve quality of life (resolution WHA53.17);

PP4 Further recalling United Nations General Assembly resolution 64/265 in which the General Assembly decided to convene a high-level meeting of the General Assembly in September 2011, with the participation of Heads of State and Government, on the prevention

¹ See page 338.

² Resolution 64/265 – Prevention and control of noncommunicable diseases.

and control of noncommunicable diseases, as well as resolution 65/238 on the scope, modalities, format and organization of the high-level meeting;

PP5 Recognizing the leading role of the World Health Organization as the primary specialized agency for health, and reaffirming the leadership role of WHO in promoting global action against noncommunicable diseases;

PP6 Noting with appreciation the first *WHO Global status report on noncommunicable diseases* launched on 27 April 2011, which may serve as an input into the preparatory process for the high-level meeting;

PP7 Noting the outcomes of the regional consultations which were held by WHO in collaboration with Member States, with the support of relevant United Nations agencies and entities, which will serve to provide inputs to the preparations for the high-level meeting, as well as to the meeting itself;

PP8 Welcoming the outcome of the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control, which was organized by the Russian Federation and WHO from 28 to 29 April 2011 in Moscow,

1. ENDORSES the Moscow Declaration, annexed to the present resolution, including as a key input for the preparations leading to the High-level Meeting;

2. URGES Member States:¹

(1) to continue to support the preparations at national, regional and international levels for the high-level meeting, including, where feasible and relevant, situation analysis of noncommunicable diseases and their risk factors, as well as an assessment of national capacity and health system response to address noncommunicable diseases;

(2) to be represented at the level of Heads of State and Government at the high-level meeting and to call for action through a concise action-oriented outcome document;

(3) to consider, as appropriate and where relevant, including in their national delegations to the high-level meeting parliamentarians, representatives of civil society, including nongovernmental organizations, academia and networks working on the control and prevention of noncommunicable diseases;

3. REQUESTS the Director-General:

(1) to continue exercising the leading role of WHO as the primary specialized agency for health working together in a coordinated way with the United Nations, its specialized agencies, funds and programmes, and other relevant intergovernmental organizations and international financial institutions, in supporting Member States, including:

(i) in undertaking concerted action and a coordinated response in order to promptly and appropriately address the challenges posed by noncommunicable diseases, including further building on available situation analyses on noncommunicable diseases and risk factors; and

(ii) in highlighting the social and economic impact of noncommunicable diseases, including financial challenges, in particular in developing countries;

(2) to take into account the outcomes from the Moscow Conference into the preparations for the high-level meeting;

(3) to ensure adequate financial and human resources within the WHO to prepare for the high-level meeting and to respond swiftly to its recommendations;

(4) to report to the Sixty-fifth World Health Assembly, through the Executive Board, on the outcomes of the first Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control and the high-level meeting, and to develop, together

¹ And, where applicable, regional economic integration organizations.

with relevant United Nations agencies and entities, an implementation and follow-up plan for the outcomes, including its financial implications, for submission to the Sixty-sixth World Health Assembly, through the Executive Board.

ANNEX

First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control Moscow, 28–29 April 2011

MOSCOW DECLARATION

PREAMBLE

We, the participants in the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease (NCDs) Control, gathered in Moscow on 28–29 April 2011.

I.

Express appreciation for the leading role of the World Health Organization and the Government of the Russian Federation in the preparation and holding of the Ministerial Conference.

II.

Recognize that the right of everyone to the enjoyment of the highest attainable standards of physical and mental health cannot be achieved without greater measures at global and national levels to prevent and control NCDs.

III.

Acknowledge the existence of significant inequities in the burden of NCDs and in access to NCD prevention and control, both between countries, as well as within countries.

IV.

Note that policies that address the behavioural, social, economic and environmental factors associated with NCDs should be rapidly and fully implemented to ensure the most effective responses to these diseases, while increasing the quality of life and health equity.

V.

Emphasize that prevention and control of NCDs requires leadership at all levels, and a wide range of multi-level, multi-sectoral measures aimed at the full spectrum of NCD determinants (from individual-level to structural) to create the necessary conditions for leading healthy lives. This includes promoting and supporting healthy lifestyles and choices, relevant legislation and policies; preventing and detecting disease at the earliest possible moment to minimize suffering and reduce costs; and providing patients with the best possible integrated health care throughout the life cycle including empowerment, rehabilitation and palliation.

VI.

Recognize that a paradigm shift is imperative in dealing with NCD challenges, as NCDs are caused not only by biomedical factors, but also caused or strongly influenced by behavioural, environmental, social and economic factors.

VII.

Affirm our commitment to addressing the challenges posed by NCDs, including, as appropriate, strengthened and reoriented policies and programmes that emphasize multi-sectoral action on the behavioural, environmental, social and economic factors.

VIII.

Express our belief that NCDs should be considered in partnerships for health; that they should be integrated into health and other sectors' planning and programming in a coordinated manner, particularly in low- and middle income countries; that they should be part of the global research agenda and that the impact and sustainability of approaches to prevent and control NCDs will be enhanced through health systems strengthening and strategic coordination with existing global health programs.

RATIONALE FOR ACTION

1. NCDs, principally cardiovascular diseases, diabetes, cancers and chronic respiratory diseases, are the leading causes of preventable morbidity and disability, and currently cause over 60% of global deaths, 80% of which occur in developing countries. By 2030, NCDs are estimated to contribute to 75% of global deaths.
2. In addition, other NCDs such as mental disorders also significantly contribute to the global disease burden.
3. NCDs have substantial negative impacts on human development and may impede progress towards the Millennium Development Goals (MDGs).
4. NCDs now impact significantly on all levels of health services, health care costs, and the health workforce, as well as national productivity in both emerging and established economies.
5. Worldwide, NCDs are important causes of premature death, striking hard among the most vulnerable and poorest populations. Globally they impact on the lives of billions of people and can have devastating financial impacts that impoverish individuals and their families, especially in low- and middle-income countries.
6. NCDs can affect women and men differently, hence prevention and control of NCDs should take gender into account.
7. Many countries are now facing extraordinary challenges from the double burden of disease: communicable diseases and noncommunicable diseases. This requires adapting health systems and health policies, and a shift from disease-centred to people-centred approaches and population health measures. Vertical initiatives are insufficient to meet complex population needs, so integrated solutions that engage a range of disciplines and sectors are needed.

Strengthening health systems in this way results in improved capacity to respond to a range of diseases and conditions.

8. Evidence-based and cost-effective interventions exist to prevent and control NCDs at global, regional, national and local levels. These interventions could have profound health, social, and economic benefits throughout the world.
9. Examples of cost-effective interventions to reduce the risk of NCDs, which are affordable in low-income countries and could prevent millions of premature deaths every year, include measures to control tobacco use, reduce salt intake and reduce the harmful use of alcohol.
10. Particular attention should be paid to the promotion of healthy diets (low consumption of saturated fats, trans fats, salt and sugar, and high consumption of fruits and vegetables) physical activity in all aspects of daily living.
11. Effective NCD prevention and control require leadership and concerted “whole of government” action at all levels (national, sub-national and local) and across a number of sectors, such as health, education, energy, agriculture, sports, transport and urban planning, environment, labour, industry and trade, finance and economic development.
12. Effective NCD prevention and control require the active and informed participation and leadership of individuals, families and communities, civil society organizations, private sector where appropriate, employers, health care providers and the international community.

COMMITMENT TO ACTION

We, therefore, commit to act by:

At the Whole of Government level:

1. Developing multi-sectoral public policies that create equitable health promoting environments that enable individuals, families and communities to make healthy choices and lead healthy lives;
2. Strengthening policy coherence to maximize positive and minimize negative impacts on NCD risk factors and the burden resulting from policies of other sectors;
3. Giving priority to NCD prevention and control according to need, ensuring complementarity with other health objectives and mainstreaming multi-sectoral policies to strengthen the engagement of other sectors;
4. Engaging civil society to harness its particular capacities for NCD prevention and control;
5. Engaging the private sector in order to strengthen its contribution to NCD prevention and control according to international and national NCD priorities;
6. Developing and strengthening the ability of health systems to coordinate, implement, monitor and evaluate national and sub-national strategies and programmes on NCDs;
7. Implementing population-wide health promotion and disease prevention strategies, complemented by individual interventions, according to national priorities. These should be

equitable and sustainable and take into account gender, cultural and community perspectives in order to reduce health inequities;

8. Implementing cost-effective policies, such as fiscal policies, regulations and other measures to reduce common risk factors such as tobacco use, unhealthy diet, physical inactivity and the harmful use of alcohol;
9. Accelerating implementation by States Parties of the provisions of the WHO Framework Convention on Tobacco Control (WHO FCTC) and encouraging other countries to ratify the Convention;
10. Implementing effective policies for NCD prevention and control at national and global levels, including those relevant to achieving the goals of the 2008–2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases, the WHO Global Strategy to Reduce the Harmful Use of Alcohol and the Global Strategy on Diet, Physical Activity and Health;
11. Promoting recognition of the rising incidence and burden of NCDs on national as well as international development agendas, and encouraging countries and international development partners to consider the level of priority accorded to NCDs.

At Ministry of Health level:

1. Strengthening health information systems to monitor the evolving burden of NCDs, their risk factors, their determinants and the impact and effectiveness of health promotion, prevention and control policies and other interventions;
2. According to national priorities, strengthening public health systems at the country level to scale up evidence-based health promotion and NCD prevention strategies and actions;
3. Integrating NCD-related services into primary health care services through health systems strengthening, according to capacities and priorities;
4. Promoting access to comprehensive and cost-effective prevention, treatment and care for integrated management of NCDs, including access to affordable, safe, effective and high quality medicines based on needs and resource assessments;
5. According to country-led prioritization, ensuring the scaling-up of effective, evidence-based and cost-effective interventions that demonstrate the potential to treat individuals with NCDs, protect those at high risk of developing them and reduce risk across populations.
6. Promoting, translating and disseminating research to identify the causes of NCDs, effective approaches for NCD prevention and control, and strategies appropriate to distinct cultural and health care settings.

At the International level:

1. Calling upon the World Health Organization, as the lead UN specialized agency for health, and all other relevant UN system agencies, development banks, and other key international organizations to work together in a coordinated manner to address NCDs;

2. Working through WHO in consultation with other multilateral organizations, international nongovernmental organizations, the private sector and civil society stakeholders to strengthen normative guidance, pool technical expertise, coordinate policy to achieve the best possible results and capitalize on synergies among existing global health initiatives.
3. Strengthening international support for the full and effective implementation of the WHO FCTC, the Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases, the WHO Global Strategy to Reduce the Harmful Use of Alcohol, the Global Strategy on Diet, Physical Activity and Health and other relevant international strategies to address NCDs.
4. Investigating all possible means to identify and mobilize the necessary financial, human and technical resources in ways that do not undermine other health objectives.
5. Supporting the WHO in developing a comprehensive global monitoring framework on NCDs.
6. Examining possible means to continue facilitating the access of low- and middle income countries to affordable, safe, effective and high quality medicines in this area consistent with the WHO Model Lists of Essential Medicines, based on needs and resource assessments, including by implementing the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property.

WAY FORWARD

With a view to securing an ambitious and sustainable outcome, we commit to actively engaging with all relevant sectors of Government, on the basis of this Moscow Declaration, in the preparation of and the follow-up to the United Nations General Assembly High-level Meeting on the Prevention and Control of noncommunicable diseases in September 2011 in New York.

The CHAIRMAN also drew attention to the financial and administrative implications for the Secretariat of the adoption of the resolution, which were as follows:

1. Resolution Preparations for the high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases, following the Moscow Conference¹

2. Linkage to programme budget

Strategic objective:

3. To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment.

Organization-wide expected result:

3.1 Advocacy and support provided to increase political, financial and technical commitment in Member States in order to tackle chronic noncommunicable diseases, mental and behavioural disorders, violence, injuries and disabilities together with visual impairment, including blindness.

3.2 Guidance and support provided to Member States for the development and implementation of policies, strategies and regulations in respect of chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities together with visual impairment, including blindness.

3.3 Improvements made in Member States' capacity to collect,

¹ First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control (Moscow, Russian Federation, 28–29 April 2011).

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|--|--|
| <p>6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex.</p> | <p>analyse, disseminate and use data on the magnitude, causes and consequences of noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities together with visual impairment, including blindness.</p> |
| <p>6.2 Guidance and support provided in order to strengthen national systems for surveillance of major risk factors through development and validation of frameworks, tools and operating procedures and their dissemination to Member States where a high or increasing burden of death and disability is attributable to these risk factors.</p> | <p>6.2 Guidance and support provided in order to strengthen national systems for surveillance of major risk factors through development and validation of frameworks, tools and operating procedures and their dissemination to Member States where a high or increasing burden of death and disability is attributable to these risk factors.</p> |

(Briefly indicate the linkage with expected results, indicators, targets, baseline)

It is envisaged that there will be an increase in the number of Member States: (i) with a unit in the ministry of health or equivalent national health authority, with dedicated staff and budget, for the prevention and control of noncommunicable diseases (indicator 3.1.4); (ii) that have adopted a multisectoral national policy on chronic noncommunicable diseases (indicator 3.2.3); (iii) with a national health reporting system and annual reports that include indicators on the four major noncommunicable diseases (indicator 3.3.4); (iv) with a functioning national surveillance system for monitoring major risk factors to health among adults based on the WHO STEPwise approach to surveillance (indicator 6.2.1).

3. Budgetary implications

- (a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).**
US\$ 4.5 million over a period of three years.
- (b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).**
US\$ 1.0 million at all levels of the Organization.
- (c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?**
Yes.

4. Financial implications

How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?

Costs will be met through income from voluntary contributions from Member States and contributions from international partners.

5. Administrative implications

- (a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant).**
All levels of the Organization.
- (b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.**
No.
- (c) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile).**
Every effort will be made to make full use of secondments from Member States, as well as employing short-term staff.
- (d) Time frames (indicate broad time frames for implementation of activities).**
Three years for all actions (the Secretariat is drawing up an implementation plan accordingly).

Mr KÖKÉNY (representative of the Executive Board), introducing the item, said that the Executive Board at its 128th session had considered both a report on the role of WHO in the preparation, implementation and follow-up of the high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases and a draft resolution on prevention and control of noncommunicable diseases. Many members had expressed strong support for WHO's efforts to increase activities in the area of noncommunicable diseases and its leadership in the preparations for the high-level meeting and committed themselves to both the preparations and the concept of the summit. Recognizing that the high-level meeting would provide a unique opportunity to draw global political attention to the new epidemic of noncommunicable diseases, the Board had considered that WHO had a responsibility to offer evidence-based solutions to reduce the burden of disease and should coordinate implementation of the outcomes of the meeting. Despite formal and informal deliberations Board members had been unable to reach consensus on the draft resolution and had agreed to defer consideration of the draft resolution, following further Member State consultation, to the current Health Assembly.

Dr GOPEE (Mauritius) welcomed the priority the Health Assembly was giving to noncommunicable diseases. The epidemiological transition to those diseases had occurred in Mauritius some 25 years earlier and their prevalence had progressed significantly, with a survey in 2009 revealing rates of 21% for diabetes (the third highest in the world) and 38% for hypertension. Although the population of the country was only 1.2 million, noncommunicable diseases accounted for 80% of the disease burden. The measures that had been implemented following the survey included the establishment of a dedicated noncommunicable diseases unit and a national screening programme; initiatives had included regulation of the palm oil content of blended oils and the imposition of a tax on tobacco. Physical activity programmes had been introduced in schools and for the general population, with extensive media coverage of the major risk factors and recommended activities. Mauritius had scaled up its interventions in line with the various resolutions and conventions adopted by the Health Assembly and WHO's strategies and action plans to combat noncommunicable diseases. Those for nutrition, cancer control and tobacco were being implemented, while initiatives relating to alcohol, respiratory diseases and mental health were being prepared. Regulations prohibiting the advertisement, promotion and sponsorship of alcoholic beverages and tobacco had been adopted, and the sale of soft drinks and unhealthy foods with high salt and sugar content had been banned in all educational institutions. Officials from the Health Inspectorate conducted regular visits to monitor compliance with the regulations. A special diabetic foot-care programme was being prepared in view of the unacceptably high amputation rate. Other initiatives included a national service framework for diabetes, cancer screening services and a master plan to strengthen the primary health-care system focusing on the essential role of primary health-care professionals in the control of noncommunicable diseases.

Notwithstanding the chronic disease burden, life expectancy at birth in Mauritius had risen to 73 years, annual mortality due to noncommunicable diseases was declining, cigarette imports had been reduced and the rates of complications from noncommunicable diseases were stabilizing. In cooperation with WHO and the International Diabetes Federation, his country had hosted the International Conference on Diabetes and Associated Diseases in 2009, which had resulted in the Mauritius Call for Action, targeting the African Region. His country had obtained first prize at the 2011 All Africa Public Sector Innovation Awards, in recognition of its mobile clinic service, which gave the population access to health education and screening, in addition to other sources of primary health care.

The major challenge at global, regional and national levels was controlling the vectors of noncommunicable diseases, by engaging with the fast-food, alcohol and tobacco industries so as to limit the harmful effects of their products on people's health. WHO's guidance in that regard, including preparation of a national salt-reduction strategy, and its technical expertise in bringing about the adoption of healthier lifestyles, especially among young people, would be welcome. Given the magnitude of the disease burden and the possible shortfall in future budgetary allocations, he

suggested that WHO should take the opportunity of the forthcoming United Nations General Assembly high-level meeting to call for the establishment of a global fund for noncommunicable diseases.

Dr FEISUL MUSTAPHA (Malaysia) said that the announcement of the high-level meeting had been useful for advocating further work on noncommunicable diseases in Malaysia, particularly in operationalizing a “whole-of-government” approach, although securing the support of ministries and agencies outside the health sector remained a challenge. His Government was committed to reducing the burden of noncommunicable diseases and their risk factors and thanked the Secretariat and particularly the Regional Office for the Western Pacific for technical support, expertise, guidelines and supporting documents, which had proved invaluable for policy and programme development. He supported the draft resolution.

Dr ALI (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that preventing noncommunicable diseases was a priority for the Region in view of the epidemiological transition it was experiencing. Intersectoral cooperation had been established, and every effort was made to prevent and combat such diseases. Morbidity and mortality from noncommunicable diseases in the Region continued to rise and rates were among the highest in the world. Prevention and control had been integrated into national development programmes and into primary health care; emphasis was being placed on capacity-building for health-care professionals, and national strategies were being strengthened to promote healthier lifestyles. The social determinants of noncommunicable disease were also being addressed multisectorally. The countries of the Region, which had participated in preparation of the global strategy for the prevention and control of noncommunicable diseases, were fully committed to its implementation. Calling for ongoing support from the Secretariat in that regard, she endorsed the draft resolution.

Dr AL HAJERI (Bahrain) said that her country had devised a plan to combat chronic diseases, which were a national priority; its implementation involved cooperation at the various levels of Government and with civil society. A national committee responsible for drafting a strategy to strengthen health care had been established with the participation of municipalities and other stakeholders. Her country had prohibited the advertisement of tobacco, whose use had been banned in the workplace. It was implementing the Global strategy on diet, physical activity and health in schools. In cooperation with the Secretariat, her Government had developed primary health care services and had opened health centres for people with chronic mental conditions, with early screening facilities. Bahrain had participated in the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control and had signed the resulting Moscow Declaration. Recognizing the growing threat posed by noncommunicable diseases and stressing the importance of WHO’s role in the context of the United Nations General Assembly high-level meeting, she reaffirmed her Government’s commitment to implementing the global strategy for the prevention and control of noncommunicable diseases. She endorsed the draft resolution.

Dr KIMANI (Kenya), noting with concern that noncommunicable diseases caused almost four times more deaths than HIV/AIDS, malaria and tuberculosis combined, added that people with the former were more susceptible to infectious diseases. Noncommunicable diseases resulted not only in chronic disabling and life-threatening conditions but had a significant social and economic impact in all countries. Their prevention should therefore be integral to the global development agenda.

Confident that WHO, as the primary specialized agency for public health, would pave the way for a successful high-level meeting in September 2011, he drew attention to his Government’s expected outcomes: recognition of noncommunicable diseases as a major global public health and developmental challenge; establishment of global mechanisms to help developing countries to integrate primary prevention programmes for noncommunicable diseases into their health systems; establishment of a global funding mechanism to support developing countries in implementing

programmes for the prevention and control of noncommunicable diseases, without jeopardizing support for communicable diseases; elaboration of global mechanisms for monitoring and reporting trends in noncommunicable diseases and countries' interventions for prevention and control; improving access to health care for people with noncommunicable diseases, particularly to affordable high-quality screening services and medical supplies; and helping civil society to support and implement noncommunicable disease initiatives. Kenya further expected that the high-level meeting would commit governments to implement noncommunicable disease policies by integrating the targets into the development goals that would succeed the Millennium Development Goals. He supported the draft resolution.

Mr FOURAR (Algeria) said that, for emerging countries such as Algeria, the control of noncommunicable diseases was a priority in view of their growing prevalence and impact on national health systems. The challenges were the high cost of lifelong treatment and care and ensuring equal access to health care, particularly for poor people. Adequate investment would be required for decades to come to control noncommunicable diseases and to improve the quality of life for current and future generations. Most developing countries were experiencing demographic and epidemiological transitions to noncommunicable diseases. Their rising incidence in Algeria had led to an integrated control strategy based on a multisectoral approach in 2003. The Government had made the control of noncommunicable diseases central to its health development plan and had quadrupled its budget allocation for health in the past 10 years. It had set up an innovative, sustainable cancer fund and had launched an investment programme to reinforce the health system infrastructure, improve equipment and enhance primary health care. Algeria had endorsed the Brazzaville Declaration on Noncommunicable Diseases Prevention and Control in the African Region and considered that innovative measures should be found to ensure access to medicines for noncommunicable diseases in developing countries.

Algeria advocated an integrated, evidence-based approach to promoting healthy lifestyles, in which international initiatives were coordinated so as to ensure compliance with commitments to foster development in developing countries. That approach would strengthen the global strategy for the prevention and control of noncommunicable diseases and mitigate the health and socioeconomic impact with a view to achieving sustainable development and reducing inequalities. Mobilization of the international community under the auspices of WHO was essential for determining the appropriate strategies, including an information system on the burden of morbidity, risk factors and major determinants; introduction of a multisectoral approach to the control of noncommunicable diseases and its integration into primary health-care; access to essential medicines; and the mobilization of the necessary financial resources.

Professor ADITAMA (Indonesia) noted that his country had contributed to noncommunicable disease prevention and control at national, regional and global levels. It had recently hosted the WHO South-East Asia Regional meeting on health and development challenges of noncommunicable diseases (Jakarta, 1–4 March 2011); the ensuing Jakarta Call for Action on Noncommunicable Diseases urged global leaders, donor partners and organizations in the United Nations system to include noncommunicable disease in internationally agreed development goals; assist countries in integrating management of those diseases in public health centres; enhance capacity-building and technical and financial support for sustainable prevention and control programmes; and support research into the prevention and control of noncommunicable diseases. In June 2011, his Government would hold a meeting, with WHO's support, to build consensus on the roles of various sectors in the prevention and control of noncommunicable diseases in Indonesia. The issue was a priority in the national health strategic plan for 2010–2014, and the Ministry of Health had prepared a comprehensive noncommunicable disease strategic plan for 2010–2015.

Dr PÁVA (Hungary), speaking on behalf of the European Union and stating that the candidate countries Turkey, Croatia, The former Yugoslav Republic of Macedonia, Montenegro and Iceland, the countries of the Stabilisation and Association Process and potential candidates Bosnia and Herzegovina, Serbia and Ukraine, aligned themselves with her statement, said that the European Union supported the draft resolution and wished to cosponsor it. The global burden of noncommunicable diseases demanded attention in all countries, at all levels of governance, and WHO should provide leadership in normative work, coordination, technical support and monitoring in that regard.

Four main issues needed attention. The control of noncommunicable diseases must be based on health promotion and prevention, at both population and individual levels, as they could largely be prevented and cost-effective public policies and interventions were available. A “health in all policies” approach, for example through the creation of health-conducive environments and improvements in health literacy, was needed to deal with the socioeconomic and environmental determinants, which often increased health inequities. The approach should be systematic and comprehensive rather than disease-specific and vertical, expanding the current focus on cardiovascular and respiratory diseases, diabetes and cancer, to cover other noncommunicable diseases that contributed to the global disease burden, such as mental disorders. A well-functioning health system was a prerequisite for implementing appropriate health policies and ensuring effective disease management; the prevention and control of noncommunicable diseases must be integrated into health system structures and functions, particularly at the primary health-care level, and health systems must monitor such diseases and the underlying risk factors for informed decision-making.

Because many developing countries faced the double burden of communicable and noncommunicable diseases, the European Union would support them in tackling the latter and their risk factors in accordance with national priorities and commitments, through, for instance, the strengthening of health systems and involvement of patient associations and other civil society organizations. She expressed appreciation to the Russian Federation for its contribution to the issue and welcomed the Moscow Declaration.

Dr KASSEM (Jordan) drew attention to the significant burden placed on health systems by noncommunicable diseases, including the high treatment costs. His Government’s Ministry of Health had launched a health awareness campaign, with emphasis on diabetes, a condition that affected more than one third of the country’s population. The treatment of noncommunicable diseases had been integrated into primary health care, and national legislation was being reviewed to ensure compliance with the WHO Framework Convention on Tobacco Control. Initiatives for the prevention of breast and colon cancer were also under way. Financial resources had been allocated to the prevention and control of noncommunicable diseases, particularly through awareness-raising and research. Every effort was made to provide adequate health care for people suffering from those diseases.

Dr VOUMBO MATOUMONA (Congo), speaking on behalf of the Member States of the African Region, underlined the increasing morbidity and mortality due to noncommunicable diseases in the Region, and warned that they jeopardized achievement of the Millennium Development Goals and threatened to increase social inequalities. A multisectoral control strategy was essential in order to tackle the social, behavioural, environmental and economic determinants. Numerous declarations, strategies and action plans had been or were being implemented in many countries of the Region, with technical support from WHO. Civil society and the private sector were also becoming involved.

The growing burden of noncommunicable diseases, in particular for low-income countries, demanded stronger partnerships; WHO’s leadership was more necessary than ever. Countries of the Region had adopted the Brazzaville Declaration on Noncommunicable Diseases Prevention and Control in the African Region and participated in the Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control in Moscow. The priorities were: to include the prevention and management of noncommunicable diseases in future Millennium Development Goals; to enhance national health systems as part of a global approach to promoting healthy lifestyles,

improving access to primary health care, information-sharing, retaining health-care staff, increasing funding for health care, expanding access to medicines and equipment, and improving infrastructure; to draw up national action plans and build institutional capacity for the prevention and control of noncommunicable diseases; for WHO to act as lead agency and the Secretariat to provide technical support to Member States in the preparation, implementation, follow-up and evaluation of their national plans and sharing of experience; to strengthen the participatory and multisectoral role of partnerships and networks; and to mobilize funding from development partners.

She urged the Secretariat to encourage African countries to participate in the high-level meeting in New York and to help them to draw up national strategic plans. She called for the establishment of a funding mechanism similar to the Global Fund to Fight AIDS, Tuberculosis and Malaria in order to control noncommunicable diseases, without diminishing the funding for communicable diseases. She called for action and supported the draft resolution.

Dr DAULAIRE (United States of America) welcomed the report. Highlighting the leadership provided by PAHO in the preparations for the forthcoming high-level meeting and commending the successful outcomes of the WHO Global Forum: Addressing the Challenge of Noncommunicable Diseases, and the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control, both hosted by the Russian Federation, he said that his Government was strongly committed to raising the profile of noncommunicable diseases as a major health concern globally and its Department of Health and Human Services was active in the areas of their prevention, control and research. Recent activities included a new initiative focused on people with multiple chronic health conditions; introduction of regulations to further restrict the promotion of tobacco use by young people; and a national campaign, launched by the First Lady, to encourage exercise and diet among children and young people. Mental health was recognized as an essential component of a comprehensive strategy to address noncommunicable diseases.

WHO had a central role to play in raising awareness and increasing prevention, early detection and control of noncommunicable diseases, building on existing activities and frameworks, sharing best practices and lessons learnt and fostering global collaboration. As the lead agency in the health sector, WHO had the authority and expertise to fulfil that role and to serve as a focal point for a “health in all policies” approach.

Mr TUITAMA LEAO TUITAMA (Samoa) said that 2011, and the Sixty-fourth World Health Assembly in particular, would be seen as the turning-point, when global calls for action were translated into instruments for reversing the epidemic of noncommunicable diseases. He urged the Secretariat and Member States not to waste the opportunity. The effect of noncommunicable diseases on the people and economy of Samoa and other Pacific islands had reached a crisis point, threatening to overwhelm their meagre resources and adversely affect social development, economic aspirations and already-fragile health systems. The islands were especially vulnerable because of their small populations, geographical isolation and vulnerability to climate change and globalization.

He urged the Health Assembly to adopt a resolution that called for political commitment to primary health-care principles and their maintenance as part of the global health and development agenda, and that would ensure that the needs of the vulnerable and most affected were adequately met. The prevention and control of noncommunicable diseases, their risk factors and health determinants should be placed high on national, regional and global development agendas. The Health Assembly’s decisions would affect the priority that country leaders accorded to noncommunicable diseases during their discussions in the United Nations General Assembly in September 2011. Health promotion and prevention at all levels was the best long-term solution for Samoa, given its limited resources and financial capacity.

He supported a research agenda that gave priority to best practice and better access to affordable, safe diagnosis and treatment for noncommunicable diseases. He further supported calls for a monitoring framework to assist progress, including the elaboration and adoption of standardized indicators.

Referring to the second preambular paragraph of the draft resolution, he proposed that the words “including small island States,” be inserted after the words “in developing countries”.

Dr DOUA (Côte d’Ivoire) said that, in discussions on drafting the resolution, his country had suggested that WHO should seize the historic occasion of the high-level meeting to advocate the establishment of a special fund to help to combat noncommunicable diseases in developing countries. He therefore proposed amending subparagraph 3(1)(ii) of the draft resolution by adding the words “related to combating these diseases” after “financial challenges”.

Dr RODIN (Canada) commented that the draft resolution advocated a multisectoral approach to the prevention and control of noncommunicable diseases. The Moscow Declaration highlighted the need for policies and practices at all levels to tackle the social, environmental, economic and behavioural determinants of noncommunicable diseases in order to foster the creation of the necessary conditions for healthy living. She congratulated the Secretariat on facilitating discussions in preparation for the high-level meeting, which had elicited various views and experiences. She urged WHO to reach beyond the usual channels in order to harness the efforts of other international parties. Canada fully supported WHO’s role as the lead United Nations agency on noncommunicable diseases. The high-level meeting presented a good opportunity for the international community to address the challenges and to strengthen political commitment to collective action.

Dr VENEGAS (Uruguay), speaking on behalf of the Union of South American Nations (UNASUR), observed that noncommunicable diseases were the main cause of death and disability worldwide and accounted for high percentages of cases of ill health and premature death in UNASUR. The main risk factors, smoking, a sedentary lifestyle and alcohol consumption, were avoidable and preventable. Most deaths caused by noncommunicable diseases occurred in developing countries, thus increasing social inequities and poverty.

Public policies to prevent and control noncommunicable diseases should be strengthened among institutions and in all sectors. Commitment to the Millennium Development Goals showed that it was easier to contribute to alliances and the development of appropriate frameworks to achieve specific health outcomes when clear objectives were set. He therefore urged WHO to take action on the social determinants of health and strengthen political commitment to promoting prevention, providing access to treatment and monitoring systems to ensure comprehensive management of noncommunicable diseases, including access to safe, effective, high-quality medicines. Specific goals for reducing noncommunicable diseases, especially with regard to the social determinants of health, should be included in the Millennium Development Goal. He supported the draft resolution and asked WHO to continue its leadership in coordinating the prevention and control of noncommunicable diseases.

Dr CAÑETE (Paraguay) supported the development of intersectoral public policies to reduce risk factors in cooperation with the private sector and civil society, including non-health sectors, which played essential roles in prevention. As there was a strong link between noncommunicable diseases and community development models and environment, with consequent social inequity, prevention and control programmes should include actions on the social determinants of health, such as poverty reduction, regulating the private sector, gender and intercultural approaches and community participation. Priority should be given to improving access to health care and guaranteeing the availability of safe, effective, high-quality medicines. Paraguay had established 500 family and community health units, which emphasized noncommunicable diseases and provided essential medicines as part of a free, high-quality health-care service. It was also conducting a national survey among the general population and the indigenous peoples on risk factors for noncommunicable diseases, whose results would assist it in formulating public policies. It was vital to have commitment at governmental level, in addition to an international policy, with respect to the financing of programmes for the prevention and control of noncommunicable diseases.

Dr SOLÍS VÁSQUEZ (Peru) concurred with the comments of previous speakers and said that her country had been monitoring noncommunicable disease since 1998, including studies of risk factors within families in seven of the country's regions between 1998 and 2001, whose findings had provided the basis for prevention measures. Cancer trends had been monitored in hospitals since 2006, and every region was required to set up a cancer registry and have at least one cancer hospital. Moreover, monitoring systems were being established in each region for risk factors such as alcohol consumption, smoking, weight, obesity, hypertension and diabetes; healthy lifestyles were being promoted. Her Government would continue to improve measures to prevent and control noncommunicable diseases, including legal and normative instruments, to ensure that people had access to good health care and treatment, subject to available financing. She urged the Director-General to continue taking the lead in addressing noncommunicable diseases in order to guarantee the health of future generations.

Dr KONG Lingzhi (China) said that her country would continue to combat noncommunicable diseases and agreed with previous speakers that WHO should take full advantage of the opportunity provided by the high-level meeting to call for noncommunicable diseases to be given high priority. WHO should also formulate an action plan for implementing the global strategy and prepare guidelines for simple indicators. It should advocate inclusion of the objectives relating to noncommunicable diseases in development agendas and in the Millennium Development Goals. The Secretariat should urge Member States to take up the challenge of the prevention and control of noncommunicable diseases.

Ms ESCOREL DE MORAES (Brazil) said that the fight against noncommunicable diseases was top of the global health agenda for 2011. Their prevention and control was of increasing importance, particularly in developing countries. Noncommunicable diseases were a serious health problem in Brazil, hitting the poorest and most vulnerable groups hardest. Nevertheless, with the expansion of primary health care and reduced tobacco consumption following the introduction of dissuasive measures, mortality associated with cardiovascular and respiratory diseases had fallen by 20%. Brazil was taking measures to promote physical activity, and food companies had agreed to reduce salt in some products. It was also taking steps to improve access to medication, including distributing free medicines through a network of well-known pharmacies under a new Government scheme.

Poor social conditions were closely linked to the prevalence of noncommunicable diseases, and many of the world's most underprivileged people remained trapped in a circle of poverty and disease. In order to ensure that all people attained the highest possible level of health, the root causes of ill health must be addressed. With that in mind, Brazil was hosting the World Conference on Social Determinants of Health (Rio de Janeiro, 19–21 October 2011) in order to allow exchange of views and experiences on strategies, policies and plans. She urged Member States to attend and work together to address social determinants and reduce inequity by developing specific measures to tackle noncommunicable diseases.

Ms BENNETT (Australia) reaffirmed her Government's commitment to further collaboration before the high-level meeting. Australia was refocusing its health system towards prevention, including establishing a new national preventive health agency to tackle noncommunicable diseases. Tobacco control measures were a key priority; recent Government initiatives included a 25% increase in excise duty on tobacco products and the introduction of the world's first plain-packaging laws. She urged all Member States to adopt the draft resolution.

Mr NACEUR (Tunisia) welcomed the report and its useful information. Tunisia had established a programme on the prevention of noncommunicable diseases, which had been integrated into its national health policies, in line with WHO guidelines. In 2010, it had adopted a comprehensive plan for noncommunicable diseases, which incorporated the six objectives set by WHO in its action plan for the global strategy for the prevention and control of noncommunicable diseases. Tunisia was also

seeking to strengthen its partnerships with other countries and parties to mitigate the impact of noncommunicable diseases. He supported the draft resolution, as it reflected the needs of WHO's different regions, and particularly welcomed the call for steps to assist countries in implementing national noncommunicable disease control strategies.

Dr KHAMIS (United Arab Emirates) said that noncommunicable diseases threatened to reach epidemic proportions in developing countries. His Government had recently reviewed its national strategies to combat those diseases, having successfully reduced the incidence of communicable diseases, particularly those targeted by its national vaccination campaign. Noncommunicable diseases, especially diabetes and cardiovascular disease, caused more than half of the country's registered deaths and were being tackled by means of science-based health policies in the light of findings from a global health survey, which had shown noticeably higher levels of obesity, inactivity, unhealthy eating and smoking among school children. Given the link between noncommunicable diseases and lifestyle, risk awareness and prevention from an early age were the first-line measures used against those diseases. Strategies for tackling noncommunicable diseases fell under the rubric of primary health care and family medicine, in conformity with WHO's guidelines on the monitoring of diabetes and cardiovascular disease at health-care centres, which were accessible throughout the country.

Ms KOIVISTO (Finland) identified 2011 as a landmark year in terms of events, strategies and action plans for tackling the important global health issue of noncommunicable diseases, starting with the Ministerial Conference in Moscow. The process, of which the current discussion formed a part, would pave the way to a successful outcome of the high-level meeting of the United Nations General Assembly. Against that background and with its own experience in the area of noncommunicable diseases, Finland was pleased to be bringing the issue of health promotion back to the European Region – the origin of the Ottawa Charter for Health Promotion – by hosting the Eighth Global Conference on Health Promotion in Helsinki in June 2013; its focus would be implementation, the role of health systems and social determinants. Her country looked forward to collaborating closely with the Secretariat, other Member States and stakeholders in preparing for the Conference.

Dr BAYUGO (Philippines) said that the prevention and control of noncommunicable diseases formed part of an initiative launched by his Government in support of global efforts to end decades of neglect and unjustified omission of chronic diseases from the global development agenda. A six-year action plan aimed to reduce mortality due to noncommunicable diseases, and a campaign to promote healthy lifestyles had been launched. The Philippines continued to participate in international research and to generate relevant data on the prevalence of risk factors in such areas as tobacco consumption, nutrition, diabetes and cardiovascular diseases. In response to the strong presence of the tobacco industry in Asia, existing tobacco laws were strictly implemented, and efforts were under way to reform the tobacco tax system and introduce legislation requiring tobacco products to carry graphic health warnings. A nationwide physical activity programme had been introduced the previous week, with senior members of Government, including the President, sending a strong message to the public about the health benefits of physical activity by participating in a cycling demonstration.

Mr CONSTANT (Trinidad and Tobago) said that the prevention and control of noncommunicable diseases required leadership at all levels, as well as a wide range of measures to address, *inter alia*, social determinants and equity. Such diseases posed multifaceted, complex challenges, consequently demanding heightened attention from the international community. He therefore urged continuous cooperation to promote intersectoral policy changes in order to build on the gains achieved by Member States in the context of their national programmes to combat chronic diseases. He supported without reservation the call for WHO to develop a comprehensive monitoring framework on noncommunicable diseases and to take the lead in assisting country implementation of the resolution expected from the high-level meeting.

Mr DAKPALLAH (Ghana) said that noncommunicable diseases threatened to erode the health gains achieved over the years. In developing countries, their burden had been such as to undermine capacity-building for their detection, management and control. Failure to respond to that need would result in costly changes in the use of health services and have a negative impact on health financing mechanisms. Ghana had therefore advocated new thinking about health-care delivery, with emphasis on its Regenerative Health and Nutrition Programme, on which its national health policy of promoting a healthy lifestyle was based so as to deal holistically with the problem of noncommunicable diseases.

Noncommunicable diseases were a developmental issue to be approached from a multisectoral perspective, with advocacy for the adoption of appropriate legislation, social mobilization and health promotion forming the central strategy. Early detection capacity, improved quality of care and more effective disease management structures should be developed at country level. Proven strategies should be used to detect and raise public awareness of noncommunicable diseases, which were best addressed in the longer term through strong leadership and governance systems working in appropriate partnership with the private sector and social support systems, among others.

Dr TSESHKOVSKIY (Russian Federation) said that measures to promote healthy lifestyles, minimize risk factors and ensure access to high-quality health care were vital elements of the strategy for the prevention and control of noncommunicable diseases, as was the need for scientific research and a multisectoral approach. WHO's activities relating to those diseases could be usefully expanded to include the provision of technical assistance for the development of national health systems and prevention and control programmes, including training in modern diagnostic and treatment methods. Given its experience in dealing with noncommunicable diseases, the Russian Federation was well placed to participate in the relevant work of WHO and other international bodies. Its national health programme encompassed a raft of measures to encourage healthier lifestyles, including hundreds of fully-equipped health centres open to all citizens. As emphasized in the Moscow Declaration, comprehensive measures for the detection and prevention of noncommunicable diseases were an essential part of the international health agenda, requiring cooperation at both global level and in countries.

Mr WAHABI (Morocco) said that noncommunicable diseases constituted a major public health burden worldwide and a socioeconomic threat. The exorbitant cost of treatment posed difficulties of access for patients, and the diseases themselves were an obstacle to progress in developing countries. Action to address the problem was a priority for Morocco, which had accordingly formulated a comprehensive integrated national plan for tackling noncommunicable diseases. He commended WHO's efforts to combat those diseases and expressed support for the draft resolution.

Dr MUKONKA (Zambia) said that his country had developed a draft strategic plan to counter the growing epidemic of noncommunicable diseases, and work was under way to establish preventive measures, enact relevant legislation and strengthen routine data collection, which had thus far been inadequate and inaccurate. Underlying weaknesses in such areas as financing, governance and medical technology nonetheless impeded the potential for delivery of the health services needed to respond to noncommunicable diseases. In that connection, emphasis must be placed on improving the quality of primary care and addressing the constraints that prevented universal coverage with those services. Special attention should also be devoted to mental health and issues affecting young people, such as alcohol and drug abuse. Existing resources earmarked for maternal and child health and communicable diseases must remain intact, however. It would therefore be necessary to seek additional resources and mechanisms for funding activities to combat noncommunicable diseases.

Dr GOUYA (Islamic Republic of Iran) said that developing countries were experiencing a growing burden of noncommunicable diseases, in addition to the substantial burden of communicable diseases that they continued to carry. The prevention and control of noncommunicable diseases required planning throughout a patient's life and demanded political and popular will. Matters to be

taken into account in such planning included ongoing studies of risk factors, continuous education for all age groups, respect for cultural norms, preventive interventions and patient care and rehabilitation. His country had established a risk surveillance system that provided valuable information for decision-making on appropriate measures. Important aspects in the prevention and control of noncommunicable diseases included governance resting fully with WHO, global political commitment, promotion of knowledge and skills, and financial and technical support. He expressed the hope that the outcome of the Health Assembly would be reflected in September's high-level meeting on the subject at the United Nations.

Dr VALENZUELA (Chile) said that efforts and action should be guided by proven scientific evidence so that the risk factors could be identified and noncommunicable diseases detected as early as possible. Joint policies should be formulated with the food industry, agriculture, trade, transport, urban development, education and finance. Formulating an integrated response at country level was complex, requiring capacity building, refocusing on primary health care and reinforcing policies on healthy lifestyles and the social, economic and environmental causes of noncommunicable diseases, monitoring and evaluating the noncommunicable disease burden, and assuring quality. In developing countries, issues related to health inequity should also be addressed.

Among a range of activities undertaken in Chile, the national health surveys had provided valuable information on the prevalence of risk factors. The multisectoral programme *Elige vivir sano* (Choose a healthy lifestyle), covering both physical and mental health, had been launched with the support and participation of the private sector.

Dr NAEEM (Afghanistan) said that his country, which had unfortunately been in conflict for more than three decades, had concentrated mainly on reducing the high rates of maternal and child mortality. It depended on limited external resources, and funds had not been available to gather information on the prevalence of noncommunicable diseases. Given the lack of priority afforded to those diseases in Afghanistan, WHO's support was requested for establishing an evidence base and a health management information system, training, monitoring and evaluation. The country also sought a commitment by donors to integrate the prevention and control of noncommunicable diseases into WHO's Basic Package of Health Services and the Essential Package of Hospital Services for Afghanistan. He thanked WHO for putting noncommunicable diseases high on the international agenda.

Dr YAHYA (Brunei Darussalam) said that specific tools such as the action plan for the global strategy for the prevention and control of noncommunicable diseases provided invaluable guidance for Member States. Effective implementation of the strategy was a major challenge, however, involving as it did policies, commitments and resources across all sectors. Inclusion of noncommunicable diseases on the agenda of the forthcoming United Nations General Assembly therefore marked a significant achievement with respect to raising their profile and highlighting their linkage with the socioeconomic and development agenda. It was consequently essential to capitalize on the opportunities thus provided to accelerate and secure the involvement and collaboration of all sectors in a concerted effort to combat noncommunicable diseases. Those diseases weighed heavily in Brunei Darussalam, where the promotion of health and a healthy lifestyle was high on the national health and development agenda. It looked to WHO to provide not only technical guidance but also a platform on which Member States could share experiences. WHO's leadership was crucial, particularly on cross-sectoral issues involving non-health bodies such as the trade and industry sectors. He supported the draft resolution.

Dr JACOBS (New Zealand) said that noncommunicable diseases were largely preventable through tackling the known risk factors and, for example, facilitating healthy choices for individuals and families. Win-win approaches must be sought to promote full multisectoral engagement in order to achieve balanced, workable, effective solutions. One important outcome of the forthcoming high-level meeting in New York would be improved tobacco control, in view of the link between smoking

and various noncommunicable diseases, including maternal and child health, which were of particular concern for New Zealand's Maori people. New Zealand had consistently taken strong action to reduce harm from smoking and urged all countries to follow suit. In its experience, regularly publicizing the results of small health targets helped to drive improvements in the prevention and management of noncommunicable diseases. Early access to good primary care services was also instrumental to cost-effective disease prevention and health promotion. Another positive outcome of the high-level meeting would therefore be a commitment to support WHO's efforts to strengthen health systems; the international organizations should coordinate their work to address the challenges of noncommunicable diseases. He strongly supported the draft resolution.

Dr PANTAZOPOULOU-FOTINEA (Greece) underlined the key role of prevention. Effective prevention of lifestyle diseases was a common goal at global and local levels. Success would require intersectoral involvement and international collaboration, in which context WHO had an important role to play. As part of its contribution to efforts to strengthen and enhance international cooperation on noncommunicable diseases, Greece had signed an agreement in March 2011 with the Regional Office for Europe establishing the Office for the Support to the Prevention and Control of Non-Communicable Diseases in Athens. Greece would provide € 2 million annually for that purpose, which it regarded as an investment in the common goal of exchange of knowledge, best practices and experiences in tackling noncommunicable diseases.

Ms HELFER-VOGEL (Colombia) said that the prevention and control of noncommunicable diseases formed an integral part of the national development plan in her country. The prevalence of noncommunicable diseases in Colombia was greatest among marginalized people and those living in poverty, who should therefore be the focus of prevention and control actions for healthy lifestyles.

Miss SIRINYA PHULKERD (Thailand) said that her country wished to cosponsor the draft resolution. Undue emphasis had been placed on the forthcoming high-level meeting of the General Assembly, whereas use of the many effective tools already available for combating noncommunicable diseases should be the more immediate concern. The increasing burden of noncommunicable diseases indicated underperformance, as in the case of work in the area of alcohol and childhood obesity, and inadequate financing. Increased resources alone were not, however, the answer; new ways of thinking were needed. Noncommunicable diseases were more difficult to deal with than communicable diseases because of the involvement of many factors and of sectors with different values and interests. Evidence suggested that the most effective, most sustainable way of dealing with noncommunicable diseases was to tackle the risk factors and social determinants and to look beyond the disease-based approach. The most cost-effective interventions, such as controlling the availability and marketing of unhealthy commodities and tax and price measures, were not welcomed by private-sector interests that profited from the epidemic of risky behaviours. Transparency, with focus on such potential conflicts of interest, was therefore crucial to a fruitful outcome to the problem of noncommunicable diseases.

Dr LEWIS FULLER (Jamaica) said that the high prevalence rates of noncommunicable diseases in Jamaica prevented it from achieving the Millennium Development Goals. National surveys had revealed an upwards trend in chronic noncommunicable diseases during the current decade, due to the risk factors associated with an unhealthy lifestyle. Action taken in countries of the Caribbean Community to halt that trend included a commitment to unite to stop the chronic noncommunicable diseases epidemic and annual observance of Caribbean Wellness Day to promote healthy lifestyles and physical activity region-wide.

The draft resolution should place more emphasis on health promotion and social marketing of healthy lifestyles and address the physical planning and reorganization of communities to provide enabling environments. She recommended the establishment of national multisectoral commissions on the policy aspects of noncommunicable diseases and, in recognition of their seriousness, integration of

noncommunicable diseases into the Millennium Development Goals. Jamaica would play its part in cosponsoring the draft resolution and pursuing the initiative at the high-level meeting in September.

Dr BRENNEN (Bahamas) supported the draft resolution. The Bahamian approach to countering noncommunicable diseases incorporated a range of activities aimed at galvanizing maximum support from a broad range of health sector and intersectoral stakeholders. Implementation activities included the development of a national health system strategic plan affording prominence to those diseases and the establishment of a committee composed of health care and community professionals to plan, implement and monitor relevant programmes. Prevention activities included the development of evidence-based nutrition and physical activity guidelines, a national tobacco control policy incorporating an initiative for smoke-free public places and a workplace wellness programme. Identification and surveillance activities comprised a community screening programme and a follow-up national STEPS survey for comparative purposes. With respect to treatment, a three-fold expansion of a pilot grant project for community organizations was planned in support of programmes promoting holistic lifestyle changes. Medications for noncommunicable diseases were provided free of charge. Against that background, the Bahamas favoured the establishment and dissemination of a database of global activities and best practices to aid countries to prevent and control noncommunicable diseases and avoid duplication of effort.

Dr GUTERRES CORREIA (Timor-Leste), speaking on behalf of the Member States of the South-East Asia Region, said that noncommunicable diseases had emerged as the leading cause of death and disability in the Region, creating growing burdens of disease and health costs that were rapidly becoming unaffordable. Although cost-effective population-based interventions were available, healthy behaviour and access to health care were compromised by poverty and low literacy levels. Lack of surveillance and research data on noncommunicable diseases was another barrier to the effective planning and implementation of prevention and control programmes, as was lack of training for human resources, which were already limited and overburdened. Available health funds were, moreover, stretched thin to meet the acute demands of tackling communicable diseases. A regional meeting two months earlier had culminated in the Jakarta Call for Action on Noncommunicable Diseases and the formulation of 10 key messages for transmission to the high-level meeting of the General Assembly, from which tangible outcomes were expected.

Mr LARSEN (Norway) urged Heads of State and Government to participate in the forthcoming high-level meeting. The Moscow Declaration provided important input to the preparations for that meeting, to which WHO should also send a strong message. The cross-sectoral agenda for prevention and control required the involvement of ministries, organizations in the United Nations system, nongovernmental organizations and the private sector, although in that connection it was essential to remain alert to conflicts of interest. In taking the leading role in fighting the epidemic, including the preparation for and follow-up to the high-level meeting, WHO must demonstrate its ability to live up to the challenge. In addition to the palpable concern over noncommunicable diseases and the need for national and international action, the current debate had highlighted the trust placed in WHO on that score. As a cosponsor of the draft resolution, he appealed to the delegates of Samoa and Côte d'Ivoire to consider withdrawing their proposed amendments; in the first instance, small island States were an important component of developing countries and were included in the definition of that term; in the second, he recalled that the draft resolution was the result of protracted negotiations, in which Côte d'Ivoire had participated.

The CHAIRMAN informed the Committee that Côte d'Ivoire withdrew its proposal.

Dr IBITOMI (Nigeria) said that the attention to noncommunicable diseases should not reduce the priority or resources consecrated to the health-related Millennium Development Goals, which was a foreseeable consequence of the heavy burden of noncommunicable diseases in developed countries.

A special fund or financing mechanism was therefore urgently needed to tackle noncommunicable diseases, similar to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Dr AL-THANI (Qatar) said that the high-level meeting to be held in New York would be a landmark event in the prevention and control of noncommunicable diseases, which were currently slowing progress towards a better world. Her country's national health strategy gave priority to those diseases, and the allocated budget would be increased annually in line with future expansion of work in that area. Preparations for the high-level meeting must have clear objectives in seeking to ensure a sufficient pool of human and financial resources for dealing with noncommunicable diseases. Technical support was needed to develop electronic data collection systems in order to evaluate progress.

Ms CHANETSA (Swaziland) supported the draft resolution but proposed inclusion of a reference in the preambular paragraphs to the Global Strategy for Infant and Young Child Feeding in view of the need for early nutrition in the context of primary prevention. With respect to paragraph 2, she proposed the inclusion of an additional subparagraph that would read: "to work comprehensively on primary prevention of noncommunicable diseases through ensuring early nutrition by enhancing rates of exclusive breastfeeding for the first six months, continued breastfeeding with adequate and safe complementary foods, and supporting women and families in carrying out these practices". The purpose of the proposed amendment was to ensure the coherence of policy decisions. Healthy diet, physical activity and the avoidance of risk factors were key elements in the prevention of noncommunicable diseases, on which a strong statement should be presented to the high-level meeting of the United Nations General Assembly in September.

Dr KOUILLA (Gabon) strongly supported the draft resolution, which reflected the global health challenges posed by noncommunicable diseases. Gabon was seeking solutions to those challenges at the domestic level through its national health development plan, which comprised programmes to combat tobacco use, drug addiction and noncommunicable diseases. An oncology centre was soon to be established, but additional human and financial resources would be needed for its operation. The control of noncommunicable diseases created an extra burden on the country's health expenditure, and he urged WHO to continue advocating additional funding to prevent noncommunicable diseases. The outcome of the forthcoming high-level meeting should include a global plan on noncommunicable diseases that was also applicable at national level, with the involvement of civil society. Measures taken locally should be monitored in order to assess their impact on the prevalence of the diseases.

Ms EL-HALABI (Botswana) said that urban growth in her country had led to more sedentary lifestyles, thus increasing the burden of noncommunicable diseases. Interventions had been introduced to address the most common modifiable risk factors and spread public health messages. School health programmes and health promotion policies offered new ways of empowering individuals to take responsibility for their own health. Risk prevention and management of noncommunicable diseases were integrated into Botswana's health service delivery system, data on the main noncommunicable diseases had been incorporated into the existing reporting system, and various centres of excellence had been opened. A WHO package of essential noncommunicable disease interventions was being tested in order to enable uniform management and the introduction of a high-quality, standardized approach at primary health care level. The absence of national data on the prevalence of noncommunicable diseases was a major challenge, however, and STEP 3 of the STEPwise survey had yet to be implemented. Botswana therefore requested support from WHO and other partners for data collection and substantive funding for tackling both noncommunicable and communicable diseases. She suggested that WHO organize an intersectoral ministerial meeting to discuss an approach to noncommunicable diseases, perhaps following the high-level meeting.

Dr ESPINOZA (El Salvador) recalled the statement made by his Government's Health Minister at the opening of the Health Assembly, which had drawn attention in particular to the problem of chronic renal disease in developing countries. There were two clearly identifiable causes of noncommunicable diseases. The first was fragmentation of health systems by prioritization of vertical programmes, generally in the form of projects; when funds were no longer provided, the resulting conditions were worse than before implementation of the project. The second was the production and intensive use of pesticides and insecticides, many of which had been prohibited in the country in which they were produced but were still being sold illegally to developing countries. Two corresponding solutions existed: health system strengthening should be given priority over vertical programmes; and developed countries should shoulder their share of responsibility in calling for tighter controls on the manufacturers of pesticides and insecticides and prohibiting their export. Those two actions would have significant health and environmental benefits, which would be greater than those achieved by funding the prevention and control of a specific disease.

Professor GHODSE (International Narcotics Control Board) acknowledged that licit drugs, such as opiates for palliative care and psychotropic substances for managing mental illness, were essential for the treatment of some noncommunicable diseases and could improve quality of life. A report published by the Board showed, however, that 90% of the global consumption of opiate analgesics was in a group of developed countries, whereas 80% of the world's population had limited or no access to those medicines. The situation was similar with regard to the consumption of psychotropic substances. The present situation was therefore far from equitable. The Board's recommendations for improvements included training and education, identification of excessively restrictive legislation and requirements for drug use and infrastructural development. The Board considered that the issues of drug dependency and the use of drugs for treating noncommunicable diseases should be incorporated into the agenda of the high-level meeting of the General Assembly, and the Board was ready to work with WHO and the international community on the preparation and follow-up of that meeting.

Ms RIJKS (International Organization for Migration) said that migrants should have access to culturally appropriate care. In line with the Moscow Declaration, her Organization recognized the right of all, including migrants, irrespective of their legal migration status, to the highest attainable standards of physical and mental health. The global migrant population of an estimated 1000 million people would shape the health challenges of the future. Migrants met barriers in terms of access to health services, were exposed to a variety of risk factors for noncommunicable diseases and suffered from socioeconomic inequality, the loss of social networks, poor integration, poor health literacy and xenophobia, all of which could lead to unhealthy lifestyles. The Organization supported WHO's focus on noncommunicable diseases and also advocated migrant-sensitive health systems. She proposed that the Member States devise mechanisms for periodic reporting on implementation of resolution WHA61.17 on the health of migrants.

In the aftermath of conflicts and natural disasters, care should also be taken to re-establish systems of prevention, treatment and control of noncommunicable diseases and to integrate displaced migrants into host communities. The strategies should be transnational in scope and include collaboration between regional bodies, governments and multisectoral partners to increase the migration health capacities of public health systems.

Mr ALOMARI (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that noncommunicable diseases were a barrier to poverty reduction, health equity, economic stability and human security, the most disadvantaged populations being the most vulnerable. National Red Cross and Red Crescent societies played a critical role in the global effort to combat noncommunicable diseases, working with national authorities to provide high-quality programmes and services to prevent disease and improve living conditions through community-based health programmes. Although the role of health professionals in treatment and care was important, it was equally important for governments to use the potential of volunteers with regard

to disease prevention and control at community level, especially given the shortage of qualified health staff for noncommunicable diseases in certain countries. Multi-stakeholder solutions and dialogue were needed.

Mr LEATHER (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN, said that his organization and the NGO Forum for Health supported WHO's action plan for the global strategy for the prevention and control of noncommunicable diseases and urged Member States to include mental health in their strategies. He noted that mental health had been included in a number of international resolutions and declarations. Furthermore, as mental disorders were linked to living conditions and were clearly implicated in the strong connection between noncommunicable diseases and poverty, the Commission on the Social Determinants of Health had affirmed that health strategies should build on the premise that improved quality of life and poverty eradication were fundamental to improving health and well-being. Mental disorders and other noncommunicable diseases were closely linked; for example, people with diabetes were twice as likely to suffer from depression, and treating both diseases improved patient compliance and cut costs. WHO should commit to action on mental health and integrate it into its approach to noncommunicable diseases.

Professor BERO (The Cochrane Collaboration), speaking at the invitation of the CHAIRMAN, urged WHO to use systematic, unbiased reviews conducted by independent organizations like hers as the basis for policies on the prevention, diagnosis and treatment of noncommunicable diseases. Although a publicly available database containing information on diagnostic and medical products could be useful, the information must be evidence-based and free from commercial bias. Many studies had shown that clinical trials of treatments sponsored by a single pharmaceutical company had produced results that favoured the company's products. WHO action plans and guidelines for the prevention of noncommunicable diseases must be based on the best available, unbiased evidence.

Dr LHOTSKA (Consumers International), speaking at the invitation of the CHAIRMAN, said that September's high-level meeting of the United Nations General Assembly should empower Member States to take effective legislative action to promote healthy diets for consumers through, inter alia, reformulation of foods, improved information, the removal of barriers to breastfeeding and, most importantly, protection from subtle and pervasive forms of marketing, such as sponsorship. The development and monitoring of nutritional standards and policy definitions must be government-led and free from conflicts of interest; experience had shown how the influence of the powerful food industry in multistakeholder initiatives could distort public health priorities. Her organization did not object to consultations with food companies, but it was concerned that companies might be allowed to fund programmes, guide policy formulation and identify priorities. She urged WHO to recognize the key role of marketing controls, protection of breastfeeding and promoting optimal complementary feeding as integral components of its noncommunicable disease strategy.

Ms RUNDALL (Corporate Accountability International), speaking at the invitation of the CHAIRMAN and also on behalf of the International Baby Food Action Network, said that tobacco and diet-related diseases were the result of corporate marketing and sales. The tobacco industry continued to flout Article 5.3 of the WHO Framework Convention on Tobacco Control, which recognized its fundamental conflict with public health policies. The private sector was set to play an increasing role in shaping policies and identifying priorities, and Member States must heed the call to remain vigilant in order to ensure that their policies on food and water were protected against companies' inherent conflicts of interest. At the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Diseases in Moscow in April 2011, for instance, the panel in the working group on food had consisted solely of representatives of the food industry, who had promoted their own partnerships and pledged voluntary self-regulation; it was to be hoped that the situation would be different at the high-level meeting of the United Nations General Assembly. Member States could not waste time or resources on unsustainable, unaffordable, ineffective solutions such as bottled

water, commercially sponsored education and processed foods alleged to have curative qualities. They should therefore strive to create clear, enforceable public health, nutrition and water standards that went beyond individual conflicts of interest and also addressed institutional conflicts of interest.

Ms HAGAN (Global Health Council, Inc.), speaking at the invitation of the CHAIRMAN, urged Member States to approve the draft resolution. The prevention of, and treatment and care of patients with, noncommunicable diseases must be incorporated into existing public health policies. Governments should develop inclusive national health and development plans in partnership with all relevant ministries, civil society and the private sector, and policies should provide incentives for making more widely available tools and technology for cost-effective management and complementarity of treatment and care. Decision-making should involve all society and be based on diverse expertise at national and international levels, such as the proposed world health forum.

Mr MWANGI (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, called on Member States and the Secretariat to ensure that the high-level meeting of the United Nations General Assembly took decisive action on the prevention, early diagnosis and long-term management of all noncommunicable diseases. Member States should ensure that WHO's global strategy was implemented equitably for prevention, for diagnosis, for treatment, for care and for support and that the focus was not confined to the four specified diseases. Its effectiveness should be ensured by strengthening health systems. Patients had to have a say in the design, leadership, implementation, monitoring and evaluation of effective, sustainable interventions, and patients' organizations should play an active role in formulating, implementing and monitoring legislation, health policies, regulatory frameworks, guidelines and standards. Emphasis should be placed on improving health literacy, increasing research on the prevalence, incidence and impact of noncommunicable diseases on the lives of patients, families and caregivers, and promoting early diagnosis and treatment to reduce morbidity and mortality. All policies should be based on the fundamental right to patient-centred health care based on the needs and choice of the individual patient, ensuring autonomy and independence.

Ms ADAMS (International Council of Nurses), speaking at the invitation of the CHAIRMAN, commended WHO's leadership in addressing noncommunicable diseases. The nursing workforce had a leading role to play in noncommunicable disease prevention, refocusing health policy and creating supportive environments that promoted healthy behavioural choices. Her organization had therefore launched a noncommunicable disease initiative to develop global nursing capacity, initially in eight countries, where nurses were preparing action plans and implementation strategies. It was also providing training and capacity development in diabetes and depression in five countries in southern Africa. Despite the potentially significant role of nurses, the global crisis in human resources for health in general and the shortage of nurses in particular represented a major barrier in many countries. Without the full involvement of nurses, including in policy discussions, the objectives of global strategies for prevention and control of noncommunicable diseases were unlikely to be implemented. She urged the Secretariat and Member States to improve the quality and quantity of interventions by investing in nursing and to make optimum use of the potential of nurses in strengthening appropriate health-care system responses to noncommunicable diseases.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, welcomed the Moscow Declaration, which highlighted the value of prevention and the need for all stakeholders to take responsibility for tackling noncommunicable diseases. To be effective, multistakeholder strategies must be fully integrated into health-care systems and extend beyond the traditional health sector. As most noncommunicable diseases were preventable, lifestyle choices and behaviours of individuals were central to any control strategy, which should include increasing health literacy, raising awareness of risks and informing people about ways to effect simple behavioural changes. The increased prevalence of

noncommunicable diseases posed a mounting challenge to health-care systems worldwide, and to public and private finances. Investing in prevention would contribute to higher economic growth and allow limited resources to be efficiently channelled to patients most in need.

The Federation's members had many new medicines in the pipeline to treat noncommunicable diseases, although further innovation would certainly be needed. They were also involved in ensuring that the medicines were appropriate for, and made available in, resource-poor settings. They worked in partnership with governments, intergovernmental organizations and civil society to help to strengthen health-care capacity in developing countries and educate populations at risk. They had implemented workplace wellness programmes that benefited their many employees worldwide. The Federation looked forward to sharing its experience as a leader in innovation and delivery of medicines and to listening to other stakeholders with a view to identifying efficient, effective and sustainable solutions to improve health and nurture future innovation.

Dr COSTEA (International Special Dietary Foods Industries), speaking at the invitation of the CHAIRMAN, commended WHO's leadership in preventing and controlling noncommunicable diseases and pledged her organization's cooperation. Good nutrition, especially in early life, was a key measure. In some countries, foods introduced after exclusive breastfeeding contributed to micronutrient deficiencies and excessive energy intake. Appropriate complementary foods for children could improve the intake of micronutrients needed to support the growing needs of infants and young children, thereby addressing known noncommunicable disease risk factors. Targeted programmes and initiatives to increase the availability of iron-fortified complementary foods had dramatically improved health outcomes and reduced anaemia. Exclusive breastfeeding for the first six months of life and the timely introduction of safe and appropriate complementary foods beyond six months were essential for children's health development and protecting against noncommunicable disease risk factors. The dietary food industry continued to invest in research and development to enhance nutrition throughout the life cycle and to ensure that its foods met the highest nutritional, safety and micronutrient needs of infants and adults according to international standards, taking into consideration known noncommunicable disease risk factors. The organization's members looked forward to supporting the efforts of Member States, the United Nations and the Secretariat to prevent noncommunicable diseases by developing evidence-based and comprehensive guidance for complementary feeding in a way that took into account the expertise and capacities of all stakeholders.

Mr PATON (Union for International Cancer Control), speaking at the invitation of the CHAIRMAN and on behalf of the International Diabetes Federation, the International Union against Tuberculosis and Lung Disease and the World Heart Federation, said that the four organizations and other partners formed the NCD Alliance, which was committed to working with Member States, the Secretariat, civil society and the private sector to ensure the success of the high-level meeting of the United Nations General Assembly on noncommunicable diseases and to support global actions against those diseases. He urged Member States to expand national responses to noncommunicable diseases by investing in coordinated multisectoral action and implementing a few priority interventions with timed targets and indicators; to support priority interventions to prevent noncommunicable diseases globally; to ensure prevention, early detection, treatment and control of noncommunicable diseases by strengthening primary health care systems and increasing access to quality assured essential medicines, technologies and affordable vaccines; to raise the priority of funding for prevention and control of noncommunicable diseases on the global health agenda; to establish goals and targets to reduce major risk factors and noncommunicable disease mortality rates; and to report regularly to the United Nations on progress towards those objectives. The high-level meeting would be a unique opportunity to raise the profile of noncommunicable diseases and to secure commitment from Heads of Government for a coordinated response, and for the allocation of increased resources.

Dr EISELÉ (FDI World Dental Federation), speaking at the invitation of the CHAIRMAN, said that oral diseases were among the most common chronic, noncommunicable diseases. They

represented a significant burden on overall health, and shared risk factors with other noncommunicable diseases, as recognized in resolution WHA60.17 on oral health. The burden of oral diseases was rising owing to rapidly changing lifestyles, especially in low- and middle-income countries, which were the least able to deal with the consequences in terms of poor health outcomes and the burden on national health budgets. An integrated, collaborative approach to noncommunicable disease prevention that included oral disease prevention and health promotion would have significant benefits in terms of strengthening health systems and oral health-care delivery. His organization worked closely with the WHO Global Oral Health Programme on integrated approaches to disease prevention based on common risk factors and health promotion. It urged WHO to recognize oral diseases as major global noncommunicable diseases and to call for their inclusion in the outcome document from the United Nations General Assembly's high-level meeting in September 2011.

Ms LACHENAL (World Federation for Mental Health), speaking at the invitation of the CHAIRMAN and on behalf of the NGO Forum for Health and the Alliance for Health Promotion, said that mental illnesses were not only a risk factor for other noncommunicable diseases, but were often a consequence of one of those diseases. Unless mental illnesses were tackled explicitly, noncommunicable disease initiatives would be less effective and, as research had shown, would cost more. It might not be possible at present to include all mental illnesses, but the WHO mental health Gap Action Programme had shown that there were cost-effective, evidence-based interventions for a limited set of diagnoses, and those should be included as part of the noncommunicable disease armamentarium. Mental illnesses should be included in some form as part of the action plan, recognizing the links with other noncommunicable diseases and the latest scientific developments in the area. Efforts to combat noncommunicable diseases should not be undermined at the outset by the exclusion of mental illnesses and substance abuse.

Dr EISELÉ (The World Medical Association, Inc.), speaking at the invitation of the CHAIRMAN and on behalf of the International Council of Nurses, the International Pharmaceutical Federation, the World Dental Federation and the World Confederation for Physical Therapy, said that the five organizations made up the World Health Professions Alliance. She urged Member States to take a holistic view of noncommunicable diseases, and not to try to tackle them individually or to reach a position where communicable and noncommunicable diseases competed for funding. Health professionals had a major role in reducing the global noncommunicable disease burden through appropriate action on health promotion, disease prevention, treatment and rehabilitation, and advocating research and finance. However, the global crisis in human resources for health was a significant barrier to progress in many countries. Action was also needed on social determinants of health. She supported WHO's leadership role, especially in emphasizing preventive health policy, and encouraged Member States to develop health systems built on a primary health care model and including prevention, rehabilitation and specialized health services.

Dr KAYI (Medicus Mundi Internationalis – International Organization for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN and on behalf of the People's Health Movement, said that the noncommunicable disease initiative should be broadened to include mental health. It was disappointing that no reference was made to the work of the Commission on Social Determinants of Health in the Secretariat's report. Unhealthy behaviours were much to blame, but structural determinants such as education, income, gender and ethnicity were also underlying causes of noncommunicable diseases and behavioural risk factors. There was also a crucial equity dimension, with variations closely linked to the social and environmental factors, not just individual behaviours. Preventive measures for social and environmental factors must be included in any outcome document from the United Nations General Assembly's high-level meeting.

In parallel with prevention, Member States should enhance access to affordable treatment for noncommunicable diseases. The draft resolution should spell out the responses of Member States and the Secretariat in terms of initiating legal and policy measures to ensure access to affordable

diagnostic tools and treatment, in particular the full use of the flexibilities of the Agreement on Trade-Related Aspects on Intellectual Property. However, rational use of medicines and diagnostic tools must be vigorously promoted in order to avoid “over-servicing”, which would burden health systems. It was also important to curb the practices of industries, such as food and agricultural corporations, that contributed to the prevalence of noncommunicable diseases. The draft resolution should therefore incorporate a call for the development of a code of conduct regulating the advertising and promotion of their products. The report gave insufficient detail on the health systems implications of noncommunicable diseases. Comprehensive primary health care services should be strengthened as the basis for chronic disease management, which called for ongoing follow-up and monitoring, and clinical audit. The drive to give more prominence to noncommunicable diseases was being conducted by some distinguished public interest civil society networks but also by some large transnational pharmaceutical companies whose main interests were marketing and profits. WHO should have a rigorous set of protocols for identifying and protecting against conflict of interest at the institutional level.

Mr Ming-Neng SHIU (Chinese Taipei) acknowledged the prevention and control of noncommunicable diseases as a high priority for Chinese Taipei, which focused on four main risk factors: tobacco use, unhealthy diet, physical inactivity and the harmful use of alcohol. A range of legislation had been introduced to combat tobacco and alcohol-related hazards; smoking was banned in most indoor public spaces; the first smoking helpline in Asia had been established and clinical smoking cessation services were funded. Legislation was being prepared with respect to unhealthy diet and lack of exercise, and a nationwide campaign on obesity prevention and control was to be launched. A comprehensive monitoring system for noncommunicable diseases and related risk factors was in place, with universal coverage for detection and treatment, such as population-based screening for cancer. Health insurance covered both treatment and special management programmes for noncommunicable diseases.

Dr ALWAN (Assistant Director-General) thanked Member States for their comments and for their contributions since the endorsement of the action plan for the global strategy for the prevention and control of noncommunicable diseases in 2008. Their contributions to the draft resolution had been encouraging and they had provided valuable guidance, which would be reflected in WHO’s workplans on prevention and control of noncommunicable diseases. Referring to preparations for the forthcoming high-level meeting of the United Nations General Assembly, he concurred that mental health disorders were a major public health problem, with inadequate access to appropriate health-care interventions in low- and middle-income countries, as well as in some high-income countries. The Secretariat was giving the matter priority through the mental health Gap Action Programme, and it aimed to expand activities. It had also developed evidence-based guidelines focusing on affordable, effective interventions that were being piloted in several countries across all WHO’s regions. It was hoped that the high-level United Nations General Assembly meeting would make a contribution in that area, as any action on strengthening health systems’ responses to noncommunicable diseases would have an equally positive impact on improving access to health care for people with mental health disorders, particularly in areas of financing, health information systems, and access to technologies and medicines. WHO had highlighted the importance of mental health disorders in the *Global status report on noncommunicable diseases 2010* and in other initiatives in preparation for the high-level meeting.

WHO took the guidelines on interaction with commercial entities very seriously in its work with partners, and was taking every possible precaution to avoid conflicts of interest in accordance with the resolutions and recommendations of the governing bodies. He expressed appreciation to The Cochrane Collaboration for its assistance in work on evidence-based guidelines. The positions and recommendations on interventions set out in the *Global status report on noncommunicable diseases 2010* had been based on a careful review of evidence and had taken into account cost-effectiveness and affordability for low- and middle-income countries.

The Secretariat's report focused on WHO's preparations for the forthcoming high-level meeting rather than the Organization's strategies in relation to noncommunicable diseases. Further information on action for health system strengthening and improving access to health care for noncommunicable diseases was set out in the action plan for the global strategy for the prevention and control of noncommunicable diseases and in the *Global status report on noncommunicable diseases 2010*.

The DIRECTOR-GENERAL also thanked the many speakers for their comprehensive comments. She welcomed the strong support expressed for WHO's leadership role in the prevention and control of noncommunicable diseases, and assured the Committee that she would work with all partners, including other organizations in the United Nations system, civil society, academia, and scientific experts, to provide support to countries in seeking public health solutions and cost-effective, affordable interventions based on the best possible evidence, avoiding any conflict of interest.

The fight against noncommunicable diseases would be long and would require sustained momentum. It was important to use the opportunity provided by international meetings to renew commitment to action and to monitor and measure progress in the prevention and control of noncommunicable diseases. Regional consultations and the Moscow meetings had paved the way for the forthcoming high-level meeting of the United Nations General Assembly. Other future meetings included the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, 19–21 October 2011); the Fifteenth World Conference on Tobacco or Health (Singapore, 21–24 March 2012); and the Eighth Global Conference on Health Promotion (Helsinki, June 2013). Those meetings were interconnected, and provided a platform for joint renewal of commitment and action. Control of tobacco was of special concern given the aggressive tactics of the tobacco industry reported at country level.

The CHAIRMAN invited comments on the draft resolution. It was his understanding that the amendments proposed by Côte d'Ivoire, Samoa and Swaziland had been withdrawn.

Mr TUITAMA LEAO TUITAMA (Samoa) thanked the sponsors, in particular Norway, for their efforts to achieve consensus on the draft resolution. He was prepared to withdraw the proposed amendment, having been assured that the definition of developing countries included the small island countries, so that the latter's needs would not be neglected.

Dr DOUA (Côte d'Ivoire) said that Côte d'Ivoire had proposed a minor amendment involving the translation of the English word "challenge", which should be rendered by "défi" in French rather than "répercussion". He agreed to withdraw the other proposed amendments.

The draft resolution, as amended, was approved.¹

Substandard/spurious/falsely-labelled/falsified/counterfeit medical products: Item 13.7 of the Agenda (Document A64/16)

The CHAIRMAN drew attention to the following draft decision on substandard/spurious/falsely-labelled/falsified/counterfeit medical products proposed by the delegations of Canada, Monaco, Russian Federation, Switzerland, United States of America and Zambia, which read:

The Health Assembly considered the report of the working group of Member States on Substandard/Spurious/Falsely-Labelled/Falsified/Counterfeit Medical Products contained in document A64/16 and decided to accept the "Next Steps" contained in the report. The Health

¹ Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA64.11.

Assembly specifically decided to extend the period set out in decision WHA63(10) in order to allow the working group to complete its work as soon as possible.

It was further decided that the working group should resume its work as soon as possible following the Sixty-fourth World Health Assembly and report on its work to the Sixty-fifth World Health Assembly through the 130th session of the Executive Board.

Mr MWAPE (Zambia), speaking as Chairman of the Working Group of Member States on Substandard/Spurious/Falsely-Labelled/Falsified/Counterfeit Medical Products, recalled that in decision WHA63(10) the Health Assembly had decided to establish the time-limited Working Group to examine matters concerning four specific issues (subparagraphs 3(a)–(d) of the decision) and that the Working Group should make specific recommendations in relation to those issues to the current Health Assembly. However, the Working Group had been constituted only in 2011 and had met only once, from 28 February to 2 March. The discussions had concentrated on arriving at a better understanding of WHO's work in the area and a clear articulation of the concepts involved, with a view to identifying principles and further clarifying the respective positions of delegations. Despite some progress, substantial differences persisted between delegations. Much work remained to be done and the Working Group had not reached the stage of making recommendations. Consequently, it requested the Health Assembly to consider extending its term to allow it to engage in further deliberations and report to the Sixty-fifth World Health Assembly through the Executive Board.

Dr DAULAIRE (United States of America) said that ensuring the quality, safety and efficacy of medical products was a shared mission, along with securing the increasingly complex global supply chain of medicines. As a result of major scientific and technological breakthroughs and globalization, regulatory authorities and health systems had to adapt to functioning in more complex environments. Interdependent relationships and networks would be needed to counter threats to the integrity of medicines and supply chain security. The United States continued to support the work by the International Medical Products Anti-Counterfeiting Taskforce to address those threats.

He endorsed the proposal to extend the term of the Working Group of Member States on Substandard/Spurious/Falsely-Labelled/Falsified/Counterfeit Medical Products, provided that its recommendations were science-based, measurable and practical and that its mandate as a time-limited and results-oriented working group continued to apply.

Dr VENEGAS (Uruguay), speaking on behalf of the Member States of the Union of South American Nations, said that falsified medical products affected developed and developing countries alike. Regulation by strong health authorities was needed to ensure the quality, safety and efficacy of all medical products being marketed and distributed. The health authorities in all 12 South American countries had been successfully working together under the auspices of the South American Council of Health on combating the falsification of medical products. The region's governments were committed to guaranteeing access to good-quality medicines at affordable prices, and fighting falsification must not jeopardize universal access to health care. He continued to support the decision taken at the previous Health Assembly to establish the Working Group; although it had met only once, it had overcome mistrust and concerns about conflicts of interest. He therefore supported the proposal to extend the term of the Working Group in the hope that it would meet twice before the next Health Assembly.

Ms ESCOREL DE MORAES (Brazil) welcomed the work of the Working Group and acknowledged the able leadership of Ambassador Mwape. Brazil had been closely engaged in the Working Group's initial work, and the long delay in its deliberations was regrettable. The Working Group had indeed overcome its members' divisions and, provided it operated in a transparent manner, was the only means of enabling WHO to make a strong response to fake medicines. She therefore supported the proposal to extend the term of the Working Group in the expectation that it would meet at least twice before the next Health Assembly. She reiterated Brazil's commitment to combating

falsified medicines, but insisted that the issue must be addressed in conjunction with the need to ensure universal access to medicines.

Mr DESIRAJU (India), speaking on behalf of the Member States of the South-East Asia Region, reiterated the importance they gave to access to good-quality, safe, efficacious and affordable medical products, and recalled that efforts had been made deliberately to confuse the issues of quality and intellectual property rights. He affirmed WHO's role in ensuring availability to good-quality, safe, efficacious and affordable medical products. He commended the work of the Working Group under Ambassador Mwape, even though it had not been set up until nine months after the adoption of decision WHA63(10). It had clearly differentiated between public health and intellectual property rights and made progress on terminology. WHO's priority, as the Director-General had made clear to the Working Group, was to protect populations from the harm caused by poor-quality, unsafe medicines by means of strict regulatory control, strict enforcement of quality standards and diligent pharmacovigilance.

He noted with relief that the International Medical Products Anti-Counterfeiting Taskforce had physically moved out of WHO's headquarters in response to demands by many developing countries, since the Taskforce's agenda was perceived to be dominated by intellectual property rights. Future discussions on enforcement of intellectual property rights should remain separate from work on the quality, safety and efficacy of medicines.

He called on the Health Assembly to extend the term of the Working Group and draw up a clear meeting schedule, to include up to three formal meetings before the next Health Assembly. The Working Group should not be sidetracked into discussions of terminology, but should discuss the possibility of establishing a Member State-driven mechanism to deal with quality, safety and efficacy issues, including strengthening drug regulatory authorities, provided that the mechanism was transparent, avoided conflicts of interest, and had a clear mandate. The Secretariat should continue to work on areas where a consensus had been reached by the Working Group. It should terminate all relations with the International Medical Products Anti-Counterfeiting Taskforce until the Working Group completed its mandate.

Professor ADITAMA (Indonesia) commended the establishment of the Working Group and its progress to date. Ensuring access to affordable medicines, technologies and other health products was essential to the protection of people in need. Principles of safety, efficacy and quality of medical products and promotion of the rational use of medicines should be at the heart of national and international policies, and compromised medical products undoubtedly represented a threat to health and well-being that WHO should counter. WHO should retain its impartial leadership in setting standards for ensuring the safety, efficacy and quality of medical products in a transparent and fair process driven by Member States and based on public health considerations. However, there should be no overlap between consideration of measures related to compromised products and those concerning enforcement of intellectual property rights. The term "substandard" should not be used to refer to medical products classified as spurious/falsely-labelled/falsified/counterfeit. He welcomed the move of the International Medical Products Anti-Counterfeiting Taskforce office away from WHO headquarters. Indeed, WHO should distance itself from the Taskforce, and the relationship between the two organizations should be redefined in favour of Member States. WHO had a crucial role to play in strengthening drug regulatory authorities, especially in developing countries, which was a key factor in combating products of compromised quality, safety and efficacy. He supported extension of the Working Group's term.

Dr IBITOMI (Nigeria) also supported extension of the term of the Working Group but urged it to fulfil its mandate as soon as possible. The developing countries were concentrating on the prevention and control of communicable diseases but lacked adequate facilities for monitoring the contribution of substandard/spurious/falsely-labelled/falsified/counterfeit medical products to their deplorable health indicators; while the Working Group continued its work, people were dying from the

effects of such products. He therefore urged the Working Group to accelerate action to achieve the objectives stated in the Working Group's report (document A64/16, Annex, paragraph 7). He supported the continued participation of WHO in the Taskforce.

Dr FOURAR (Algeria) said that the availability of good-quality, safe, effective and affordable medical products was a major concern of the Member States of the African Region. WHO should therefore play a major role in combating the manufacture, sale and consumption of counterfeit products, particularly in view of economic globalization. The volume and sophistication of the trade in such products across borders rendered their manufacture highly lucrative, particularly in developing countries with weak border controls and regulatory systems. The situation was exacerbated by the inaccessibility of official medical products in poor communities, partly owing to the position adopted by major pharmaceutical manufacturers. Their monopolies prevented manufacture of generic versions and kept prices high so that low-income countries were unable to meet the needs of their people for safe and effective medicines. Intellectual property rights were an important aspect of encouraging public health innovation and were one of the determinants of access to affordable medicines. The fight against counterfeit medicines was therefore linked to a complex and intersectoral area.

Counterfeit medicines endangered the health of consumers. Countries must adopt a common approach and WHO had to fulfil its role by setting international norms for pharmaceutical products and promote measures to ensure the availability of good-quality and affordable medicines. Member States should respect those norms and principles. He welcomed the establishment of the Working Group and its progress to date. It should give attention to WHO's provision of support to countries in strengthening national capacity for pharmaceutical regulation and the implementation of effective coordination and collaboration to ensure regional and subregional harmonization in that area, and in promoting collaboration between national regulatory authorities for exchange of information and inspection techniques. It should also consider setting up an intergovernmental negotiating body for the preparation of an international legal instrument to counter the manufacture, export, import and trade in counterfeit products and to regulate surveillance of supply and distribution systems. He supported extending the term of the Working Group and urged Member States to show flexibility and a spirit of compromise in the fight against substandard/spurious/falsely-labelled/falsified/counterfeit medical products.

Dr GOUYA (Islamic Republic of Iran) noted the continuing growth of the criminal trade in substandard/spurious/falsely-labelled/falsified/counterfeit medical products which seriously affected his country, other countries in the Eastern Mediterranean Region and developing countries. International support was essential to successful countermeasures. He commended the progress of the Working Group to date and supported extension of its term by at least one year. The Working Group's report should be submitted to the Sixty-fifth World Health Assembly.

Ms LANTERI (Monaco) said that it was paramount that the international community set about controlling and preventing the manufacture, distribution and use of substandard/spurious/falsely-labelled/falsified/counterfeit medical products. International and multisectoral cooperation was vital and should involve health, legal, police and customs authorities. She welcomed the work of the International Medical Products Anti-Counterfeiting Taskforce in that regard. The Secretariat should also work to enable Member States better to identify and prevent the distribution and use of such products. She welcomed the progress made by the Working Group and agreed that its term should be extended to allow it to finish its work as quickly as possible. The draft decision contained a provision for the Working Group to report on its work to the Sixty-fifth World Health Assembly.

Dr PÁVA (Hungary), speaking on behalf of the European Union, said that the candidate countries Turkey, Croatia, The former Yugoslav Republic of Macedonia, Montenegro, Iceland, the countries of the Stabilisation and Association Process and potential candidates Albania and Serbia, as well as the Republic of Moldova and Armenia aligned themselves with her statement. Ensuring the

safety, quality and efficacy of medical products should be a global health priority. Concern had been growing about substandard/spurious/falsely-labelled/falsified/counterfeit medical products, and the increase in, and sophistication of, the manufacture of such products and their complex distribution patterns had resulted in their entry into the supply chain of lawful products, seriously undermining public confidence in health-care systems. As the problem affected all countries, WHO should continue its important role in fighting counterfeit medical products, particularly with regard to its normative, practical and implementation-related work.

The report of the Working Group pointed to numerous shared concerns, emphasizing the need for global action. The European Union supported the measures being taken by WHO, listed (document A64/16, Annex, paragraph 6) as enhancing the availability of safe, good-quality medical products and strengthening national regulatory authorities and health systems. Intensification of control and prevention should begin without delay. She acknowledged the concerns raised during the meeting of the Working Group about governance of the International Medical Products Anti-Counterfeiting Taskforce. Although she considered that the Taskforce had been efficient, some matters, including definitions and the nature of the relationship between WHO and the Taskforce, required further thought and discussion. She therefore welcomed the proposed extension of the term of the Working Group as that would allow it to concentrate on the outstanding issues and avoid any duplication of work. She urged participants to show willingness to reach agreement on issues in order to make sure that the work produced results. When the Working Group reconvened, it should look primarily at efforts to counter falsified medical products and their production, while differentiating clearly between substandard and falsified medicines and maintaining a public health focus. Any discussions should also avoid issues related to the infringement of intellectual property rights.

The problem of substandard/spurious/falsely-labelled/falsified/counterfeit medical products was complex, ranging from policy questions on the availability and affordability of medicines to the criminal acts performed by those who deliberately manufactured and sold falsified medicines, regardless of the implications for public health. Although each issue should be addressed individually, strengthening national regulatory capacity was also vital. Questions on the quality and affordability of medicines were vital and were being discussed in other forums within WHO. In parallel with any further discussion by the Working Group, Member States and the Secretariat should concentrate on improving the quality, safety and efficacy of medicines from producers who wished to manufacture legitimate products but lacked the capacity to do so.

Mr HAJI (United Republic of Tanzania), speaking on behalf of the Member States of the African Region, expressed appreciation of the Director-General's leadership in the fight against substandard/spurious/falsely-labelled/falsified/counterfeit medical products. Such products represented a major public health threat as their illegal manufacture, distribution, widespread availability and indiscriminate use were detrimental to health and could lead to therapeutic failure, exacerbation of disease, disability and injury, wastage of scarce resources, loss of confidence in health-care systems, and death. Poor legislation, inadequate enforcement of existing legislation, lack of any harmonized definition of counterfeit medical products, the high cost of existing lawful medical products and weak national medicines authorities were the main reasons for the proliferation of such products, which affected the African Region most. In addition, manufacturing of such products was mainly driven by the prospect of big profits.

In accordance with decision WHA63(10), the Regional Office for Africa had set up a Regional Task Force and organized a consultative meeting with Member States in July 2010 at which measures proposed included the strengthening of, and networking between, national regulatory authorities, professional organizations and law enforcement agencies.

The Working Group had been established as a time-limited and results-oriented group expected to make specific recommendations. Welcoming its progress, he noted that it had not yet completed its work and he therefore supported the proposal that its term be extended to allow it to do so.

Mr ROSALES LOZADA (Plurinational State of Bolivia) said that his Government was firmly committed to the fight against substandard/spurious/false-labelled/falsified/counterfeit medical products. He supported the draft decision to extend the term of the Working Group, which was an appropriate forum for discussing the issue. It was important to disassociate WHO from past parallel initiatives that had generated much controversy and had not been prompted by public health considerations. He supported the proposal of the delegate of Uruguay that the Working Group should hold at least two more meetings before the 130th session of the Executive Board in January 2012.

Dr MOHAMMED (Iraq) said that globally unified standards for pharmaceutical products and companies were important and that standards for vaccines should be included in national legislation. Collaboration with the public sector and nongovernmental organizations should be strengthened and the importance reaffirmed of monitoring standards of medical products. In addition, all medical products should be registered in order to allow regulation and control of the products, their distribution and use. Work should concentrate on setting quality standards and ensuring the availability of medical products at affordable prices and should avoid mixing discussion of intellectual property issues with issues related to substandard/spurious/false-labelled/falsified/counterfeit medical products.

Ms WISEMAN (Canada) said that, as the leading global health body, WHO must show leadership in the fight against substandard/spurious/false-labelled/falsified/counterfeit medical products. She supported the proposed extension of the term of the Working Group but considered that the time-limited and results-oriented nature of the mandate should continue. Discussion of further meetings of the Working Group was premature and she urged its members to pledge to complete the work as soon as possible. It was important that the working group continue to build on its progress to date.

The International Medical Products Anti-Counterfeiting Taskforce was the sole forum where national regulatory authorities could work together and with other sectors. Participation in the Taskforce's discussions had contributed to Canada's success in controlling and preventing the manufacture and distribution of counterfeit medical products. It was important that any outstanding governance and mandate issues should be addressed in order to allow WHO to continue its leadership role in that area, particularly with regard to the setting of norms and standards and capacity building.

Dr RUBERU (Sri Lanka) said that Sri Lanka was one of the few countries in the world to provide free access to health care for its entire population, with supply of pharmaceutical products accounting for a large proportion of the health budget. In recent years the cost of pharmaceutical products had increased for a variety of reasons, resulting in a gap between required and available funds in the national budget. Rational prescribing of medicines and efficient management of them were therefore crucial. Highlighting the role that the introduction of good-quality generic pharmaceutical products had played in his country's health-care system, he drew attention to the national legislation and regulatory framework introduced in order to guarantee good-quality, safe and efficacious medical products on the domestic market.

He welcomed the work of the Working Group and its examination of the role of WHO both in ensuring availability of good-quality, safe and affordable medical products and in the prevention and control of the former medical products. His country would contribute constructively to its continued activities, one focus of which should be on making developing countries better able to produce good-quality generic medicines through technology transfer and funding. He supported the proposal to extend the term of the Working Group.

The Secretariat should not allow agencies responsible for enforcing intellectual property rights, such as the International Medical Products Anti-Counterfeiting Taskforce, to affiliate their work with that of WHO.

Dr NIRACHA USSAVATHIRAKUL (Thailand) noted the progress made at the first meeting of the Working Group. She supported the request to extend its term by one year, but emphasized that, in

its work on counterfeit medical products, WHO should focus on public health issues alone and not intellectual property rights. Cooperation with any outside entity, such as the International Medical Products Anti-Counterfeiting Taskforce, should be transparent and avoid conflicts of interest. WHO should therefore suspend all relations with the Taskforce until the Working Group's work was finalized and its recommendations adopted by the Health Assembly.

Dr YANO (Kenya) expressed concern at the fact that the Working Group had met only once, after a delay, and had been unable to complete its mandated work. Acknowledging the importance of improving access to affordable, quality, safe and efficacious medicines, he supported the request to extend the Working Group's term by one year.

Mr KUDO (Japan) said that Japan was supporting WHO's activities related to combating counterfeit medical products by conducting training and making professionals available, thereby helping to improve the accessibility, quality and rational use of medicines in developing countries. Japan supported WHO's involvement with the International Medical Products Anti-Counterfeiting Taskforce, which played a significant role. However, the failure of the international community to strengthen measures to combat counterfeit medical products was a matter for concern. The measures, monitoring system and inspection methods contained in the Taskforce's guidelines should be actively implemented. He endorsed the request to extend the Working Group's term.

Mr BEN AMMAR (Tunisia) said that, thanks to a State-supervised system of distributing medical products, Tunisia was free of counterfeit products but could not remain indifferent to events elsewhere. While the debate had reached stalemate over terminology, hundreds of lives were at risk owing to counterfeiters' greed and a lack of means to control the markets. As the counterfeiting of products was a matter of international public health, WHO was the right forum for resolving the problem. The unfortunate confusion over intellectual property rights in connection with the International Medical Products Anti-Counterfeiting Taskforce might lead to serious problems with regard to the medicines supply chain. The Taskforce had been set up precisely because of the lack of consensus on establishing an international convention and should not be abandoned until a better alternative approach could be adopted.

Dr SINOLINDING (Philippines) commended the work of the Working Group on counterfeit medical products from a public health perspective and agreed that it was important to improve access to affordable, good-quality, safe and efficacious medicines. WHO should continue to strengthen national regulatory authorities and health systems, while supporting work on generics and the rational selection and use of medical products. He looked forward to the completion of the Working Group's mandate.

Dr AYDINLI (Turkey) said that, despite national and international countermeasures, medical products were being increasingly counterfeited. According to the European Parliament, 1% of the medicines sold in Europe through the lawful supply chain were falsified. In the rest of the world, the figure could be as high as 30%. Since 1 January 2010, Turkey had been applying a tracking system aimed at monitoring medicines in cooperation with the whole supply chain. Products were identified by a serial number and code, allowing medicines to be traced from producer to end user. The system covered prescription and non-prescription medicines as well as medical nutritional products. Convinced that national efforts should be supported by an international commitment to promoting access to affordable, good-quality medicines, Turkey was willing to share its experience with other countries.

Ms TOLSTOÏ (France) said that France was committed to combating the growing threat of falsified medical products to international public health. She reassured France's partners that the fight against counterfeit medicines was not intended to block trade in generic medicines, which were also

being counterfeited. Although in her view the term “falsified” was the most appropriate, the Working Group should be left to decide on the terminology. WHO had a central role to play in the fight against counterfeit products, France and many other Member States fully supported the work of the International Medical Products Anti-Counterfeiting Taskforce, whose multidisciplinary nature should be preserved. It was to be hoped that the Working Group would complete its work before the Sixty-fifth World Health Assembly.

Dr AGHNAJ (Morocco) commended WHO’s role in ensuring the safety, quality and efficacy of medical products and the deliberations of the Working Group, which should be authorized to continue its work for another year. Given the international scale of the problem, more should be done in Africa to combat counterfeit medical products. Cooperation and partnerships between developing countries should be enhanced, for example by designating a regional reference laboratory. Morocco’s national medicines quality control laboratory possessed the necessary experience and expertise.

Mr CONSTANT (Trinidad and Tobago) said that all the proposals made by the Working Group in its report would benefit countries in their fight against counterfeit medical products, especially small developing countries such as his. With their small national regulatory agencies they faced several challenges, including an underdeveloped medicines manufacturing sector and imported counterfeit products; a programme to monitor and regulate imports must be established. The proliferation of Internet trade in medical products made a necessity of good practices. Regional harmonization, as exemplified by the activities of the Pan American Network for Drug Regulatory Harmonization, was another useful method of combating counterfeit medicines. The Network’s relevant working group had proposed several initiatives for harnessing national experience through international linkages.

Dr FRANCO GAME (Ecuador) welcomed the Working Group’s report. As good-quality, safe and efficacious medicines were essential to enjoyment of the right to health, it was incumbent on States to ensure access to them. There had nevertheless been a considerable increase in the number of falsified medicines on the market, owing in part to weak health vigilance systems. Governments should implement national and regional strategies to end unscrupulous practices. She supported the request to extend the Working Group’s term.

Ms ZHANG Xiaobo (China), noting the Working Group’s report, expressed her country’s support for WHO’s work on combating counterfeit medical products from a public health perspective. WHO should provide an international platform for the exchange of information, supporting national regulatory bodies and promoting public awareness. Member States should do more to exchange information and cooperate in combating counterfeit products while respecting each country’s own legislation. The Working Group should focus on improving the definitions of counterfeit products in order to make the fight against counterfeit products more effective. China agreed to the extension of the Working Group’s term.

Dr LEWIS FULLER (Jamaica) welcomed the leading role of WHO in combating substandard/spurious/falsely-labelled/falsified/counterfeit medical products and their adverse effect on public health. The provision of good-quality, safe and efficacious products must remain a priority for the Organization since it was particularly relevant to countries, like Jamaica, lacking the capacity to manufacture their own products.

She welcomed the report of the Working Group, in particular the recommendation for an intergovernmental negotiating body to draw up legally binding instruments to combat those compromised products. She recommended that other relevant existing documents also be taken into consideration by the Working Group as it continued its work.

Dr Ming-Neng SHIU (Chinese Taipei) also welcomed the report of the Working Group. Chinese Taipei had a well-established system of evaluation and surveillance to ensure the quality, safety and efficacy of medical products. The provision of legitimate medicines, provided by medical services and covered by health insurance, was always guaranteed. Illegal drugs could be obtained in Chinese Taipei through various channels, and some dealers even managed to promote them through the media and misleading health education programmes. Countermeasures had been introduced, including an interdepartmental task force.

He welcomed WHO's three future roles, as proposed in the report. Chinese Taipei would continue to collaborate with government agencies and others in combating illegal medical products and halting the spread of counterfeit drugs.

Mr BESANÇON (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, said that, in countries with a high burden of communicable diseases, falsified medical products had already begun to result in drug resistance and reverse achievements made. In several regions people were also at risk from medicines that might have been accidentally adulterated, produced to a poor standard and/or degraded by poor storage facilities. Such issues should not be ignored, but it was important to distinguish them from deliberate falsification. Falsification of medicines had remained a global threat to public health since a resolution on the issue had first been proposed in 2008. Member States should pledge themselves to take definitive action to prevent the falsification of medicines and ensure that trust in health systems was not dented.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, drew attention to the dire effects of falsified medicines on people's health, including causing drug resistance or even death. Vigorous action was needed from the global community to tackle a growing phenomenon: in 2010, a 10% rise compared with two years before had been reported in the number of substandard/spurious/false-labelled/falsified/counterfeit products, with a significant proportion affecting licensed wholesale distributors or pharmacies.

A multistakeholder and multidisciplinary response led by the Secretariat and Member States was needed, with both local and global cooperation, in order to ensure patient safety and halt the production of those compromised medicines.

Mr GOPAKUMAR (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN, noted the right of all people to access to safe, good-quality and efficacious medicines. A requirement was the assured availability of satisfactory medicines at affordable prices, as that would remove the incentive to trade in or purchase compromised medicines.

Efforts to address the issue should also involve strengthening drug regulatory systems, particularly in African countries. He therefore urged Member States to switch their attention from short-term solutions to the root causes of the proliferation of compromised medicines.

Mr MWANGI (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, said that substandard/spurious/false-labelled/falsified/counterfeit medical products posed a real threat to patients and the quality and safety of the medicines available to them. Such products also risked eroding patients' trust in health-care systems and failed treatment of illnesses or diseases. WHO should therefore take the lead with urgent action to protect patients globally, bringing together all relevant stakeholders to address the issue. As patients often lacked sufficient knowledge or choice to avoid exposure to those compromised products, all partners needed to work to ensure that adequate information and solutions were provided.

The DIRECTOR-GENERAL expressed appreciation of the comments made by Member States and others and reaffirmed her commitment to supporting the work of the Working Group in order to counter definitively the risks posed by substandard/spurious/false-labelled/falsified/counterfeit medical products.

The CHAIRMAN said that he took it that the Committee wished to approve the draft decision.

The draft decision was approved.¹

Health-related Millennium Development Goals: WHO's role in the follow-up to the high-level plenary meeting of the sixty-fifth session of the United Nations General Assembly on the review of the Millennium Development Goals (September 2010): Item 13.3 of the Agenda (Documents A64/11, A64/11 Add.1 and EB128/2011/REC/1, and resolution EB128.R1) (continued from the ninth meeting)

The CHAIRMAN drew attention to a revised version of the draft resolution on WHO's role in the follow-up to the United Nations High-level Plenary Meeting of the General Assembly on the Millennium Development Goals (New York, September 2010), which incorporated the amendments proposed during the Committee's ninth meeting and which read:

The Sixty-fourth World Health Assembly,

PP1 Recalling resolutions WHA63.15 and WHA61.18 on monitoring of the achievement of the health-related Millennium Development Goals, and WHA63.24 on accelerated progress towards achievement of Millennium Development Goal 4 to reduce child mortality: prevention and treatment of pneumonia;

PP2 Expressing deep concern at the slow pace of progress in achieving Millennium Development Goals 4 and 5 on reducing child mortality and on improving maternal health;

PP3 Acknowledging that much more needs to be done in achieving the Millennium Development Goals as progress has been uneven among regions and between and within countries, despite the fact that developing countries have made significant efforts;

PP3bis Recognizing that adequate antenatal care reduces the risks of maternal mortality, prematurity and other poor related outcomes that will increase the challenges of taking care of very young neonates; [Jamaica]

PP4 Recognizing the need to work towards greater transparency and accountability in international development cooperation **regarding health [USA]**, in both donor and developing countries, focusing on adequate and predictable financial resources as well as their improved quality and targeting;

PP5 Welcoming the United Nations Secretary-General's Global Strategy for Women's and Children's Health launched at the United Nations High-level Plenary Meeting of the General Assembly on the Millennium Development Goals (New York, September 2010), and acknowledging the strong political and financial commitment by Member States to follow up and implement the strategy;

PP6 Noting the United Nations Secretary-General's request that WHO lead a process to determine the most effective international institutional arrangements for global reporting, oversight and accountability on women's and children's health, including through the United Nations system;

PP7 Stressing that the monitoring of resource flows and results is a vital requirement for improving the accountability and responsiveness by governments and international development partners **in addressing health issues; [USA]**

PP8 Welcoming the establishment of the Commission on Information and Accountability for Women's and Children's Health, which consists of high-level representatives;

~~**PP9** Noting that the objectives of the Commission on Information and Accountability for Women's and Children's Health are:~~

¹ Transmitted to the Health Assembly in the Committee's fifth report and adopted as decision WHA64(10).

- (1) ~~to determine international institutional arrangements for global reporting, oversight and accountability on women's and children's health—this accountability framework will encompass results and resources, and identify the roles of the different partners involved;~~
- (2) ~~to identify ways to improve monitoring of progress towards women's and children's health while minimizing the reporting burden on countries, including establishing a set of core indicators, efficient investment in data generation and better data sharing;~~
- (3) ~~to propose actions to overcome major challenges to accountability at the country level, including strengthening of country capacity and addressing major data gaps such as the monitoring of vital events;~~
- (4) ~~to identify opportunities for innovation provided by information technology that will facilitate improved accountability for results and resources, and to propose ways of ensuring that these opportunities are harnessed to bring maximum benefits to countries;~~
- [Thailand]

PP10 Stressing that aspects **concerns [USA]** related to health equity and rights should also be addressed in efforts to achieve the Millennium Development Goals;

PP11 Stressing ~~furthermore [Canada]~~ that the Commission ~~on Information and Accountability for Women's and Children's Health [Canada]~~ should take into account relevant existing data collections and existing performance indicators;

PP12 Welcoming the final report of the Commission and its set of recommendations for strengthening accountability for resources and results in women and children's health, [Canada]

1. REQUESTS the Executive Board:

(1) **to hold a discussion at its 130th Session in January 2012 on the implementation of the recommendations of the Commission; [Canada]**

2. URGES Member States: [Thailand]

(1) **to implement the recommendations provided by the Commission on Information and Accountability for Women's and Children's Health to improve the accountability of results and resources; [Thailand]**

3. REQUESTS the Director-General:

(1) to ensure the effective engagement of all **key [Canada]** stakeholders in the **follow-up to the [Canada]** work of the Commission; ~~on Information and Accountability for Women's and Children's Health [Canada]~~

(2) to report to the ~~Sixty-fourth~~ **fifth [Canada]** World Health Assembly on progress **achieved in the work of the Commission on Information and Accountability for Women's and Children's Health [Canada]** in connection with the agenda item concerning the Millennium Development Goals.

Dr PÁVA (Hungary), speaking on behalf of the European Union, proposed further amendments to the draft resolution. In the third preambular paragraph bis, the term “poor related outcomes” should be replaced by “complications of pregnancy and delivery that can result in poor health outcomes for mothers and newborns”, and the end of that paragraph the words “very young” should be deleted. A footnote should be added to the words “URGES Member States” in paragraph 2, reading “And regional economic integration organizations, as appropriate”.

Mr BLAIS (Canada), supported by Dr WALAIORN PATCHARANARUMOL (Thailand), proposed further amendments to some sections of the draft resolution that Canada had previously amended, in order to strengthen the text. Paragraphs 1 and 2 should be inverted, while in original paragraph 1, the words “to hold a discussion” should be replaced by “to review progress”, and the

clause should be restructured to read: “to review progress on the implementation of the recommendations of the Commission, starting at its 130th session in January 2012”.

In subparagraph 3(2) the words “to the Sixty-fifth World Health Assembly” should be replaced by “annually until 2015 to the Health Assembly”.

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

The draft resolution, as amended, was approved.¹

(For continuation of the consideration of this agenda item and approval of a draft resolution, see summary record of the eleventh meeting, section 2.)

The meeting rose at 15:25.

¹ Transmitted to the Health Assembly in the Committee’s fifth report and adopted as resolution WHA64.12.

ELEVENTH MEETING

Monday, 23 May 2011, at 09:15

Chairman: Dr W. AMMAR (Lebanon)

1. FIFTH REPORT OF COMMITTEE A (Document A64/57 (Draft))

Dr KULZHANOV (Kazakhstan), Rapporteur, read out the draft fifth report of Committee A.

The report was adopted.¹

2. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Health-related Millennium Development Goals: WHO's role in the follow-up to the high-level plenary meeting of the sixty-fifth session of the United Nations General Assembly on the review of the Millennium Development Goals (September 2010): Item 13.3 of the Agenda (Documents A64/11 and A64/11 Add.1) (continued from the ninth meeting)

The CHAIRMAN drew attention to the draft resolution on working towards the reduction of neonatal mortality proposed by Argentina, Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Plurinational State of Bolivia, and Uruguay, to which Algeria, Angola, Bangladesh, Costa Rica, Cuba, Democratic Republic of the Congo, Dominican Republic, El Salvador, Ghana, Guatemala, Honduras, Mexico, Mozambique, Nicaragua, Panama, Senegal and Trinidad and Tobago wished to be added as sponsors, and which read:

The Sixty-fourth World Health Assembly,

PP1 Recalling resolution WHA58.31 advocating universal coverage of maternal, newborn and child health interventions;

PP2 Recalling the ~~launch of the~~ [Ecuador] Millennium Development Goals **4 and 5, [Ecuador]**, with their targets **to reduce, between 1990 and 2015, under-five mortality by two-thirds and maternal mortality by three-quarters** for health care and human development to be met by 2015, the fourth of which commits the international community to reduce by two thirds the mortality rate among children under five between 1990 and 2015, while the fifth is to reduce maternal mortality by three quarters over the same period; [Ecuador]

PP3 Recognizing the importance of the Global Strategy for Woman's and Children's Health – launched in September 2010 by the Secretary-General of the United Nations and acknowledging the report of the Commission on Information and Accountability for Women's and Children's Health;

PP4 Recalling the Partnership for Maternal, Newborn and Child Health, which reflects the growing international interest in and attention to this issue, and whose objective is to coordinate and intensify national, regional and global activities along the continuum of care for maternal and child health to achieve the Millennium Development Goals;

¹ See page 338.

PP5 Taking into account the request by Member States to implement the WHO Regional Strategies;

PP6 Aware that WHO Member States have undertaken a number of actions and programmes to reduce neonatal morbidity and mortality and meet the targets set out by the MDGs, developing their respective *National Plans for the Accelerated Reduction of Maternal and Child Mortality*, to improve **equitable [UK]** access, timeliness, continuity and quality of health care for women of childbearing age and newborns;

PP7 Noting the conclusion of the World Health Assembly that there has been insufficient **and uneven [Thailand]** progress towards achieving MDG 5 **and an increase in measles, mumps and rubella in a number of countries [Thailand]**, and that, while MDG 4 has progressed in the reduction of **during [Niger]** post-neonatal mortality, it has stagnated in relation to the reduction of neonatal mortality;

PP8 Concerned by the limited resources for disease prevention and treatment of newborns in developing countries, which contribute to high neonatal mortality rates;

PP8bis Recognizing the evidence that early and exclusive breastfeeding significantly prevents neonatal mortality; [India]

PP9 Recognizing that neonatal mortality is a significant social and economic burden that seriously affects countries and in particular developing countries, that rates should be reduced both by preventing the most common problems such as prematurity, sepsis and respiratory conditions, and also by implementing basic, high-impact and low-cost interventions founded on solid scientific evidence;

PP9bis Recognizing that universal access to cost-effective neonatal survival interventions, through the application of outreach, family, community and facility-based clinical services, averts a huge proportion of neonatal deaths worldwide; [Thailand]

PP10 Aware that meeting the targets of MDGs 4 and 5 will require intense **health and intersectoral [Thailand]** efforts **with a high level of political commitment; [Thailand]**

1. URGES Member States:

(1) to ensure that health authorities in countries with high neonatal mortality rates use their stewardship and leadership to involve other institutions and sectors, to strengthen capacity to achieve a greater reduction in avoidable neonatal and perinatal mortality in the context of improving the continuum of maternal and child health;

(2) to further promote political ~~will to apply~~ **commitment for effective implementation of the [Thailand]** existing **national, [UK]** regional and/or global plans ~~and implement~~ **with the application of [Thailand]** evidence-based strategies and interventions, **including the Baby-Friendly Hospital Initiative, [China]** to improve neonatal health **and increase access to quality maternal, newborn and child health services; [UK]**

(3) to advance neonatal care as a priority and develop, as appropriate, plans ~~based on~~ **for universal access to cost-effective [Thailand]** interventions, including information and awareness-raising **behaviour change communication, [Niger]** **skilled birth attendants and early postnatal care and early and exclusive breastfeeding; [UK]**

(4) to strengthen the neonatal mortality surveillance system including data and vital statistics collection as well as monitoring and reporting **mechanisms; [UK]**

2. REQUESTS the Director-General:

(1) to continue to raise awareness within the international community about the global burden of neonatal mortality and promote, based on current best practices, targeted plans to increase access to high quality and safe health services to prevent and treat neonatal conditions within an integrated mother and child health package;

(2) to strengthen regional and country level institutional capacity and human resources (including skilled birth attendants and essential newborn care, **including the Baby-**

Friendly Hospital Initiative, [China]) to identify innovative solutions, and promote research to address the main causes of neonatal mortality such as prematurity, sepsis, respiratory conditions and infections, in particular of nosocomial origin;

(3) to support coordination of actions with WHO bodies and **United Nations agencies [UK]** other stakeholders and strengthen or build partnerships to promote intra and inter-regional collaboration in order to enhance effectiveness of action in this specific area;

(4) to provide Member States with the necessary assistance and technical advice to develop and implement national policies, plans and strategies for the prevention and reduction of perinatal and neonatal mortality, and related maternal morbidity and mortality;

(5) Ensure a successful outcome for the report of the Commission on Information and Accountability for Women's and Children's Health and the implementation of the recommendations contained therein. [Niger]

The CHAIRMAN also drew delegates' attention to a minor error in the seventh preambular paragraph, in which reference was made to measles, mumps and rubella instead of the maternal mortality ratio and asked the Secretariat to read out the corrected paragraph in full.

Ms McLELLAN (Assistant Secretary) read out the corrected version of the seventh preambular paragraph : "Noting the conclusion of the World Health Assembly that there has been insufficient and uneven progress towards achieving MDG 5 and an increase in the maternal mortality ratio in a number of countries, and that, while MDG 4 has progressed in the reduction of post-neonatal mortality, it has stagnated in relation to the reduction of neonatal mortality;"

Dr FRANCO GAME (Ecuador) welcomed the addition of the countries named by the Chairman as cosponsors of the draft resolution and said that the draft resolution had also received the endorsement of the 43 countries comprising the Group of the Americas. She proposed some minor amendments: in the seventh preambular paragraph, "post" should be replaced by "child". In order to ensure that the draft resolution also contained provisions for healthy neonates, after "interventions" in subparagraph 1(3), the following should be inserted: "including actions to address sepsis and nosocomial infections". Finally, in subparagraph 2(3), "WHO bodies" should be replaced by "relevant WHO entities."

Mr MÉSZÁROS (Hungary), speaking on behalf of the European Union, expressed his appreciation of the Secretariat's timely work in preparing the consolidated text. He too had some further amendments to propose. In the title, and wherever else appropriate, the words "perinatal and" should be inserted before "neonatal". In the third preambular paragraph, "acknowledging" should be changed to "welcoming" for the sake of consistency with the wording of the eighth preambular paragraph of the draft resolution on follow-up to the United Nations' high-level meeting on the Millennium Development Goals.¹ At the beginning of the fourth preambular paragraph, "recalling" should be replaced by "recognizing". With regard to the eighth preambular paragraph bis, he proposed that "reduces" should be used in place of "prevents" and that ", and recalling, in this regard, the importance of the implementation of the global strategy for infant and young child feeding and the WHA63.23 and other related resolutions." should be inserted at the end of the paragraph. In the ninth preambular paragraph bis, "survival" should be replaced by "health", "clinical" by "prevention, promotion and treatment", and "averts" by "significantly reduces". In the same paragraph, "including" should be inserted after "interventions," and "perinatal and" before "neonatal deaths". The amended paragraph would read: "Recognizing that universal access to cost-effective neonatal health interventions, including through the application of outreach, family, community and facility-based prevention, promotion and treatment services, significantly reduces a huge proportion of perinatal and

¹ Subsequently adopted as resolution WHA64.12.

neonatal deaths worldwide.” In subparagraph 1(2), “equitable” should be inserted after “increase”, while, in subparagraph 2(1), “including reproductive health” should be inserted at the end of the subparagraph. In addition, the wording of subparagraph 2(5) should be amended to echo subparagraph 3(2) of the draft resolution on follow-up to the United Nations’ high-level meeting on the Millennium Development Goals.¹

Mr WEEKS (United Kingdom of Great Britain and Northern Ireland), welcoming the comments made by the delegate of Hungary, requested that his country also be listed as a sponsor of the draft resolution, as amended.

Dr PARRONDO BABARRO (Spain) requested that his country too be listed as a cosponsor of the draft resolution.

In the absence of further comments, the CHAIRMAN said that he took it that the Committee wished to approve the draft resolution, as amended.

The draft resolution, as amended, was approved.²

Draft WHO HIV/AIDS strategy 2011–2015: Item 13.6 of the Agenda (Document A64/15) (continued from the ninth meeting)

The CHAIRMAN invited consideration of a revised version of the draft resolution proposed by the delegations of Angola, Argentina, Brazil, Cape Verde, Panama, Paraguay, Timor-Leste and the United States of America, which reflected the outcomes of an informal working group and read:

The Sixty-fourth World Health Assembly,

Recalling resolution WHA63.19 which requested the Director-General, inter alia, to develop a WHO HIV/AIDS strategy for 2011–2015 that builds on previous WHO HIV/AIDS strategies and plans endorsed by several Health Assemblies, including resolutions WHA53.14, WHA56.30, WHA59.12 and WHA59.19;

Having considered the draft WHO HIV/AIDS strategy 2011–2015,³

1. ENDORSES the global health sector strategy on HIV/AIDS, 2011–2015;
2. AFFIRMS the vision and strategic directions of the global health sector strategy on HIV/AIDS, 2011–2015 and that the global strategy aims to guide the health sector’s response to HIV/AIDS, including recommended actions at country and global levels, as well as contributions to be made by WHO;
3. WELCOMES the alignment of the global health sector strategy on HIV/AIDS, 2011–2015 with other strategies addressing related public health issues, including the UNAIDS strategy for 2011–2015;⁴

¹ Subsequently adopted as resolution WHA64.12.

² Transmitted to the Health Assembly in the Committee’s sixth report and adopted as resolution WHA64.13.

³ Document A64/15.

⁴ *Getting to zero: UNAIDS strategy 2011–2015*. Geneva, UNAIDS, 2010.

4. URGES Member States:
 - (1) to adopt the global health sector strategy on HIV/AIDS, 2011–2015;
 - (2) to implement the strategy according to the four strategic directions to guide national responses as described in the strategy;

5. REQUESTS the Director-General:
 - (1) to give adequate support to implementation of the global health sector strategy on HIV/AIDS, 2011–2015, including provision of support to Member States for country implementation and reporting on progress on the health sector response to HIV/AIDS;
 - (2) to monitor and evaluate progress in implementing the global health sector strategy on HIV/AIDS, 2011–2015, and to report, aligned with reporting of other UN agencies, progress through the Executive Board to the Sixty-fifth, Sixty-seventh and Sixty-ninth World Health Assemblies.

Dr KONG Lingzhi (China) welcomed the revised text and expressed his appreciation of the efforts of the delegate of Brazil in coordinating and facilitating work on it. For the sake of swift adoption of the strategy, he could support the draft resolution. However, he reiterated that China would only use the strategy as reference material when developing its own national HIV/AIDS prevention plan; each country's strategy should take into account its own national situation.

Dr TSESHKOVSKIY (Russian Federation), echoing the delegate of China, said that his country accepted the draft resolution for information purposes and fully supported the strategy prepared by WHO for the next few years. He observed that the resolution lacked any indication that the strategy must be elaborated within the national context, which included both cultural and legislative initiatives.

Ms WISEMAN (Canada) endorsed the draft resolution but stressed that the strategy should be used only as a guide by countries when implementing their individual health sector responses to HIV/AIDS. The Secretariat should continue to provide Member States with support to help to strengthen their national responses to HIV/AIDS. She welcomed the focus on strategic collaboration with other global health partners to achieve the goals and targets contained in the strategy and looked forward to the detailed operational plan that would provide more particulars of the steps needed to develop a coordinated, evidence-based approach to HIV response by the health sector.

In the absence of further comments, the CHAIRMAN said that he took it that the Committee wished to approve the draft resolution.

The draft resolution was approved.¹

Smallpox eradication: destruction of variola virus stocks: Item 13.8 of the Agenda (Document A64/17)

The CHAIRMAN invited consideration of a revised version of the draft resolution proposed by the delegations of Australia, Barbados, Canada, Colombia, Democratic Republic of the Congo, Ethiopia, Lesotho, Mexico, New Zealand, Russian Federation, Uganda and United States of America, which read:

The Sixty-fourth World Health Assembly,
PP1 Recalling resolution WHA33.4, which called on WHO Member States to transfer any stocks of variola virus to an approved WHO collaborating centre, resolution WHA49.10,

¹ Transmitted to the Health Assembly in the Committee's sixth report and adopted as resolution WHA64.14.

which recommended a date for the destruction of the remaining stocks of variola virus, subject to a decision by the Health Assembly, and resolution WHA52.10, which authorized temporary retention of the virus stocks to a later date, subject to annual review by the Health Assembly;

PP2 Noting that the Health Assembly decided in resolution WHA55.15 to authorize further, temporary, retention subject to all approved research being outcome-oriented, time-limited and periodically reviewed and agreed to a proposed new date for destruction being set when research accomplishments and outcomes allowed consensus to be reached on the timing of destruction of variola virus stocks;

PP3 Noting also that these authorizations were granted to permit essential research for public health purposes, including the development of antiviral agents and improved and safer vaccines, and for high-priority investigations of the genetic structure of the virus and the pathogenesis of smallpox;

PP4 Recalling also resolution WHA55.16, which called for a global public health response to natural occurrence, accidental release or deliberate use of biological and chemical agents or radio-nuclear material that affect health;

PP5 Recalling further resolution WHA60.1, which called for a major review in 2010 of the results of the research undertaken, currently under way, and the plans and requirements for further essential research for global public health purposes, taking into account the recommendations of the WHO Advisory Committee on Variola Virus Research, so that the Sixty-fourth World Health Assembly may reach global consensus on the timing of the destruction of existing variola virus stocks;

PP6 Having considered the report of the Advisory Group of Independent Experts to review the smallpox research programme (AGIES), which contains the committee's recommendations for further research and that variola virus is currently the best target for in vitro testing of new drug candidates;

PP7 Having also considered the report of the twelfth meeting of the WHO Advisory Committee on Variola Virus Research, which reflected the overall assessment of the Committee that progress towards the goals for which the research was permitted has been exceptional but is not yet complete;

PP8 Reaffirming the view of previous Health Assemblies that the destruction of all variola virus stocks remains the goal of WHO and all Member States;

PP9 Recognizing that while the destruction of all authorized variola virus stocks is an irrevocable event that could affect global security, the ability to synthesize the virus now or in the near-future adds to these **health and** security concerns such that the decision to destroy the research stocks must be made with great care;

PP10 Further noting with satisfaction that the WHO-led inspections of the two authorized repositories reaffirmed the safety and security of the virus stocks;

~~PP11 Deeply concerned that unauthorized or yet undiscovered stocks of variola virus might exist, as was brought to the attention of the Advisory Committee on Variola Virus Research;~~

~~PP12 Concerned that the destruction of known variola stocks would not prevent the deliberate or accidental release from unauthorized or clandestine stocks and samples, a catastrophic event for the global community requiring rapid distribution of safe and effective countermeasures;~~

PP11 Deeply concerned that unauthorized or as yet undiscovered stocks of variola virus might exist and that the deliberate or accidental release of any smallpox viruses would be a catastrophic event for the global community;

~~PP13~~12 Noting the need to make response capacity universal by placing adequate supplies of vaccines and other antiviral agents, once licensed by ~~stringent~~ regulatory authorities, at WHO's disposal for use in any country experiencing cases of smallpox,

1. STRONGLY REAFFIRMS the view of previous Health Assemblies that the remaining stocks of variola virus should be destroyed;
2. DECIDES to authorize the further, temporary, retention of the existing stocks of live variola virus at the current locations specified in resolution WHA52.10, for the purpose of enabling further international research, on the understanding that steps should be taken to ensure that all approved research would remain outcome-oriented and periodically reviewed;

2bis FURTHER DECIDES to include a substantive item: “Smallpox eradication: destruction of variola virus stocks” on the provisional agenda of the Sixty-ninth World Health Assembly;

3. CALLS on **each** Member State to ~~certify~~ **confirm** to the Director-General by May 2012 through official written communication that they do not **currently** possess live variola virus within their borders **and, if they previously possessed variola virus stocks, or to certify to the Director-General by May 2012 through official written communication that all those** stocks **and samples** of live variola virus have been transferred to the official repositories or destroyed in accordance with resolution WHA33.4;
4. FURTHER CALLS on Member States to ensure that the outcomes of the World Health Assembly-approved research agenda are available to all in the event of an outbreak of smallpox by donating to the WHO strategic smallpox vaccine reserve or putting into place the appropriate mechanism, to allow for donation of medical countermeasures effective against smallpox upon their licensure by a regulatory authority;
5. FURTHER REAFFIRMS the need to reach consensus on a proposed new date for the destruction of variola virus stocks when research outcomes critical to an improved public health response to an outbreak permit and when the World Health Assembly has been assured that all stocks of live variola virus have been transferred to the two official repositories or destroyed;
6. REQUESTS the Director-General:
 - (1) to continue the work of the WHO Advisory Committee on Variola Virus Research;
 - (2) to continue to review the membership of the Advisory Committee to ensure it reflects the necessary expertise for the evolving nature of its deliberations, with the inclusion of experts in all areas under discussion, and includes balanced geographical representation and adequate representation from developing countries;
 - (3) to propose to the 130th session of the WHO Executive Board revisions to the mandate of the Advisory Committee on Variola Virus Research, taking into account the Committee’s discussion at its twelfth meeting on its future role and other relevant information;
 - (4) to ensure that variola virus research results and the benefits of this research are made available to all Member States;
 - (5) to continue regular inspections of the two authorized repositories to ensure that conditions of storage of the virus and of research conducted in the laboratories meet the highest requirements for biosafety and biosecurity and to make available the reports of the inspections for public information after appropriate scientific and security redaction;
 - (6) to consider, in consultation with Member States and the WHO Advisory Committee on Variola Virus Research, the desirability of creating a strategic global smallpox antiviral stockpile to be housed physically by WHO or virtually by Member States;

(6bis) to propose, at an appropriate time, measures to be used to verify the destruction of virus stocks in the official repositories when the World Health Assembly reaches global consensus on the timing of the destruction;

(7) to report to the Sixty-sixth World Health Assembly, through the Executive Board, on the ~~certifications~~ **confirmations** received in accordance with operative paragraph 3 of the present resolution and to the Sixty-ninth World Health Assembly on progress in the research programme and related issues.

Dr DAULAIRE (United States of America), recalling the provisions of resolution WHA52.10 and other subsequent resolutions regarding the research agenda using variola virus stocks, said that setting a date for the destruction of all remaining virus stocks was inappropriate and ill-advised; destroying the stocks would leave human beings vulnerable to a smallpox outbreak. The inadvertent or intentional release of the virus from sources outside the two official repositories remained a potential threat to the global community, particularly as most of the population lacked immunity to infection. He therefore advocated retaining the two official repositories of the virus for use in outcome-oriented, time-limited research until the WHO-authorized research agenda was completed and public health officials had obtained the tools to respond safely, effectively and efficiently to a potential smallpox outbreak with tested, certified and licensed countermeasures. He drew attention to the report of the Advisory Group of Independent Experts to review the smallpox research programme, which stated "The Scientific Review document provided to the [Advisory Group] argues that work with live [variola virus] may be indispensable for the development and approval of antiviral drugs against smallpox", and to a recent article in the medical literature that highlighted the need for continued research using the live virus. Knowing that Member States could be counted on to work actively to safeguard global health security, he stated his country's willingness to make its expert scientists available to answer questions from Member States about the research agenda.

He noted that the number of cosponsors of the draft resolution stood at 26: Armenia, Australia, Barbados, Belarus, Canada, Colombia, Democratic Republic of the Congo, Denmark, Estonia, Ethiopia, Fiji, Italy, Jamaica, Japan, Kazakhstan, Lesotho, Malawi, Mexico, Mozambique, New Zealand, Russian Federation, Samoa, Uganda, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, and United States of America.

Mr DESIRAJU (India) welcomed the strong affirmation in the draft resolution of the view of previous Health Assemblies on the need to destroy the remaining stocks of the variola virus. He noted with appreciation the provisions of paragraphs 2, 2bis and 4, in particular the reference to making the outcomes of the WHO research agenda available to all in the event of an outbreak of smallpox. Also noting the language of subparagraph 6(6)bis, he was ready to approve the draft resolution.

Mr BAEIDI NEJAD (Islamic Republic of Iran), speaking on behalf of the Member States in the Eastern Mediterranean Region, welcomed the report and reminded Member States that, following the confirmed eradication of the disease, the Health Assembly had set three separate deadlines for eradication of the remaining virus stocks; none had been met. Resolution WHA52.10 had authorized the retention until 2002 of the existing stocks at two authorized repositories for research purposes. Research activities had been approved as long as they were outcome-focused, time-limited and underwent periodic review. Although timelines for approved research had been extended and, in many cases, exhausted, the research programmes continued to be prolonged. The research had led to considerable scientific advances, including the sequencing of the entire genomes of viruses from numerous different strains, but he maintained that all necessary research requiring live variola virus had been completed and, in accordance with the findings of the Advisory Group of Independent Experts to review the smallpox research programme, that any further studies would have only limited public health impact and would further delay destruction of the virus stocks. Destruction of the virus would remove the possibility of an accidental or deliberate release of the virus into the atmosphere,

which event would cause a catastrophic re-emergence of the disease. He therefore called on Member States to agree on a deadline for eradication of the remaining stocks.

The draft resolution would need substantial changes for his country and the other Member States of the Eastern Mediterranean Region to be able to approve it. It should fix a date in the near future for the destruction of the remaining virus stocks held in the authorized repositories; terminate authorization of research involving live variola virus; ensure global ownership of the achievements of all previous research activities, thereby guaranteeing universal and equitable access to the outcomes of the research, including antiviral agents, vaccines and diagnostic tools; prohibit genetic engineering of the variola virus; and put in place strict, transparent and accountable oversight mechanisms to monitor fulfilment of those provisions, particularly the destruction of existing stocks.

Dr HWOAL (Iraq) said that a specific deadline for destruction of all remaining variola stocks was clearly needed. Such a decision should be based on scientific principles to allow the addressing of any situation that might arise. Use of the remaining stocks of live variola virus for research should proceed within a dedicated framework with a clear timetable, in order to allow the conclusion of the research. The outcomes of the research should be examined carefully in order to establish whether the research was still valid. Any research must be carried out within a set time frame and earlier research must be carefully reviewed to ascertain the validity of the new research, which should not be a repeat of anything done earlier or a means of delaying destruction of the stocks. The new research must also be subject to criteria concerning its economic feasibility and impact. WHO must work with stakeholders on a comprehensive scientific assessment of all research conducted in that area and report back on its achievements in terms of the desired objectives in dealing with any epidemic or devising effective early detection methods and coping with cases of the disease. Any weaknesses found that needed further study must be precisely identified. The number of studies needed must also be determined, as must the study method and the stocks needed. He urged Member States to work together to agree on a date for destruction of the remaining virus stocks in order to allow adequate financial resources to be raised and suggested that a monitoring and follow-up committee should also be established.

Dr KENYA MUGISHA (Uganda) thanked the Secretariat for its report and other relevant documents on the item under discussion. Noting that variola virus stocks might exist in places other than those authorized by the Health Assembly, he observed that deliberate or accidental release of the virus could originate from such unauthorized stocks. An appropriate response was therefore needed in the event of an accidental or deliberate release of the virus. Furthermore, as research had been taking place to develop appropriate diagnostic techniques, vaccinations and other therapies, it was necessary to retain the available and openly declared stocks of the variola virus in safe storage. The time was not ripe for destruction of the authorized stocks.

Dr LEWIS FULLER (Jamaica) supported the position of the United States of America and wished to cosponsor the resolution. She acknowledged the circumstances in which the threat of bioterrorism was still a major concern, and appreciated the need for further research. The realization that the world population was susceptible to variola virus infection meant that a pandemic was a real possibility, whether by deliberate or natural occurrence. It might be necessary to develop smallpox vaccines and therapeutic agents; that would need the existing viral stocks. She underlined the role of the WHO Advisory Committee on Variola Virus Research and of WHO in ensuring that the regulations and guidelines governing the matter were adhered to and outcomes and monitoring reports validated.

Dr TAKEI (Japan) thanked the Secretariat and the WHO Advisory Committee on Variola Virus Research for their excellent reports. Japan supported the draft resolution and wished to cosponsor it. He thanked the United States of America for drafting the resolution and proposing a way forward. In view of the present circumstances and international health risk management, it was important to create

a further research agenda and discuss stockpiling of vaccines, the final public health goal being the destruction of variola virus. He therefore welcomed further discussion and the submission of a report to the Sixty-sixth World Health Assembly on the confirmation of the transfer and destruction of variola virus stocks. He also looked forward to information on progress of the research programme and related issues to be considered by the Sixty-ninth World Health Assembly.

Dr BAYUGO (Philippines) reaffirmed his country's belief that, for the claim of eradication to be realized, no trace of the live virus should be kept, as its possession posed a significant global public health risk. It likewise favoured forming a group to conduct a comprehensive review of published and unpublished studies concerning live variola virus; an external review of the report by an independent group of experts; and the formation of the WHO smallpox laboratory network for the rapid and reliable detection of any emergence of the variola virus, without such laboratories' storing any live variola viruses but with, instead, the use of molecular techniques not requiring the use of live viruses. However, the world first needed to be assured that essential research had been completed and that the response to a smallpox epidemic was already adequate in terms of diagnostics, treatment and management.

He therefore recommended: first, that the Director-General and participants in the Sixty-fourth World Health Assembly should decide upon a fixed date for the destruction of all remaining variola virus stocks as a commitment to the global eradication initiative; and secondly, that the Health Assembly should be requested to reaffirm its decision not to authorize variola virus research that was not essential to public health. He further requested that the Director-General:

- (a) increase transparency on the activities of the WHO Advisory Committee on Variola Virus Research and provide all Member States with a list of members of the committee, together with a declaration and disclosure of potential conflicts of interest, minutes of meetings and a report on the comprehensive review of all research concerning the variola virus as well as the membership, meetings and reports of expert committees asked to perform an external review of the Health Assembly report;
- (b) ensure that the two laboratories made the variola virus research results and the benefits of such results available to all;
- (c) ensure that appropriate and high-level biosafety practices, security and containment procedures were strictly enforced and regular site visits made to the remaining repositories of the virus in order to prevent introduction of the virus into the community pending the final date of destruction of all stocks.

Mrs NYONI (United Republic of Tanzania) said that, as more than half of the world's population was not immunized against smallpox and as monkeypox had been discovered in parts of western and central Africa, the danger existed of a crossover to humans. That could trigger human-to-human transmission of monkeypox virus and a pandemic that would need robust interventions, including mass vaccination. Retention of variola virus stocks was essential to permit vital research and enable a potential outbreak of smallpox to be contained. She therefore supported the retention of variola virus stocks and encouraged the sharing of information and technology transfer for capacity-building of laboratories in developing countries.

Ms PATTERSON (Australia) said that her country was pleased to be cosponsoring the resolution on the destruction of variola virus stocks. Temporary retention of existing live variola virus stocks for outcome-oriented research was vital to human health.

Dr BELAYNEH (Ethiopia) supported the decision to retain the variola virus stocks in the Russian Federation and the United States of America. WHO's review of the smallpox research programme concluded that more research was needed to protect public health. The eradication of smallpox had resulted in decreased immunity and people under the age of 30 had no immunity. There had consequently been a dramatic rise in cases of monkeypox in central Africa.

An effective vaccine for smallpox could have direct benefits for dealing with monkeypox in the region. She voiced concern that the smallpox virus might exist outside the official repositories and be released unintentionally or used as a bioweapon, which was a serious health worry for the international community.

Dr MEMISH (Saudi Arabia), speaking on behalf of all six members of the Gulf Cooperation Council (Bahrain, Kuwait, Qatar, Saudi Arabia, United Arab Emirates and Yemen), said that they had taken note of the report of the Secretariat and the Advisory Group of Independent Experts on the issue stating that there was no reason to go ahead with variola virus research. A deadline needed to be set for the destruction of stockpiles. There was also a need to establish the mechanisms to define that procedure and to make all information regarding variola virus research available to WHO. Destruction of all the stockpiles was essential.

Mr ROSALES LOZADA (Plurinational State of Bolivia) said that the variola virus stocks should be destroyed as affirmed at previous Health Assemblies. Resolutions WHA52.10 and WHA55.15 had approved the retention of some stocks for research purposes. However, all the data provided by research indicated that the relevant public health goals had already been reached and it was therefore important to move forward to destruction.

Mr MÉSZÁROS (Hungary), speaking on behalf of the European Union, said that Turkey, Croatia, The former Yugoslav Republic of Macedonia, Montenegro, Iceland, Bosnia and Herzegovina, Serbia, Ukraine, the Republic of Moldova, Armenia, Norway and Switzerland aligned themselves with his statement. He thanked the Secretariat for the report. In the light of the draft resolution, the European Union supported the draft resolution to authorize the temporary retention of the live variola virus stocks at their present locations as specified in resolution WHA52.10. The purpose was results-oriented research to ensure an improved public health response to any disease outbreak. The Health Assembly should reach consensus on a new date for the destruction of virus stocks as soon as the research had been completed.

Mrs NYAGURA (Zimbabwe) supported WHO's proposal for a smallpox laboratory network to detect any emergence of the variola virus. The European Region and Region of the Americas possessed such laboratories, and emphasis should be placed on capacity-building for regions that were not so equipped. So long as the two repositories maintained stocks of the virus, there would be a global threat of re-emergence of the disease. She urged the Director-General to continue accumulating stockpiles of the vaccines.

With regard to the draft resolution, she expressed concern that, despite numerous resolutions of previous Health Assemblies on destruction of the stocks, the Russian Federation and the United States of America were allowed to maintain them.

The report failed to specify how clinical research could be conducted without human subjects infected with variola virus. She expressed further concern that the resolution proposed by the United States of America took the smallpox situation two decades backwards. She was also worried that all existing virus stocks were required to be transferred to the Russian Federation or the United States of America. If both countries continued to maintain virus stocks against the wishes of most Member States, they lacked any moral authority to ask other countries to destroy their stocks or transfer them to their repositories. She called for the immediate destruction of the stocks and requested that the draft resolution be amended accordingly.

Dr TSESHKOVSKIY (Russian Federation) welcomed the work of the WHO Advisory Committee on Variola Virus Research. Despite the successes achieved and the studies into safe and effective antiviral agents and smallpox vaccines, the work had not been completed and time was needed for further research. Destruction of all strains of live variola virus would be irreversible and such an unprecedented step would demand the utmost caution. His country was heeding the possible

existence of unknown, unauthorized stocks of variola virus. It was important to reach a consolidated decision on retention of stocks in the two official repositories for use in further research on safe and effective protection against a possible outbreak of smallpox.

The WHO biosafety inspection teams had inspected both containment facilities and determined that they were safe and secure for work with live variola virus. The conclusion reached was that both facilities should be retained for research. Only upon acceptance of that would it be possible to consider the matter of destroying the existing official virus stocks. He urged Member States to support the draft resolution.

Dr AL HAJERI (Bahrain) thanked the Member States that had called for the destruction of the variola virus stocks. The last cases of smallpox in her country dated back to 1954. Bahrain at present had no stocks of smallpox vaccine and planned to proceed with a single purchase of the item for countries of the Gulf. She supported the resolution on the destruction of variola virus stocks.

Dr WATT (United Kingdom of Great Britain and Northern Ireland) supported the intention of the draft resolution, which sought to ensure a further temporary retention of stocks to enable approved time-limited research to continue. Her country was pleased to sponsor the resolution and encouraged other Member States to approve it.

Mr MEI Yang (China) said that the WHO Advisory Committee on Variola Virus Research and the WHO Secretariat had done substantial work on monitoring and research.

Under the supervision and support of WHO, the relevant institutions had conducted molecular biological research. Great progress had been made on anti-variola agents and new vaccines. All those research results had provided bases for early treatment and diagnosis of smallpox. It was important to destroy the stocks to prevent the reappearance of smallpox. He supported the termination of the use of live variola virus and hoped that the Health Assembly would set a timeline for the destruction of such stocks.

The Secretariat should provide Member States with timely reports and notifications on the progress of such research, and Member States should be able to share the antiviral agents and vaccines deriving from the research.

Dr SOLÍS VÁSQUEZ (Peru) observed that resolution WHA60.1 had reaffirmed the need to destroy the variola virus stocks and asked the Director-General to undertake a broad study in 2010, on the basis of which the Sixty-fourth World Health Assembly had been expected to set a date for destruction of the variola virus stocks, while the WHO Advisory Committee on Variola Virus Research continued its work. Recognition was needed of the importance of such research to public health on a global scale for the sake of preventing any re-emergence of the disease. There should be a detailed annual report to the Health Assembly on the finalized research results. As a resurgence of smallpox would have a serious global health impact, Peru supported destruction of the variola virus stocks.

Ms HAMILTON (Canada) noted with satisfaction that the draft resolution was based on the report of the WHO Advisory Committee on Variola Virus Research, which concluded that the live variola virus was still required for the development of vaccines. The live virus stocks should be retained for public health purposes and a decision on a firm date for destruction of the stocks would be premature. She noted that the priority was the eventual eradication of all stocks and emphasized that the resolution would allow the matter to be reconsidered in five years' time, which would provide an appropriate timeline for further review. Her country was confident that the official stocks would one day no longer be required and could be destroyed.

Mrs KHOELI (Lesotho) supported the draft resolution. She noted from the report that information had been archived and would be accessible to all interested parties. The vaccine stockpiles

should be easily and transparently monitored by WHO, as should the laboratory networks. The findings of the two repositories were indeed reassuring.

Lesotho duly recognized those findings and noted that the virus stocks could be used in essential research for public health purposes. However, it was also concerned about the possibility of the existence of unauthorized or undiscovered stocks, which could be accidentally or deliberately released. If all stocks were to be destroyed, the world would be unable to respond fast enough in an emergency.

Mr MENESES GONZÁLEZ (Mexico) said that he had carefully reviewed the report of the Advisory Group of Independent Experts and felt that the retention of stocks of variola virus for research purposes, with all requisite safety measures, was essential to guaranteeing human health and security. He supported the work of the WHO Advisory Committee on Variola Virus Research.

Ms ROOVÄLI (Estonia) supported the retention of stocks of variola virus in the two official repositories and confirmed Estonia's cosponsorship of the draft resolution.

Dr CHAWETSAN NAMWAT (Thailand) welcomed the report by the Secretariat and the systematic review conducted by the Advisory Group of Independent Experts. While security procedures at the two repositories for variola virus stocks had remained of high quality and the scientific research on the virus had been substantial, there was no longer adequate justification for retaining those stocks since enough vaccines and diagnostic tools existed to deal with any potential outbreak of smallpox in the future. The continued retention of the variola virus stocks represented a grave threat to global security and therefore he could not support the draft resolution. He reiterated his country's position that the stocks should be destroyed immediately. If that did not happen, Thailand suggested that the Secretariat and Member States ought to consider introducing smallpox vaccination in order to ensure global health security.

Mr ADAM (Israel) expressed full support for the draft resolution and said that Israel wished to be included as a cosponsor.

Dr RASAE (Yemen) wished to place on record that Yemen had never held any stocks of variola virus.

Ms LANTERI (Monaco), having noted the conclusions in the Secretariat report, said that Monaco believed the draft resolution to contain suitable provisions for continuing research on the variola virus while guaranteeing transparent outcomes and global health security. She supported the draft resolution and wished to add her country to the list of cosponsors.

Dr CHONG CHEE KHEONG (Malaysia) welcomed the findings of both the WHO Advisory Committee and the Advisory Group of Independent Experts, which had shown the considerable progress made in developing anti-variola agents and enhanced vaccines, but urged the Health Assembly to set a definitive date for the destruction of remaining variola virus stocks.

Dr FAKEYE (Nigeria) reaffirmed the view expressed at previous Health Assemblies that the destruction of all variola virus stocks should remain the goal of WHO and its Member States. He therefore strongly supported the call for all Member States to confirm by May 2012 that they possessed no variola virus stocks within their borders.

WHO should provide support to developing countries in increasing their capacity for variola virus research so that they could participate more advisedly in future discussions on the issue.

Pending consensus on the timing for destruction of existing stocks, he supported the continued retention of variola virus stocks in the two repositories of the Russian Federation and United States of America, respectively.

Dr MOHAMED FIKRI (United Arab Emirates), commending the work of the Secretariat and the WHO Advisory Committee, supported the comments made by the delegate of Saudi Arabia.

Professor HAQUE (Bangladesh) said that, although variola virus stocks remained in only a few countries, it was recognized by many that such stocks presented some risk of recurrence of smallpox outbreaks. He supported all efforts to reach consensus on the final destruction of stocks and called for a transparent process based on the best available scientific research.

Ms HELFER-VOGEL (Colombia) reiterated her country's support for the draft resolution.

Professor ADITAMA (Indonesia), recalling the global consensus that the remaining stocks of variola virus in two WHO repositories should be destroyed, urged Member States to use the Sixty-fourth World Health Assembly as the forum in which to agree on the timing of the destruction of those remaining stocks.

Dr DAULAIRE (United States of America) affirmed that the United States supported the destruction of remaining variola virus stocks once the programme of WHO-authorized research had been completed. That research had led to substantial developments over the previous decade – new vaccines, antiviral agents and diagnostic tools. The world had benefited, even though many had called earlier for destruction of stocks. Moreover, as indicated in the Secretariat's report, WHO had supervised the research and the results had been widely shared and reported in the scientific literature. It was difficult to define the pace of research, and fully developed, licensed and certified countermeasures for smallpox were not yet available. The report of the Advisory Group of Independent Experts to review the smallpox research programme had indicated that research should continue in order to develop vaccines that were as effective as, but safer than, current licensed vaccines against variola infection. Furthermore, the report of the United States Institute of Medicine of the National Academies had found that live stocks of variola virus were essential for the development of therapeutics and the assessment of resistance to antiviral agents. There was therefore a public health benefit in maintaining stocks of live virus to enable such work to continue. The United States was committed to ensuring that research results were made available to the global community and was working with Member States to strengthen laboratory capacities.

Dr Chin-Hui YANG (Chinese Taipei), reaffirming resolution WHA60.1, expressed appreciation to the Advisory Committee for its recent work and the report of its twelfth meeting in November 2010, and supported the proposed establishment of a worldwide WHO network of high-level smallpox diagnostic laboratories, which would facilitate early detection of any smallpox outbreak. Summarizing the action taken since the eradication of smallpox from Chinese Taipei in 1955, she reported that secure stocks of vaccine totalled seven million doses; she therefore welcomed the development of WHO standard operating procedures for such stocks. Chinese Taipei looked forward to continued collaboration with Member States and the Secretariat on developments in the area.

Ms LIM (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN and on behalf of 43 civil society organizations from around the world, urged the Health Assembly to support the immediate destruction of remaining stocks of variola virus. Since the first independent expert recommendation in 1986 that stocks should be destroyed, numerous Health Assembly resolutions and expert recommendations had called for destruction, yet stocks continued to exist. The virus served no essential public health purpose; effective diagnostic tools, vaccines and other means of responding to smallpox outbreaks were already available, and vaccines were prepared using the related but less dangerous vaccinia virus. Resolution WHA60.1, adopted after Member States and civil society had united to counter attempts to genetically engineer variola virus, had called for a deeper examination of the need to maintain virus stocks. The resulting review of virus research by the Advisory Committee in 2010 had concluded that there was no compelling reason to retain virus

samples. Moreover, all Member States had destroyed or transferred their variola stocks between 1976 and 1979. There was no justifiable reason for maintaining stocks, which might in fact lead to the risk of unnecessary research, constituting a threat to all countries. She recalled that the last recorded case of smallpox, in 1978, had resulted from a laboratory accident. The destruction of variola virus stocks was the final step in the great achievement of smallpox eradication, and was the single most important action to ensure that the disease never reappeared. She urged the Health Assembly to authorize cessation of research and to set an irrevocable date for the destruction of remaining variola virus stocks.

The CHAIRMAN invited the Committee to consider the draft resolution. No amendment had been proposed, although some reservations had been expressed.

Mr BAEIDI NEJAD (Islamic Republic of Iran) observed that several delegations, including his own, had expressed serious reservations about the concepts articulated in the draft resolution, and had supported the view that substantive amendments would be needed to render the text acceptable. The fundamental element, destruction of remaining variola stocks, which had been called for in various previous Health Assembly resolutions, had been ignored. After 30 years of retention of stocks on a “temporary” basis, the setting of a time frame and definitive target date for destruction was surely due. Because of time constraints, however, there might be insufficient time for the Committee to reach consensus on such a serious and sensitive matter. In that event, the Member States of the Eastern Mediterranean Region would call for a secret ballot in accordance with Rule 76 of the Rules of Procedure of the World Health Assembly.

Dr DAULAIRE (United States of America) pointed out that paragraph 2bis of the draft resolution referred to the inclusion of a substantive item on the destruction of variola virus stocks on the provisional agenda of the Sixty-ninth World Health Assembly, which provided a clear indication of date. It was his understanding of Rule 76 of the Rules of Procedure that a vote by a show of hands should be taken to determine whether the Committee agreed to vote by secret ballot on the draft resolution.

The LEGAL COUNSEL confirmed that Rule 76 stipulated that the Committee must first vote by a show of hands to determine whether it wished to vote by secret ballot.

Mr MÉSZÁROS (Hungary), speaking on a point of order, requested a short suspension before the vote in order to let delegations consider the situation.

Mr BAEIDI NEJAD (Islamic Republic of Iran) said that he would prefer first of all to try to achieve consensus on the text of the draft resolution. However, if the sponsors insisted on presenting the text as submitted, he would call for a secret ballot under Rule 76, in accordance with the procedure confirmed by the Legal Counsel.

The CHAIRMAN proposed that the meeting should be suspended to allow time for delegations to consider how best to proceed.

It was so agreed.

The meeting was suspended at 11:00 and resumed at 11:25.

The CHAIRMAN said that it was his understanding that the Committee wished to refer the draft resolution to an informal working group to see whether consensus could be reached on a revised text.

It was so agreed.

The CHAIRMAN said that, in the absence of any objection, he took it that the Committee wished to defer further consideration of the agenda item pending the outcome of the informal working group's deliberations.

It was so agreed.

(For approval of the draft decision, see the summary record of the thirteenth meeting, section 2.)

Cholera: mechanism for control and prevention: Item 13.9 of the Agenda (Documents A64/18 and EB128/2011/REC/1, resolution EB128.R7)

Dr BUSS (representative of the Executive Board) recalled that the Board had discussed the report on cholera at its 127th session in May 2010 and had noted the close links between the attainment of the Millennium Development Goals, the importance of intersectoral policies and action, and global warming. A draft resolution had been tabled by Bangladesh but the Board had deferred further consideration until its 128th session, to allow sufficient time for analysis and the submission of proposed amendments. At the 128th session, the Board had considered a revised draft resolution, noting that cholera remained a public health problem in many parts of the world and that coordinated prevention and control activities needed intensification. After further amendment, the resolution had been adopted (resolution EB128.R7). The Health Assembly was requested to consider the draft resolution recommended therein.

Dr DLAMINI (South Africa), speaking on behalf of the Member States of the African Region, expressed support for the WHO Global Task Force on Cholera Control and welcomed the establishment of the Strategic Health Operations Centre at the Regional Office for Africa. Cholera was not receiving enough global attention despite repeated epidemics in countries that were endemic and non-endemic for the disease, and the fact that the disease was impeding progress towards the Millennium Development Goals. Since cholera had a short incubation period, rapidly expanding outbreaks could result if there were delays in implementing control measures because of weaknesses in early warning systems. Spread of the disease was a consequence of poverty, poor environmental conditions and natural disasters, and there was considerable interplay between prevention, surveillance and response preparedness. Community involvement, transparent sharing of information and policy dialogue were key elements of the prevention and control of cholera and other waterborne diseases. Programmes to improve health, water supply and environmental conditions were integral components of development policies and plans, and should be adequately funded and implemented. Member States should undertake surveillance and reporting of cholera in accordance with the International Health Regulations (2005), and should integrate surveillance of cholera into national surveillance systems. Efforts should be made to mobilize additional technical and financial resources to combat cholera and other diarrhoeal diseases, and to increase community participation and advocacy concerning the intersectoral nature of prevention and control measures. In line with Article 43 of the International Health Regulations (2005), trade and travel restrictions should not be imposed on affected or at-risk countries without public health justification. Finally, while the development of safe, effective and potentially affordable oral cholera vaccines was to be welcomed, vaccine use should complement, and not be a substitute for, other recommended prevention and control methods, particularly improvements in water supply and sanitation.

Dr IBRAHIM (Somalia), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that epidemics of cholera and other diarrhoeal diseases had occurred recently in the Region, especially in countries experiencing emergencies, including conflicts, which could result in compromised hygiene, inadequate surveillance, destruction of health infrastructures, disruption of programmes, lack of security, and poor coordination between humanitarian organizations. Member States and partners should strengthen efforts to improve environmental health, especially in high-risk

areas, increase community participation and scale up advocacy as to the intersectoral aspects of cholera prevention and control.

He supported the draft resolution recommended by the Board in resolution EB128.R7.

Professor HAQUE (Bangladesh), speaking on behalf of the Member States of the South-East Asia Region, said that cholera continued to pose a formidable challenge, particularly in areas of health inequities and poor environmental health. The key factors were poverty, lack of access to safe drinking-water and sanitation, weak health infrastructures, and lack of awareness of the need for behavioural change. The situation was exacerbated by climate change. The report highlighted the evidence-based preventive measures available and the need for strong political commitment and leadership in the work to combat cholera. The Global Task Force on Cholera Control should be strengthened and include a representative of the Member States of the South-East Asia Region. Despite progress in the development of affordable oral cholera vaccines, vaccine use should be a supplement to, and not a substitute for, conventional control interventions. The countries of the Region supported the resolution recommended by the Board in resolution EB128.R7, which would enable the international community to tackle cholera in a more systematic and concerted manner, and would reinforce the recently approved resolution on drinking-water, sanitation and health.¹

Dr ST. JOHN (Barbados) said that, in late 2010, member countries of the Caribbean Community had been urged to increase surveillance for cases of cholera after the outbreak in Haiti. The risk of importation of cholera remained high for those countries but the risk of rapid spread of the disease was considered low owing to enhanced sanitary conditions and public health infrastructure.

Heightened vigilance had been maintained within Barbados' health-care system since the outbreak, and its preparedness and response efforts had been strengthened. Several actions, including a review of its national cholera action plan, aimed at minimizing the risk of importation, had raised awareness among stakeholders on their involvement in surveillance, preparedness and response activities. Barbados' next annual conference on disaster preparedness would be devoted to cholera.

She supported the draft resolution.

Dr AL HAJERI (Bahrain) welcomed the efforts of WHO to support countries in preventing and controlling cholera. At the national level, Bahrain had done its utmost to provide adequate drinking-water and improve hygiene and sanitation, so as to prevent the main causes of cholera transmission. Other measures included the development of a surveillance system to detect and screen for the disease and to improve conditions for its control.

Bahrain urged all regions to inform the international community immediately of any new cases of cholera. Bahrain itself carried out diagnostic and awareness-raising activities and continued to cooperate with other countries to help to combat cholera. Bahrain supported the draft resolution.

Mr MAMACOS (United States of America) said that his country was committed to reducing the burden of waterborne infectious diseases and would continue providing support for research to combat and control cholera, including its ecological, environmental and social determinants. The United States looked forward to working with WHO, host country governments and other multi- and bi-lateral partners in launching a comprehensive approach to combating the disease, particularly in Africa.

Turning to the draft resolution, he proposed that the second preambular paragraph be amended to read: "Recognizing that cholera is not being sufficiently addressed despite its prevalence in epidemic form in at least 51 countries in both endemic and non-endemic areas ...". In the third preambular paragraph, the word "poverty" should be moved to the end of the paragraph. In the sixth preambular paragraph, the words "is intertwined" should be replaced with "necessitates close

¹ Resolution WHA64.24.

cooperation”, and in the eighth preambular paragraph the words “that are based on improved access to potable water, sanitation and hygiene” should be added at the end.

In subparagraph 2(3), he proposed the addition of: “and to prioritize close cooperation with other clusters, including but not limited to WASH and logistics, to maximize the effectiveness of the overall multilateral humanitarian response”. Finally, in subparagraph 2(10), the word “evaluate” should be added before the “efforts” in the second line.

Dr HWOAL (Iraq) said that cholera, and particularly its relationship with contaminated water, should be given high priority by the Secretariat and Member States. All people should have access to safe drinking-water and a clean environment and on that basis there was a great need for adequate surveillance of the quality of drinking-water, sanitation and drainage systems. Those working in the health and environment sectors needed to be fully aware of the need to invest in health, so as to avoid transmission of cholera and to improve the capacity of health workers and ministries to avoid conditions conducive to its transmission and to detect the disease early on. Clear standards should be set so that all citizens could be adequately informed and the necessary medication or vaccinations provided.

Dr TAKEI (Japan) expressed support for the draft resolution and, noting relevant text contained therein, emphasized the importance of long-term measures to improve hygiene and sanitation through ensuring safe water supply and the use of cholera vaccines.

He recalled the recently approved resolution on drinking-water, sanitation and hygiene,¹ of which Japan had originally been a cosponsor, and reiterated Japan’s commitment to ensuring safe water supplies and sanitation in developing countries. Increased momentum in that regard should contribute to the prevention of cholera and other waterborne diseases.

Mr MAULUDU (Papua New Guinea) said that in 2009 his country had experienced its first recorded outbreak of cholera in more than 50 years, which had affected several provinces. Health workers had since then been working rapidly to improve the national surveillance systems and establish a coordination and response task force to slow the spread of the outbreak. National capacity had increased significantly and Papua New Guinea was witnessing a decline in the number of cases in the areas affected by the outbreak, thanks in part to local awareness-raising campaigns.

The country had benefited greatly from innovations in cholera vaccines but it would need to include innovations in oral rehydration therapies in its list of treatments in order to reduce the cholera death toll.

He proposed that the draft resolution be amended to include a new subparagraph 1(6), to read: “The WHO Global Task Force on Cholera Control will consider safe and effective innovations in oral rehydration therapy that can provide additional benefit in treatment outcomes and report to the Sixty-fifth World Health Assembly.”

Dr KONG Lingzhi (China) said that China was one of the many countries in which cholera posed a grave public health risk. The country had adopted several preventive and control measures and welcomed the efforts also made by the Secretariat in that regard.

She endorsed the Secretariat’s analysis of the current global cholera situation and recommendations on how to improve it in the future. China would continue to strengthen its cooperation with the Secretariat and other Member States and would actively promote prevention and control measures.

She supported the draft resolution.

¹ Resolution WHA64.24.

Dr CHAWETSAN NAMWAT (Thailand) recalled a scientific study that had demonstrated the cost-effectiveness of oral cholera vaccine, as measured by cost per disability life year saved. The use of that type of vaccine had reduced morbidity and mortality and he welcomed both the efforts of other countries to conduct collaborative vaccine studies and the positive example of the development of safe and effective medicines at affordable prices.

As the oral cholera vaccine had already been recommended by the Strategic Advisory Group of Experts on immunization, he encouraged its use in areas where cholera was endemic. Vaccination should nevertheless not disrupt the provision of other priority health interventions to control or prevent cholera.

He supported the draft resolution.

The meeting rose at 12:00.

TWELFTH MEETING

Monday, 23 May 2011, at 14:40

Chairman: Dr W. AMMAR (Lebanon)

TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Cholera: mechanism for control and prevention: Item 13.9 of the Agenda (Documents A64/18 and EB128/2011/REC/1, resolution EB128.R7) (continued)

Mr ZEVALLOS AGUILAR (Peru) recalled that in 1991 Peru had suffered a serious cholera epidemic, which by the end of 1992 had spread to 19 countries across Latin America, causing some 6300 deaths. Twenty years had passed since that event, providing lessons and evidence regarding cholera risk factors and outbreak patterns in the various regions of Peru. The current cholera outbreak in Haiti posed a threat to Latin America as a whole, after a decade with no reported case. Countries should therefore remain vigilant and strengthen epidemiological surveillance, preparedness and response plans and preventive measures, so as to reduce the likelihood of a new cholera epidemic.

Epidemiological surveillance of cholera formed part of Peru's wider reporting obligations. On the basis of past experience, a national preparedness commission had been established in order to prepare and implement a prevention and response plan addressing the potential risk of the reintroduction of cholera in Peru.

The draft resolution contained in resolution EB128.R7 acknowledged the need for cholera prevention to be multisectoral, for example with regard to safe water and sanitation. Joint international efforts were essential in a globalized world. He supported the draft resolution and said that his country would continue to contribute to the development of better control and prevention measures.

Mrs TOELUPE (Samoa) supported the draft resolution and acknowledged the work of the Secretariat and the Global Task Force on Cholera Control. She also wished to place on record Samoa's thanks to development and other bilateral partners for their continuing help with water, sanitation, surveillance, and environmental health programmes.

Dr NDOUNDO (Chad) said that Chad had suffered more than 10 cholera epidemics during the previous 20 years, the last of which in June 2010 had caused high morbidity and mortality. Two new developments were noteworthy: the occurrence of outbreaks outside the winter months, and the fact that the disease had become endemic in certain parts of the country, particularly the Lake Chad region. The Lake Chad epidemic had led to cross-border contamination in Cameroon, Niger and Nigeria. Despite the allocation of significant resources and energy to combating the 2010 epidemic, the 2011 epidemic had seriously affected the morale of a country already weakened by resource constraints. He drew attention to the little-known three-step decision-making tool for assessing the risk of an outbreak, the capacity to contain a potential outbreak, and the feasibility of a mass immunization campaign using oral cholera vaccines. The use of that tool, which had been developed by WHO, should be encouraged in all affected countries. Those countries should also benefit from WHO's support for further research, in order to harmonize national strategies, including the use of oral cholera vaccines to mitigate or avert future epidemics. He supported the draft resolution.

Ms NGHATANGA (Namibia), noting that Namibia had experienced cholera outbreaks in recent years as a result of floods in the north of the country, emphasized the importance of cross-border

planning, information exchange and preparedness to ensure the prevention, containment and control of such outbreaks. The Secretariat should be requested to continue providing technical support to affected States to improve cross-border cholera interventions, and she urged Member States affected by cholera to work together in that regard. She welcomed the initiative to further develop oral cholera vaccines, and supported the draft resolution.

Dr TSESHKOVSKIY (Russian Federation) noted a steadily increasing global trend in cholera outbreaks, in particular due to the endemicity of the disease in resource-constrained countries in Asia and Africa as a result of poor sanitation conditions and weak primary health-care systems. The outbreak of cholera in Haiti in 2010 had been precipitated by the earthquake that had destroyed the local health and sanitation infrastructure. That epidemic had had serious social and economic consequences, and the disease had spread into neighbouring countries, leading to the threat of a cholera pandemic.

He supported the draft resolution, which emphasized the need for a comprehensive, multisectoral approach to planning cholera prevention measures, including the adequate use of vaccination, improved education on sanitation, and the provision of clean and safe drinking-water. The Russian Federation's epidemiological surveillance system for cholera was effective, predictive and included environmental monitoring and reporting. It facilitated the development of evidence-based recommendations for epidemic preparedness and prevention.

His Government supported the continued strengthening of the national laboratory network and scientific research into diagnostic methods, treatment and vaccines, and would continue to train personnel in those areas. Taking into account the limited resources available to developing countries in the fight against cholera and other diseases, he welcomed WHO's efforts to provide technical and financial support. The Russian Federation was prepared to continue cooperating in those efforts.

Professor ONDOBO ANDZE (Cameroon) said that his country had suffered several cholera epidemics since 2010, with a total of 6478 cases and 213 deaths. Cholera was a serious threat to developing countries, especially in sub-Saharan Africa, a region which already had a high burden of other pandemics and emerging diseases. Many factors contributed to the spread of cholera, including insalubrious conditions, poor access to potable water, low latrine use, and poor personal and community hygiene. Several countries in the African Region were still unable to provide universal access to potable water, even in the short term, a shortcoming which even affected treatment centres established in response to the epidemics.

Cholera was monitored under the integrated disease surveillance and response strategy, but few countries had early detection systems that enabled them to provide an appropriate and timely response to epidemics. Systems were slow to react and not sufficiently sensitive, used poor quality data, and were incomplete. Insufficient resources were allocated to the development of such systems, as few donors were prepared to invest in epidemiological surveillance, despite that being an essential part of action to prevent and combat diseases with epidemic potential such as cholera.

Countries tended to develop their own responses and emergency plans, including contingency plans, which were often uncoordinated, while cross-border activities were ignored. There was a glaring lack of resources for the implementation of community-based actions, which had led to delays in some health campaigns, and the resulting spread of the disease.

Member States faced many challenges besides drinking-water and sanitation, including inadequate surveillance systems, the lack of integrated social improvement schemes and the uncontrolled movement of people across borders. The primary problem remained the lack of financial resources for the implementation of community-based actions, which were crucial to the fight against cholera. Access to free health-care services remained limited, owing to the lack of resources; especially emergency public health funds during the early stages of an epidemic. Cross-border surveillance and epidemiological information sharing among neighbouring countries, supported by WHO, should be extended.

Dr SHONGWE (Swaziland) said that cholera had not received the attention it deserved. Its incidence was related to poor hygiene and sanitation, a lack of drinking-water, and poverty. Cholera prevention and control should therefore follow a comprehensive and integrated approach involving all relevant sectors, including poverty reduction mechanisms. Adequate technical and financial resources should be provided for a coordinated, multisectoral approach. He supported the work of the Global Task Force on Cholera Control.

Mr CONSTANT (Trinidad and Tobago) said that his country had taken actions to enhance cholera preparedness, in response to the regional situation. An updated cholera preparedness plan had been circulated to relevant health-care personnel. The Public Health Laboratory had adequate stock for the storage and processing of stool samples, and subnational laboratories had received training from the Caribbean Epidemiology Centre in *Vibrio cholerae* identification, as part of a national capacity-building exercise.

Referring to the draft resolution, he said that enhanced syndromic surveillance for diarrhoeal illness was practised in his country, and particular attention was being directed to the investigation of clusters in captive populations. Sufficient technical and financial resources were available, and multisectoral collaboration was in place for mobilizing preparation, prevention and control measures for diarrhoeal illnesses including cholera. Trinidad and Tobago was not in an endemic or epidemic state for cholera and would follow guidelines issued by PAHO and WHO on the applicability of vaccination campaigns to its current context. PAHO continued to provide support to the Ministry of Health in strengthening cholera preparedness, as well as in responding to other health emergencies. Further technical cooperation was planned in capacity building, as well as in local preparedness assessments. He supported the draft resolution as amended by earlier speakers.

Dr MALAMA (Zambia), welcoming the progress made in the development of a cholera vaccine, said that such a vaccine would play a complementary role in the control and prevention of cholera outbreaks in Zambia and many other countries. Zambia had strengthened its human resource skills and capacity so as to improve surveillance systems, and had successfully implemented guidelines for integrated disease surveillance and response. The National Epidemic Preparedness Committee provided a multisectoral response structure, but cross-border collaboration needed to be improved in the fight against cholera and other disease outbreaks at the subregional or regional level, and the African Region initiative to establish a regional fund for the prevention and control of outbreaks and epidemics should be supported.

With the support of WHO, Zambia had hosted the first intercountry cross-border meeting on cholera in March 2011, which had led to the signing of Memorandums of Understanding between participating ministerial representatives of Angola, Congo, Democratic Republic of Congo, Namibia and Zambia to enhance collaboration, coordination, and timely information sharing.

Dr SINOLINDING (Philippines) stressed a concerted, multidisciplinary approach to cholera prevention, supported by a solid cross-border surveillance system that captured information on critical factors such as water sources, sanitation coverage, environmental conditions and cultural practices.

The complete and accurate reporting of cases in affected Member States, as prescribed by the International Health Regulations (2005), should not be the sole basis for imposing sanctions and travel restrictions on States endemic for the disease. WHO, as the lead international health organization, should continually provide assistance, based on a systems approach, to avoid the one-off implementation of health interventions. In that regard, he supported the proposed revitalization of the Global Task Force on Cholera Control.

WHO should continue to coordinate the provision of assistance under the Paris Declaration on Aid Effectiveness, including the transfer of vaccine-manufacturing technology and further research to produce cheaper and more effective oral vaccines.

Dr Chia-En LIEN (Chinese Taipei) recalled resolution WHA44.6 on cholera, which had provided support to Member States to reduce cholera morbidity and mortality and to diminish the socioeconomic consequences of the disease. Nevertheless, cholera remained a public health problem in many developing areas. He expressed regret that the earthquake in Haiti in 2010 had led to a severe outbreak of cholera, causing more than 4500 deaths. PAHO and other health partners had supported the Haitian authorities in their response, including social mobilization, health promotion, and the provision of cholera treatment services. At the same time, Chinese Taipei had collaborated with the National Public Health Laboratory of Haiti on a three-year Haiti Epidemic Prevention Project, and had provided training programmes for epidemiologists from that laboratory to enhance disease surveillance and laboratory testing quality.

Effective public health interventions such as proper and timely case management, improved environmental management, improved hygiene, and access to and appropriate use of vaccines, would depend on an adequate system of surveillance and health care. Chinese Taipei would continue to collaborate with Haiti and other affected Member States in that regard.

He welcomed and supported the draft resolution contained in resolution EB128.R7.

Dr FUKUDA (Assistant Director-General) said that the disproportionate impact of cholera on populations in poverty, its unwelcome appearance in times and places of crisis, and its propensity to become endemic, together with the additional adverse effect of climate change on the spread of the disease, meant that cholera remained a major global public health problem.

The main causes of cholera included unclean water and substandard hygiene and sanitation. Effective action in those areas could be complemented by the use of oral cholera vaccines. Increased surveillance efforts around the world would serve to improve Member States' access to information on the disease, and in that regard it was important to revitalize the Global Task Force on Cholera Control.

The Secretariat would continue to work with Member States on those and other issues referred to in the draft resolution.

Mr KAZI (Bangladesh) said that, as the initiator of the draft resolution, his delegation had consulted with others on the amendments that had been proposed. The delegate of the United States of America had withdrawn his proposed amendment to the second preambular paragraph. The other amendments proposed by the delegate of the United States, to the third, sixth and eighth preambular paragraphs, and to subparagraphs 2(3) and 3(10), were acceptable. After consultations with the delegate of Papua New Guinea, agreement had been reached on an amendment to add the following wording at the end of subparagraph 2(5): "as well as to consider safe and effective innovations in oral rehydration therapy that can provide additional benefit in treatment outcomes".

Following consultations with the delegate of the United Kingdom on amendments proposed to the fourth preambular paragraph, agreement had been reached on the addition of the words "and sanitation behaviour" after "improved hygiene" and on the insertion of the word "adequate" before the word "sanitation".

With those amendments, he commended the draft resolution to the Committee for approval.

Mr MAMACOS (United States of America), responding to a request for clarification from the CHAIRMAN, confirmed that he had withdrawn his delegation's proposed amendment to the second preambular paragraph.

Ms KORTUM (Assistant Secretary), recapitulating the amendments proposed to the draft resolution, said that the word "poverty" would be moved to the end of the third preambular paragraph, which would begin with words "Reiterating that the spread of cholera is a consequence of natural disasters" and end with the words "absence of effective health systems, inadequate health care, and poverty". In the fourth preambular paragraph, the words "and sanitation behaviour" would be inserted after the words "improved hygiene" and "adequate" before the word "sanitation". In the sixth preambular paragraph, "is intertwined" would be replaced by "necessitates close cooperation". The

eighth preambular paragraph would be amended to end with the words “that are based on improved access to potable water, sanitation and hygiene”.

The words “and to prioritize close collaboration with other clusters including but not limited to WASH and logistics, to maximize the effectiveness of the overall multilateral humanitarian response” would be added to the end of subparagraph 2(3), and the words “as well as to consider safe and effective innovations in oral rehydration therapy that can provide additional benefit in treatment outcomes” would be added at the end of subparagraph 2(5). Finally, subparagraph 2(10) would be amended to read “to report to the Sixty-fifth World Health Assembly, through the Executive Board, on the global cholera situation and evaluate efforts made in cholera prevention methods and control.”

The CHAIRMAN said that, in the absence of any objections, he would take it that the Committee wished to approve the draft resolution contained in document EB128.R7, as amended.

The draft resolution, as amended, was approved.¹

Malaria: Item 13.10 of the Agenda (Documents A64/19 and EB128/2011/REC/1, resolution EB128.R13)

Dr BUSS (representative of the Executive Board) said that the Board had considered an agenda item on malaria at its 128th session. On the basis of a report contained in documents EB128/14 and EB128/14 Add.1, it had adopted resolution EB128.R13, in which it recommended a text to the Health Assembly for adoption.

Dr KALESHA (Zambia) welcomed the progress made in malaria prevention and control, particularly in the African Region, where the number of malaria deaths had been reduced by 50%. Zambia had recorded a 60% decline in malaria cases, exceeding the targets set by the Abuja Declaration and the Roll Back Malaria Partnership. That reduction had been achieved through strong national leadership, concerted efforts and well-coordinated partnerships, and community ownership and involvement.

The nine areas for action highlighted in the report, if implemented effectively, would contribute to sustaining gains and reducing transmission. It was essential for governments to keep malaria high on the political agenda, so as to ensure sustained national and financial commitment to requirements such as indoor residual spraying and insecticide-treated bednets.

The resistance of malaria to artemisinin-based medicines was of great concern, and available treatments should be safeguarded. The Secretariat should support countries in strengthening their regulatory frameworks so as to effectively halt the use of monotherapies and substandard medicines. The introduction of quality assurance mechanisms should also be considered.

She welcomed the move to curb resistance to insecticides through the adoption of best practices, as well as through better monitoring and evaluation. The transfer of technology relating to artemisinin combination therapy in malaria-endemic countries in order to strengthen capacity to meet WHO prequalification standards was also appreciated and long overdue. Such activities should be scaled-up, in order to improve access to quality medicines for vulnerable populations.

She supported the draft resolution.

Dr DOPHU (Bhutan) said that malaria was endemic in 10 of the 11 Member States in the South-East Asia Region. The Secretariat’s leadership and support from WHO and other partners had been welcomed. Significant progress had been made in reducing malaria-related morbidity and mortality, but nevertheless malaria remained a major public health problem in the Region.

He supported the draft resolution, but highlighted three issues for consideration. First, although parasite-based diagnosis was essential, the choice of method (microscopy or rapid diagnostic tests)

¹ Transmitted to the Health Assembly in the Committee’s sixth report and adopted as resolution WHA64.15.

should depend on the nature of each country's health system, as the two methods were complementary.

Secondly, although the Member States supported the principle of artemisinin-combination therapy, that did not necessarily mean the use of fixed-dose tablets. Treatment could be given with two separate medicines taken together; that would ensure more flexibility and lower costs for prescribing health personnel. The Health Assembly in resolution WHA60.18 had supported the use of artemisinin-combination therapy without urging Member States to ban the import and production of artemisinin alone for use in combination with other antimalarials. The Secretariat should support Member States in introducing artemisinin-combination therapy, but should not pressure them to ban single artemisinin products. Such products should, however, be strictly monitored to prevent the use of artemisinin monotherapies.

Thirdly, despite the remarkable success of the malaria control programme, WHO's role in facilitating cross-border malarial activities had become increasingly important, in particular when countries were moving towards malaria elimination.

Dr ARUNOTHONG SURACHET (Thailand) expressed concern that the Secretariat had misinterpreted the references to artemisinin therapies contained in subparagraphs 1(3) and 2(4) of resolution WHA60.18. He recalled that the original draft of the resolution had contained an operative paragraph banning the production, import, sales and distribution of single artemisinin products, but that had not been accepted by the Health Assembly and thus had not been included in the final text of the resolution because artemisinin-combination therapy could be delivered using either the co-administration of two separate agents, including an artemisinin-based medicine, or a fixed-dose combination. Thailand's experience showed that the use of two separate medicines was as effective, more flexible and much cheaper than the only fixed-dose combination treatment available in the country that cost US\$ 15, a price 15 times higher than the WHO tender prices.

Trust and social credit were essential to the reform of WHO's structures and financing, and any deliberate misinterpretation would undermine that trust. He therefore asked the Director-General to investigate the misinterpretation of resolution WHA60.18, remove paragraph 14 from document A64/19, and put a stop to attempts to pressure Member States into banning the availability of single artemisinin formulations. It was possible to support a ban on artemisinin monotherapy while not supporting the prohibition of single artemisinin production or import for use in coordinated treatments.

He proposed additions to two operative paragraphs in the draft resolution. A new subparagraph should be added to follow subparagraph 1(7), to read: "to carefully consider implementing artemisinin-combination therapy based either on fixed-dose combination or administration of two separate drugs, taking into account the local evidence of effectiveness in the field, cost benefit, compliance, regulatory capacity, budget burden, feasibility and long-term sustainability". A second new subparagraph should be inserted after subparagraph 3(6), to read: "to support Member States to continually monitor the progress of artemisinin-combination therapy relative to artemisinin monotherapy, and to discontinue monitoring of the production, import and distribution of artemisinin single drugs for the use in artemisinin-combination therapy".

Dr HWOAL (Iraq) said that, despite a reduction in transmission, Iraq had registered more than 1000 cases in recent years. WHO should provide technical assistance for capacity building and training for health personnel involved in malaria eradication efforts. Given the importance of vector control, appropriate use should be made of environmentally-friendly insecticide-treated products. Partnerships with international organizations and civil society were essential to achieving improved diagnosis and the integration of malaria treatment into primary health care systems. Furthermore, greater attention should be paid to awareness-raising of the importance of malaria eradication as a Millennium Development Goal target.

Dr COPELAND (Jamaica) said that, having eradicated malaria more than 40 years earlier, Jamaica had successfully halted and reversed local transmission of the disease when it had been

reintroduced into the country in 2006. The recent outbreak, which had resulted in 412 cases over the previous four years, was now controlled; only one locally transmitted case had been identified during 2011. The nine action areas defined in the report had been essential in implementing her country's Strategic Action Plan to Prevent and Control Malaria.

Diagnosis and surveillance guidelines had been evaluated and improved, and had also been expanded to include the use of geographical information service mapping to target areas for intervention. Insecticide testing had shown that in some areas mosquitoes were showing resistance to the insecticide malathion, and she therefore requested support for capacity building in countries that were disease-endemic and non-endemic through training in testing, using the global plan for the prevention and management of insecticide resistance. Integrated vector management was being implemented, though it urgently required more support. She recommended that WHO establish a programme to train and certify entomologists and malariologists. Finally, support should be made available for country-specific operational research on reducing transmission and malaria elimination.

Dr NJUGUNA (Kenya), speaking on behalf of the Member States of the African Region, welcomed the global progress in combating malaria, but expressed concern that the disease remained one of the leading causes of death in the Region, in particular in children under five years of age. The use of insecticide-treated bednets, indoor residual spraying and improved access to malaria interventions had led to a reduction in malaria transmission in sub-Saharan Africa. Africa needed to adopt a comprehensive approach to malaria control based on vector elimination. A further important goal was universal access to affordable and accessible rapid diagnostic testing and malaria therapies.

Malaria had a serious impact on socioeconomic development in the Africa Region, and must be combated if progress was to be made in attaining Millennium Development Goals 4 (Reduce child mortality), 5 (Improve maternal health) and 6 (Combat HIV/AIDS, malaria and other diseases). As Member States could not individually control and eliminate malaria, support was needed for regional cooperation and external partnerships, and the African Leaders Malaria Alliance had been founded in order to stimulate regional eradication efforts. The Region appreciated the support it had received from development partners, and appealed to other partners for increased funding. He urged the Secretariat to facilitate technology transfer to malaria-endemic countries, to enable the local production of malaria control products. The five-step Global plan for artemisinin resistance containment¹ should also be implemented in the Region. It was essential to combat mosquito resistance to insecticides, and that required the development and implementation of a global plan of action.

Supporting the draft resolution, he said that many manufacturers in sub-Saharan Africa had been unable to meet WHO prequalification standards, and he asked the Secretariat and other technical partners for help to overcome the barriers. Technical assistance and increased funding should be made available for research and development in malaria control and prevention. WHO should encourage technology transfer to manufacturers of pharmaceuticals and other health products in Africa. Finally, the use of insecticides to eliminate the vector, including DDT, should continue until affordable alternatives were available.

Dr KONG Lingzhi (China) thanked WHO for coordinating international action on malaria prevention and control. China had launched a national action plan for malaria elimination, supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria, with the aim of eradicating cases of local malaria infection by 2015. The Chinese Government was also supporting the Mekong subregion, neighbouring countries and affected African countries in developing malaria programmes. The Secretariat and developed countries should seek to meet the needs of developing countries in areas such as the use of microscopy to detect vector-borne parasites, affordable artemisinin therapy, and detection of drug resistance. She supported the draft resolution.

¹ *Global plan for artemisinin resistance containment*. Geneva, World Health Organization, 2011.

Mr DAKPALLAH (Ghana) said that malaria, the leading cause of morbidity in Ghana, continued to be a major public health concern, particularly in pregnant women and children under five years of age; the latter group also had the highest malaria mortality rates. The economic burden of malaria in Ghana was estimated at US\$ 730 million per annum, with a significant loss in productivity. To meet those challenges, Ghana had adopted a four-pronged approach for the control and elimination of malaria, which included emphasis on the distribution of insecticide-treated bednets; case management using appropriate chemotherapy; continuing vaccine trials; and larviciding. That multifaceted approach had started yielding results, and some areas had reported a significant reduction in outpatient cases of malaria. However, inadequate diagnostic capacity had led to many cases of fever being diagnosed as malaria.

He supported the draft resolution, which provided for a multipronged approach to malaria prevention and control. Larviciding was particularly important because of its relevance to the environmental aspects of malaria.

Mr MAULUDU (Papua New Guinea) said that malaria was the most important public health problem apart from HIV/AIDS and other recently introduced infections. Malaria had long been prevalent in lowland, coastal and island regions of his country, and had spread to the highlands as a result of development, road construction and climate change. Malaria risk stood at 90%, one of the highest levels outside sub-Saharan Africa, in a population of 6.5 million. The malarial epidemiology of Papua New Guinea was complex owing to the country's great ecological, cultural and linguistic diversity. In the coastal and island regions, malaria was the main reported cause of morbidity, in particular in young children and pregnant women, and was one of the commonest causes of morbidity and mortality in the highlands where it was not endemic but epidemics were frequent. Furthermore, malaria was the most common outpatient diagnosis and the second leading cause of admission, despite the fact that a high percentage of the population in malaria-endemic regions of the country had developed some degree of immunity to the disease.

The National Malaria Control Programme Strategic Plan 2009–2013 focused on improving malaria control outcomes, with particular emphasis on reducing malaria-related morbidity and mortality. With the support of WHO and other partners, Papua New Guinea would continue to strengthen the strategic plan in the areas of leadership and governance; system strengthening and capacity building; accurate diagnosis and prompt, effective treatment of malaria; vector control; epidemic preparedness and response; and behaviour change and communication.

He supported the draft resolution.

Dr BAYUGO (Philippines) said that the burden of malaria in the Philippines was declining. Stronger investment in the malaria programme by the Government and the private sector demonstrated the country's commitment to eradicating malaria by 2020, and a medium-term plan for the period 2011–2016 was being developed to support that goal. Having already achieved its Millennium Development Goal targets, the Philippines would work to sustain the gains that had been made. Malaria should remain high on national political and development agendas in order to ensure predictable long-term national and international funding for its control.

He supported the Director-General's decision to convene a technical expert group on a first-generation malaria vaccine, which would make policy recommendations when the full results of clinical trials were known.

Integrated vector management should be adapted to ensure the optimal use of national resources for vector control, especially in countries with limited human and programme resources. Policies and guidelines were needed on the long-term disposal, re-use and recycling of long-lasting insecticide-treated bednets, which were made of materials that were harmful to the environment if not properly managed, especially in countries where there had been mass distribution programmes.

It was essential to continue and expand information exchange on the health status of migrant workers, with particular reference to malaria, and to improve case management on the basis of

adequate referral mechanisms in both sending and receiving countries, particularly where countries were seeking certification of malaria-free status.

Dr AL NASSER (Kuwait) said that the malaria mortality rate, although high in many countries, was decreasing as a result of measures taken by the Secretariat and Member States. Kuwait had recorded 69 cases of malaria in migrant workers in 2010. The Ministry of Health had adopted measures to ensure that the country remained free of malaria, including provision of diagnostic tests for screening foreign workers. Malaria treatment centres had been established, and up-to-date statistics were being compiled to inform treatment regimes. The Ministry of Health was also working in the area of vector control, and would continue to promote cross-border cooperation for the further reduction of transmission.

Dr AL HAJERI (Bahrain) said that Bahrain had been malaria-free for more than a decade. Nevertheless, the Ministry of Health continued to take the necessary steps to maintain that status and prevent reintroduction from abroad. Vector control strategies had been developed and the country was working with the Secretariat within the framework of a regional plan of action. She supported the draft resolution.

Mr PRAZ (Switzerland) said that, even though the global burden of malaria had been significantly reduced, universal coverage with antimalarial interventions was only halfway to being achieved and progress was threatened by increasing resistance to antimalarial medicines and insecticides. Switzerland, under the umbrella of the Swiss Malaria Group, a public-private network, remained committed to fighting the disease through funding for malaria research and medicine and insecticide production.

Supporting the draft resolution, he said that it lacked a reference to Millennium Development Goals 4 and 5 in line with the opening paragraph of document A64/19. In subparagraph 1(1) the words “the targets” should be replaced by “contributing to Goals 4 and 5, as well as other targets”.

Mr MAMACOS (United States of America) stressed the importance of global malaria control to health and well-being in disease-endemic settings, especially for women and children, and the negative impact of malaria on household incomes, economic and social development, and political stability in the affected countries. The report reflected well the current challenges to global control efforts and the still-devastating burden of morbidity and mortality. He supported the call for action to combat a major threat to progress, namely mosquito resistance to insecticides. The United States, the biggest donor in the field, encouraged all donor and recipient countries to continue their efforts underpinned by adequate funding and strong political commitment; affected nations, especially in Africa, should strive to increase their national health spending.

He supported the draft resolution but proposed three amendments. As indoor residual spraying was a major intervention, the last part of subparagraph 1(2)(a), after the words “effective coverage”, should be amended to read: “particularly through (i) replacement and continuous provision of long-lasting insecticide-treated bednets and targeted communication about their usage, and/or (ii) regular application of indoor residual spraying with insecticides”. The following text should be added to the end of subparagraph 2(6): “provided such assistance is made available in accordance with clear and transparent protocols for the selection of manufacturers to receive this assistance, and that such assistance is provided in a strategic, prioritized and transparent way”. Subparagraph 3(5) should be amended to read: “to promote transfer of technology to manufacturers of artemisinin combination therapies in malaria-endemic countries and to strengthen their capacity to meet WHO prequalification standards, provided such assistance is made available in accordance with clear and transparent protocols for the selection of manufacturers to receive this assistance, and that such assistance is provided in a strategic, prioritized and transparent way”.

He could not support the amendments proposed by the delegate of Thailand. Nobody was calling for the production of artemisinin monotherapies to be halted, for there was a market for them;

but they did need monitoring to ensure they were not sold on their own. He suggested that the meeting be suspended to consider a compromise on the matter.

Ms CADGE (United Kingdom of Great Britain and Northern Ireland) welcomed the report and supported the draft resolution. In spite of progress in reducing malaria mortality through the use of insecticide-treated bednets, new antimalarial treatments and indoor residual spraying, the disease still caused an unacceptably high number of deaths each year, especially among women and children. It put the health and well-being of pregnant women and unborn children at risk; it threatened to throw households into poverty; and it undermined the stability of economies. Efforts to eliminate mortality should include promoting better bednet use and replacement strategies, diagnostic tests and preventive treatment during pregnancy, and the strengthening of the associated health services.

Outlining her Government's action and commitment to strengthening malaria control through significant, cost-effective and transparent investment, she acknowledged the influential role of the African Leaders Malaria Alliance, the Global Malaria Programme and the Roll Back Malaria Partnership – with the guidance and support of WHO – in halting the marketing and use of artemisinin monotherapies. She particularly commended WHO's Global plan for artemisinin resistance containment. She requested time to consider the amendments proposed by the delegate of Thailand to the draft resolution.

Mr GORI MOMOLU (Equatorial Guinea) said that his country had a national programme to combat malaria through vector control and prevention, effective disease management, and surveillance and operational research. Activities to reduce malaria transmission included a massive campaign of indoor residual spraying and the extensive distribution of insecticide-treated bednets, especially to all pregnant women attending antenatal checks at hospitals across the country. In order to achieve effective disease management, public health professionals, medical faculties, pharmacies and private physicians had reached consensus in 2008 on the use of artemisinin-based combination therapy (artesunate plus amodiaquine). Malaria control programmes in Equatorial Guinea included free diagnosis and antimalarial treatment, as necessary, for every person visiting official health centres, and pregnant women received free intermittent preventive treatment with sulfadoxine-pyrimethamine from the second trimester of pregnancy.

Between 2004 and 2009, combined control measures had produced significant results, more than halving all-cause mortality among children aged under five years and reducing the prevalence of plasmodia in children aged under 15 by 45%. In order to sustain those achievements, the Government had developed a national strategic plan for 2009–2013 and a programme supported by the Social Development Fund. World Malaria Day had been celebrated across the country and a campaign had been initiated to raise awareness about the malaria prevention and control measures recommended by the Ministry of Health and Welfare.

Professor ADITAMA (Indonesia) said that the activities covered by Indonesia's comprehensive national malaria control programme received financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria and other partners. Indonesia attached great importance to community participation and to incorporating malaria into other disease control programmes, and was on course to meet Target 6.C (have halted by 2015 and begun to reverse the incidence of malaria and other major diseases) of Millennium Development Goal 6 (Combat HIV/AIDS, malaria and other diseases).

Dr OBARA (Japan) welcomed the draft resolution, which was particularly timely in view of the need to set new directions and to tackle drug and insecticide resistance. If incorporated into an integrated vector management programme, malaria control could also help to combat dengue and other vector-borne diseases. Japan was a contributor to the Global Fund to Fight AIDS, Tuberculosis and Malaria and provided technical assistance via the Japan International Cooperation Agency.

Dr TSESHKOVSKIY (Russian Federation) said that his country assisted many developing countries in the fight against malaria through technical and financial cooperation with WHO. Vector control and treatment programmes had helped to reduce transmission and to enable some malaria-affected countries, including in the European Region, to come close to eliminating the disease. In countries where malaria remained endemic, further work was needed to reduce transmission, and Russian specialists would continue to assist WHO in the development of antimalarial agents and second-generation vaccines, and was ready to provide specialist expertise in planning, monitoring and evaluation of antimalarial programmes, especially in Africa, and in improving prevention, diagnosis, and treatment. He supported the draft resolution.

Ms MORENO (Paraguay) commended the report and the progress made towards the elimination of malaria, notwithstanding the many remaining obstacles. Although in Paraguay far greater social disruption was caused by outbreaks of dengue, malaria was endemic and costly to both the State and individuals. There should be sustained political and financial commitment to strengthening surveillance systems. Timely diagnosis and treatment, vector control, and studies on plasmodial resistance to antimalarials and vector resistance to insecticides were vital. Fully integrated malaria control and prevention contributed to achievement of the Millennium Development Goals.

Paraguay had reduced the number of cases of malaria from about 10 000 in 1999–2000 to one indigenous case and two imported cases in 2011. With WHO's support, her country had developed a plan for 2011–2015 with a view to fully eliminating transmission. Bearing in mind resolutions WHA58.2 and WHA60.18, the elimination of malaria worldwide called for clearer guidelines, specific measures, stricter criteria and cooperation with neighbouring countries and at regional level.

Dr CHONG CHEE KHEONG (Malaysia) said that his country had recently launched a 10-year strategic plan to ensure that it eliminated malaria by 2020. In view of the number of malaria-affected countries in the Region, it was essential to strengthen regional collaboration. Malaysia looked forward to working with the Secretariat and other organizations to enhance capacity for surveillance and vector control through national and international dialogue and training.

Professor ONDOBO ANDZE (Cameroon) endorsed the report. The draft resolution did not address a serious waste-management problem: between 2008 and 2010, vast numbers of insecticide-treated bednets had been distributed in sub-Saharan Africa and an increasing number were being discarded before the end of their four-year lifespan, meaning that they were still toxic. The text did not take account of their negative effects on the environment, on agriculture, on public health and, hence, on development. In some communities they were even reportedly being used as fishing nets. The Secretariat needed to give thought to proposing guidelines for Member States to develop policies on the matter. Cameroon would support a slightly expanded and amended version of the resolution under consideration.

Mr CORRALES (Panama) said that malaria posed a serious health problem in Panama, with high social and economic costs. Regions with indigenous populations, which were home to only 10% of the country's population, accounted for more than 85% of the total cases registered nationally. As a major reason was the lack of cultural relevance of national programmes to the health issues affecting indigenous people, it had been concluded that it was necessary to develop a comprehensive and culturally sensitive methodology for tackling malaria, taking into account the distinctive features of indigenous populations, in terms of language, social organization, belief and value systems, world view, economic principles and production methods adapted to the ecosystems in which they lived. Analysis of the results of a study on malaria patterns in one indigenous region should contribute to the refocusing and strengthening of the policies, plans and programmes of the Ministry of Health so as to reduce the incidence of malaria among indigenous populations while recognizing the need to preserve their cultural heritage and ancestral knowledge. He supported the draft resolution.

Ms EL-HALABI (Botswana) endorsed the draft resolution. The significant decline in her country's disease burden had given it a realistic chance of meeting the Millennium Development Goal target for malaria, and the focus had shifted to elimination of the disease. Botswana greatly appreciated the technical and financial support of WHO, UNICEF and its many development partners and urged them to continue providing assistance to meet the 2015 elimination target, progress towards which was threatened by a decline in funding. The results attained so far illustrated the value of such funding and support.

Mr PEAT (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, stressed the key part played by leadership, partnership, increased resources and new operational models in the significant reduction in malaria cases in disease-endemic countries since 2000. Mass distribution of insecticide-treated bednets to at-risk populations – together with awareness-raising to ensure they were used correctly – had enabled his organization to protect and save the lives of a great many people, and its volunteers, trained and supervised by health ministry staff, were providing isolated communities in remote areas with access to effective diagnostics and treatment. Sustained education on how malaria was transmitted gave families the confidence to prevent, diagnose and treat it and empowered communities. Investing in malaria control led to significant improvements in maternal and child health while contributing to health system strengthening and building the capacity of health ministries to scale up programmes and sustain progress towards eliminating the disease and meeting the targets set by the Roll Back Malaria Partnership and the Millennium Development Goals.

Mr AL KEHALY (Yemen), referring to his country's considerable success in combating malaria, said that it had been included in an integrated control programme covering several other diseases. Other measures had included mobilizing support from civil society, launching awareness-raising campaigns, introducing rapid diagnostic tests and distributing medicines to the most serious cases. It was crucial to root out the causes of the disease.

Ms CHAVEZ (Global Health Council, Inc.) welcomed the report and urged delegates to approve the draft resolution. The progress made in combating the disease over the previous decade had been remarkable but was fragile. Funding levels in 2010 had been less than one third of the annual resource needs identified in the Global Malaria Action Plan, and increased financial support would be required to sustain the gains achieved. The international community must continue investing in research and the development of new tools – such as medicines, insecticides, vaccines and diagnostic tools – in order to respond to increasing drug resistance. Member States were urged to support implementation of WHO's Global plan for artemisinin resistance containment, and the development and implementation of a global plan for the prevention and management of resistance to insecticides. Coordination at the country and global levels was essential to maximize the effective use of funding for service delivery, procurement, and research and development.

Dr Chia-En LIEN (Chinese Taipei) outlined action taken in Chinese Taipei since 1946 that had led to the eradication of malaria in 1965, and the prevention of resurgence through to the present day. Its experience of working on malaria prevention and control with Sao Tome and Principe over the previous eight years had strengthened his country's appreciation of the importance of coordinated global efforts for the effective control of epidemics. He strongly supported the draft resolution, especially subparagraphs 1(1), 2(1) and 2(3).

Dr NAKATANI (Assistant Director-General) said that the Secretariat had noted the comments and suggestions made by delegates and would take them into account in its future work. Many speakers had mentioned the developments of the past four years, including the emergence of drug resistance, the widespread availability of artemisinin-combination therapies and rapid diagnostic tests, and issue of the sustainability of funding.

In response to the comments made by the delegate of the Philippines, he said that an expert group was being organized and guidelines developed on the recycling and re-use of insecticide-treated bednets. Responding to the delegate of Bhutan, he said that both microscopy and rapid diagnostic tests were useful and complementary and should be used according to country contexts and needs.

As for the important issue raised by the delegate of Thailand about the phasing out of artemisinin monotherapies, he said that stopping the spread of resistance was a far more pressing concern, as reflected in the theme of World Health Day 2011: “Antimicrobial resistance: no action today, no cure tomorrow”. The Secretariat was recommending Member States to use artemisinin-combination therapies through fixed-dose combinations or co-blistered combinations of two medicines. The former were easier to administer but not all artemisinin-combination therapies were currently available in that form, making it necessary to manufacture artemisinin for co-blistering with other medicines. In the spirit of resolution WHA60.18, the Secretariat was working with Member States’ regulatory authorities and checking manufacturers’ web sites to see whether they were making artemisinin available on its own, and, if so, taking the matter up with their chief executive officers. The phrase in paragraph 14 of document A64/19 about which the delegate of Thailand had expressed concern, namely “most large companies have stopped production of these medicines”, should have read “most large companies have accepted to stop sales and marketing and have subsequently stopped production of these medicines”.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) asked what medicines were available for co-blistering with artemisinin. Paragraph 14 of document A64/19 was unacceptable as it distorted the intention of resolution WHA60.18. It should have stated clearly that artemisinin-combination therapies could involve the use of a fixed-dose combination therapy – two medicines in one tablet – or the co-dispensing of two separate medicines, one of which was artemisinin. If the Health Assembly urged Member States to stop the production of single artemisinin monotherapies, that would contradict the policies of States in which artemisinin was co-blistered or co-administered for combination treatment. The second half of paragraph 14 sent out the wrong signal, which had reportedly led some companies to stop producing artemisinin. He requested further clarification from the Secretariat.

Dr NAKATANI (Assistant Director-General) assured the delegate of Thailand that the Secretariat did not oppose the production of artemisinin, which was needed as a component of combination therapies, but was calling for the discontinuation of the marketing and sale of artemisinin monotherapies. That was consistent with the message put out on the Global Malaria Programme’s web site.

The CHAIRMAN proposed that the meeting be suspended to give the delegations of Thailand, the United Kingdom of Great Britain and Northern Ireland and the United States of America time to reconcile the various proposed amendments. If they failed to reach a compromise, consideration of item 13.10 would be resumed the next day and the Committee would move on to consider item 13.11 on eradication of dracunculiasis.

The meeting was suspended at 16:55 and resumed at 17:10.

(For approval of the draft resolution, see the summary record of the thirteenth meeting, section 2.)

Eradication of dracunculiasis: Item 13.11 of the Agenda (Documents A64/20 and EB128/2011/REC/1, resolution EB128.R6)

Dr BUSS (representative of the Executive Board) said that the Board had considered the eradication of dracunculiasis at its 128th session. On the basis of a report contained in document EB128/15, it had adopted resolution EB128.R6, in which it recommended a draft text to the Health Assembly for adoption.

The CHAIRMAN said that the Secretariat had amended the fifth preambular paragraph of the draft resolution contained in resolution EB128.R6 to reflect updated statistics on the situation regarding dracunculiasis in disease-endemic countries at the end of 2010.

Dr POZNYAK (Assistant Secretary) said that the amended fifth preambular paragraph of the draft resolution read: “Noting with satisfaction the excellent results achieved by the countries where dracunculiasis is endemic in decreasing the number of cases from an estimated 3.5 million in 1986 to 3190 reported cases in 2009 and less than 1800 reported cases in 2010”.

Mr ASSOGBA (Benin), speaking on behalf of the Member States of the African Region, said that, although the target of eradicating dracunculiasis by 2009 set by the Health Assembly in resolution WHA57.9 had not been met, the incidence of the disease had declined significantly. In spite of limited resources, the number of countries in Africa where the disease was endemic had dropped to four, namely Ethiopia, Ghana, Mali and Sudan. Continuing security problems, political instability and limited supplies of safe drinking-water constituted the main obstacles to surveillance and effective case containment. He urged WHO and the development partners to provide assistance to enable the countries concerned to interrupt dracunculiasis transmission by the end of 2011. Critical steps included organizing a communication network in the four countries in order to heighten the awareness of their populations and secure their active participation in detecting cases within the community, combined with continuing certification activities in countries that met the eradication criteria.

He urged the Health Assembly to adopt the draft resolution.

Mr DAKPALLAH (Ghana) said that his country expected to declare itself officially free of dracunculiasis transmission by the end of July 2011, 14 months after the last indigenous case had been reported, in spite of setbacks caused by ethnic conflict and a weak water infrastructure network. Ghana reaffirmed its commitment to eradicating the disease and emphasized the need for continuing support for surveillance in the disease-endemic countries poised to achieve that goal. He recommended that the resolution contained in resolution EB128.R6 should be adopted, monitored and implemented, and requested technical support for the interruption of transmission.

Mr McIFF (United States of America), noting the significant reduction in the suffering and economic hardship caused by dracunculiasis as a result of progress in eliminating the disease to date, congratulated the countries that had achieved certification of dracunculiasis elimination and those, like Ghana, that had recently entered the pre-certification phase. Their efforts demonstrated the effectiveness of the basic interventions used by the national eradication programmes, the Secretariat and their partners.

He supported the draft resolution. Nevertheless, constant, even intensified, support was needed in the final stages of eradication to reduce the risk of increased transmission and spread. Given the guinea worm’s unusually long incubation period of one year, and the fact that it would take at least that long for Health Assembly recommendations to show an impact, by that time the disease might have been eradicated or fresh outbreaks might have occurred. Reports to the Health Assembly should therefore be submitted on a yearly rather than a biennial basis. Accordingly, the words “every two years” in subparagraph 5(3) should be replaced by “every year”.

Ms CADGE (United Kingdom of Great Britain and Northern Ireland), welcoming the progress made towards eradication of dracunculiasis, called for greater efforts in disease-endemic areas such as southern Sudan and the monitoring of new cases detected in Chad. Community-based networks had been crucial to Nigeria and Niger being declared free of dracunculiasis in 2009 and should encourage countries to build on those successes in ways that strengthened their health systems. The fact that Burkina Faso was close to being declared free of transmission reflected the strength of community-level surveillance and national commitment. The international community had a duty to sustain the funding and support needed to continue making good progress, and WHO should consider

documenting the lessons learnt for dissemination to other neglected tropical and infectious disease communities. She supported the draft resolution as amended by the delegate of the United States of America.

Dr CHAWETSAN NAMWAT (Thailand), noting the dramatic decrease in reported cases of dracunculiasis, said that global eradication could be achieved in the near future through intensified interventions in the remaining four disease-endemic countries and surveillance in the countries that had achieved disease-free certification or pre-certification. He supported the draft resolution as it stood.

Dr AGOUDAVI (Togo) expressed appreciation to WHO for the support his country had received in achieving eradication of dracunculiasis. Not a single indigenous case had been reported in three years as a result of efforts in surveillance; case management; information, education and communication; wider availability of water filters; and better drinking-water supply systems. Togo was therefore on track to achieve disease-free certification imminently. The pre-certification activities launched in 2009 had included dracunculiasis awareness-raising, community-based surveillance by local health workers and provision of information on the reward system. Those activities would continue regardless of whether the country achieved certification in view of the new cases detected in neighbouring Ghana.

Dr HWOAL (Iraq) stressed the need for intensified efforts to combat dracunculiasis, even though there remained just four disease-endemic countries. Such efforts should include improving diagnosis, training health-sector professionals in the treatment of detected cases, raising awareness of prevention methods within the health system, mobilizing every sector of society, and building partnerships for the participation of civil society and international organizations.

Ms BOLLY-RAPHAEL (Côte d'Ivoire) said that, in spite of the commendable progress made in combating dracunculiasis, more must be done in terms of surveillance, awareness-raising and expanding the supply of safe drinking-water to communities in order to interrupt transmission and to eradicate the disease. Transmission had been interrupted in Côte d'Ivoire in 2007, after a 40-year struggle, and the country had joined the group of those in the pre-certification phase. Following scientific field surveys, the certification report was being finalized. She supported the draft resolution.

Mr VICENTI (Italy) expressed satisfaction with the progress made in the fight against dracunculiasis and with the reduction in the number of cases in disease-endemic countries. He strongly supported the draft resolution and, with a view to maintaining the momentum of progress towards the goal of total eradication, endorsed the yearly reporting requirement proposed for inclusion in the text by the delegate of the United States of America.

Dr RIEK (Sudan) described the southern region of Sudan, which had accounted for 94% of new dracunculiasis cases reported in 2010, as "the largest exotic pathology museum of guineaworm disease in the world". Dracunculiasis had a negative impact on the population, especially in the neglected communities with the worst health and socioeconomic indicators, as well as on the region's future prospects for reconstruction and development as an independent sovereign republic. Eradicating the disease would deliver a peace dividend to those most in need, and his Government was committed to interrupting transmission by 2013 and achieving certification by 2016. Dracunculiasis eradication would require a great deal of work, commitment, partnership and support. He too supported the draft resolution.

Dr NAKATANI (Assistant Director-General) assured the Committee that the Secretariat would strive to eradicate dracunculiasis in cooperation with Member States and other partners. In response to the request for annual reporting made by the delegate of the United States, he said that the Secretariat

already received monthly reports from affected countries, and would be prepared to submit annual reports to the Health Assembly.

The CHAIRMAN said that, in the absence of any objections, he took it that the Committee wished to approve the draft resolution contained in document EB128.R6, as amended.

The draft resolution, as amended, was approved.¹

The meeting rose at 17:35.

¹ Transmitted to the Health Assembly in the Committee's sixth report and adopted as resolution WHA64.16.

THIRTEENTH MEETING

Tuesday, 24 May 2011, at 09:20

Chairman: Dr W. AMMAR (Lebanon)

1. SIXTH REPORT OF COMMITTEE A: Item 8 of the Agenda (Document A64/63 (Draft))

Dr KULZHANOV (Rapporteur), read out the draft sixth report of Committee A.

Mr MÉSZÁROS (Hungary) noted that the report contained a technical error regarding the resolution on the health-related Millennium Development Goals. In the ninth preambular paragraph bis, the European Union had requested that the term: “neonatal survival interventions” be changed to “neonatal health interventions”.

Speaking on behalf of the European Union, he thanked Brazil for its initiative and the request to cosponsor the resolution on the draft global health sector strategy on HIV, 2011–2015. However, as he understood it, cosponsorship was no longer legally possible. He therefore asked for this oral request to cosponsor the resolution to be entered in the records of the meeting.

The CHAIRMAN said that the correction would be made as stated by the delegate of Hungary.

The report was adopted.¹

2. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Malaria: Item 13.10 of the Agenda (Documents A64/19 and EB128/2011/REC/1, resolution EB128.R13) (continued from the twelfth meeting)

Dr DOLEA (Assistant Secretary) read out the seven proposed amendments to the draft resolution. A new seventh preambular paragraph bis agreed by the informal working group would read: “Recognizing that artemisinin-based fixed-dose combinations are highly preferable to the loose individual medicines co-blistered or co-dispensed”.

In subparagraph 1(1), the delegate of Switzerland had proposed adding, in the fifth line after “Millennium Development Goal 6,”: “and contributing to Millennium Development Goals 4 and 5 as well as other targets set by the Health Assembly in resolution WHA58.2”. In subparagraph 1(2)(a), the delegate of the United States of America had proposed the following amendments in the second line after “effective coverage”: to insert the words “particularly through (i) replacement and continuous provision of long-lasting insecticide-treated bednets and targeted communication about their usage,” followed by “and/or (ii) regular application of indoor residual spraying with insecticides”. Subparagraph 1(7)bis, as agreed by the informal working group, would read: “to promote scaling up of artemisinin-based combination therapy, where appropriate, either as a fixed-dose combination or as co-administration of two separate drugs, with a system to ensure a high level of adherence to

¹ See page 339.

treatment, taking into account the local evidence on effectiveness, cost-effectiveness, availability and affordability, regulatory capacity, budget burden, feasibility and long-term sustainability”.

In subparagraph 2(6), at the end of the paragraph the delegate of the United States had proposed adding: “provided such assistance is made available in accordance with clear and transparent protocols for the selection of manufacturers to receive this assistance, and that such assistance is provided in a strategic, prioritized and transparent way”.

In subparagraph 3(5), the delegate of the United States had proposed deleting the words “in order” and replacing them with “and” so that the text read: “... combination therapies in malaria-endemic countries and to strengthen their capacity ...”, and inserting at the end of the paragraph: “provided such assistance is made available in accordance with clear and transparent protocols for the selection of manufacturers to receive such assistance, and that such assistance is provided in a strategic, prioritized and transparent way”. The final amendment to subparagraph 3(6bis) would read: “to support Member States to continually monitor the progress of accessibility, affordability and use of artemisinin-based combination therapy”.

Mrs TZIMAS (Germany) proposed to further amend the proposed change in subparagraph 1(2)(a), by adding at the end of the subparagraph the words “in accordance with WHO regulations”.

Mr MAMACOS (United States of America), noting that request, observed that the requirement to adhere to WHO regulations was covered in subparagraph 1(6) by “to comply with existing commitments and international regulations”.

Mrs TZIMAS (Germany) said that she would nevertheless prefer to keep her proposed addition to subparagraph 1(2)(a).

Mr MAMACOS (United States of America), at the request of the CHAIRMAN, accepted the change proposed by Germany.

The draft resolution, as amended, was approved.¹

Dr NAKATANI (Assistant Director-General), referring to paragraph 14 of document A64/19 in response to the concern raised by the delegate of Thailand as to the meaning of that paragraph, said that most large companies had stopped marketing oral artemisinin monotherapies and weak regulation of pharmaceutical markets remained a major issue. The final sentence should begin on a new line to show that it concerned facts gathered by the Secretariat.

Smallpox eradication: destruction of variola virus stocks: Item 13.8 of the Agenda (Document A64/17) (continued from the eleventh meeting, section 2)

The CHAIRMAN recalled that, at its eleventh meeting, the Committee had deferred further debate on the item pending the outcome of consideration by an informal working group of the draft resolution introduced at that meeting.

Mr DESIRAJU (India), speaking as the chairman of the informal working group, said that the informal group had held two meetings on 23 May 2011 in which 50 Member States had participated. A major area of discussion had centred on whether the Sixty-fourth World Health Assembly should decide on a final date for the destruction of the variola virus stocks held in the two authorized repositories. Most delegates had agreed that any such decision must be based on evidence and rigorous

¹ Transmitted to the Health Assembly in the Committee’s seventh report and adopted as resolution WHA64.17.

scientific research, but views had differed as to when the Health Assembly should consider a review of such research and which body should be authorized to carry out the review. Suggestions for the latter had included the WHO Advisory Committee on Variola Virus Research (established by resolution WHA52.10), the Advisory Group of Independent Experts to review the smallpox programme, and a new multidisciplinary, possibly intergovernmental, expert group. Some delegates had considered that those Member States which had already confirmed to WHO the destruction or transfer of variola virus stocks in their possession should do so again, although others had felt it unnecessary for all Member States to be called upon to provide such an official written communication. In relation to the possible existence of unknown, unauthorized or as yet undiscovered variola stocks, some delegates considered that, once Member States had confirmed the destruction or transfer of stocks, it was not appropriate to discuss whether they still held stocks. The question of accidental release of such stocks had also been raised. The discussion had been marked by a high degree of engagement and commitment to the stated WHO objective of eventual destruction of remaining variola virus stocks. However, it had not proved possible to reach consensus on the text of the draft resolution, especially given the differing views on the areas he had mentioned. It had been agreed that he should report accordingly to Committee A.

Dr SILBERSCHMIDT (Switzerland) proposed that, given the continuing absence of consensus, further consideration of the item should be deferred to the Sixty-seventh World Health Assembly. In the meantime, existing Health Assembly resolutions on the matter should remain valid and continue to apply. The intervening period was not too long but would allow time for consideration of the important issues tabled for the next two Health Assemblies, and also for the Secretariat to prepare the ground with a view to obtaining consensus at that Health Assembly on a resolution on the destruction of variola virus stocks.

Mr BAEIDI NEJAD (Islamic Republic of Iran) expressed appreciation of the useful, substantive discussions in the informal working group. Deferral to the Sixty-seventh World Health Assembly, as proposed by the delegate of Switzerland, was not acceptable; it was too far in the future. The Sixty-fourth World Health Assembly had been mandated by resolution WHA60.1 to make a decision on the timing of the destruction of existing variola stocks, and it would therefore not be advisable to stipulate such a long delay before the matter was concluded. He requested that the text of any eventual proposed decision be circulated in writing.

Dr DAULAIRE (United States of America) observed that the discussions had been long and challenging. Consideration of the matter had been perceived as a difference between the countries of the North and those of the South, but most of the 27 cosponsors of the draft resolution were from the South, seven from sub-Saharan Africa. Smallpox was a matter of global consequence and global security: an issue at the heart of the responsibilities of WHO and the World Health Assembly, and, if possible, it should therefore be resolved by consensus, as it always had been in the past. The United States considered that there was strong support for the draft resolution as submitted. However, it had not proved possible to achieve consensus on the text. He looked to the Chairman and the Secretariat to uphold the principles that had been set out. The suggestion by the delegate of Switzerland was constructive but much time had been taken up by the item at the current Health Assembly, and deferral from one Health Assembly to another would not be in the best interests of reform or the timely consideration of other important public health matters.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) said that opinion was so divided that it appeared unlikely that consensus could be reached, especially on the final day of the current Health Assembly. As consensus on such difficult questions required sufficient time, he proposed that, when the matter came up again at a future Health Assembly, a working group to consider the item be established immediately. Deferral to the Sixty-seventh World Health Assembly, as proposed by the delegate of Switzerland, would entail too long a delay. He therefore proposed that the matter be tabled for discussion at the Sixty-sixth World Health Assembly.

Dr KIMANI (Kenya) proposed that the item be deferred to the Sixty-fifth World Health Assembly in 2012 and that the current Health Assembly set up a working group that would report at that time. The working group should base its discussions on the report of the meetings of the informal working group held at the current Health Assembly on 23 May 2011.

Mrs NYAGURA (Zimbabwe) said that her delegation had participated in the meetings of the informal working group and appreciated the efforts made to reach consensus on the way forward. The Health Assembly should always try to resolve such important matters, which affected global health security, by consensus. However, as further time was apparently needed, she supported the proposal made by the delegate of Switzerland.

Ms LANTERI (Monaco) said that her delegation, too, had participated in the informal working group meetings and considered that the Health Assembly should always take decisions by consensus as that was the best way to make progress. She supported the Swiss proposal, which should be set out in a decision reaffirming previous resolutions, and which would allow time for conclusion of work being undertaken and for additional informal consultations.

The CHAIRMAN said that three proposals were before the Committee, namely that further consideration on the item be deferred until the Sixty-fifth, the Sixty-sixth or the Sixty-seventh World Health Assembly. He invited comments on the deferral of the item to the Sixty-sixth World Health Assembly, as proposed by the delegate of Thailand.

Dr DAULAIRE (United States of America) said that he too looked forward to the achievement of consensus. Speakers appeared to consider that deferral for three years would leave enough time for consideration of the complex topics raised in the informal working group. The United States would certainly consult with Thailand on some of the areas mentioned by its delegation. However, such discussions were time-consuming and health officials had many other matters to handle. It would be better not to rush and thereby leave the matter unresolved again at a future Health Assembly.

The DIRECTOR-GENERAL, observing that Member States appeared to agree that, in line with previous practice, the matter should be resolved through consensus, thanked delegates for their hard work and spirit of compromise in their efforts to reach agreement. While she respected the prerogative of Member States to make decisions, she said that she was happy to facilitate further discussions. Since there appeared to be moves towards a consensus decision, she suggested that, if the Committee agreed, the meeting should be suspended to allow further informal consultations to determine whether that consensus was possible.

The CHAIRMAN said that in the absence of any objection he would take it that the Committee agreed to that suggestion.

It was so agreed.

The meeting was suspended from 10:00 to 11:25.

The DIRECTOR-GENERAL thanked Member States for their advice and their flexibility in signifying their consensus on the text of a draft decision, which included two paragraphs taken from the draft resolution and which read:

“The World Health Assembly decided to strongly reaffirm the decisions of previous Health Assemblies that the remaining stocks of variola virus should be destroyed.

The Health Assembly also reaffirmed the need to reach consensus on a proposed new date for the destruction of variola virus stocks when research outcomes crucial to an improved public response to an outbreak so permit.

It also decided to include a substantive item, “Smallpox eradication: destruction of variola virus stocks”, on the provisional agenda of the Sixty-seventh World Health Assembly, through the Executive Board, following the Sixty-sixth World Health Assembly.”

The DIRECTOR-GENERAL added that the Secretariat would continue working with Member States. She suggested that the period of the mandates of the WHO Advisory Committee on Variola Virus Research and the Advisory Group of Independent Experts to review the smallpox programme should be extended accordingly.

The draft decision was approved.¹

3. SEVENTH REPORT OF COMMITTEE A (Document A64/64 (Draft))

Dr YOUNES (Secretary) read out the draft seventh report of Committee A.

The report was adopted.²

4. CLOSURE OF THE MEETING

After the customary exchange of courtesies, the CHAIRMAN declared the work of Committee A completed.

The meeting rose at 11:30.

¹ Transmitted to the Health Assembly in the Committee’s seventh report and adopted as decision WHA64(11).

² See page 339.

COMMITTEE B

FIRST MEETING

Wednesday, 18 May 2011, at 15:30

Chairman: Dr M.T. VALENZUELA (Chile)

1. OPENING OF THE COMMITTEE: Item 14 of the Agenda

The CHAIRMAN welcomed participants and Dr Ali Jaffer Mohamed, who, as Chairman of the Programme, Budget and Administration Committee of the Executive Board, would report on several issues on the agenda dealt with on behalf of the Executive Board by that Committee at its fourteenth meeting (Geneva, 12 and 13 May 2011).

She informed the Committee that Dr Ante-Zvonimir Golem (Croatia) and Mr Zanglely Dukpa (Bhutan) had been nominated for the offices of Vice-Chairmen of Committee B, and Mr T. Tuitama Leao Tuitama (Samoa) for the office of Rapporteur.

Decision: Committee B elected Dr A.-Z. Golem (Croatia) and Mr L.Z. Dukpa (Bhutan) as Vice-Chairmen, and Mr T. Tuitama Leao Tuitama (Samoa) as Rapporteur.¹

2. ORGANIZATION OF WORK

The CHAIRMAN appealed to speakers to limit their statements to three minutes. As agreed in plenary, agenda items 13.13 to 13.17 would be transferred from Committee A to Committee B. They would be dealt with after consideration of items 15 to 20. As also agreed, the Committee would consider agenda item 17.8 the following morning.

Mr MÉSZÁROS (Hungary) noted that the European Union worked closely with WHO on a wide range of matters. In view of the exchange of letters in 2000 between WHO and the European Commission, he requested that, in accordance with Rule 46 of the Rules of Procedure of the World Health Assembly and as on previous occasions, the European Union be invited to participate as an observer, without vote, in the meetings of the Health Assembly, its committees and subcommittees or other subdivisions dealing with matters within the competence of the European Union.

It was so agreed.

¹ Decision WHA64(3).

3. HEALTH CONDITIONS IN THE OCCUPIED PALESTINIAN TERRITORY, INCLUDING EAST JERUSALEM, AND IN THE OCCUPIED SYRIAN GOLAN:
Item 15 of the Agenda (Documents A64/27, A64/INF.DOC./1, A64/INF.DOC./2, A64/INF.DOC./3 and A64/INF.DOC./4)

The CHAIRMAN drew the Committee's attention to a draft resolution proposed by the delegation of Lebanon, on behalf of the Arab Group, and Palestine:

The Sixty-fourth World Health Assembly,

Mindful of the basic principle established in the Constitution of WHO, which affirms that the health of all peoples is fundamental to the attainment of peace and security;

Recalling all its previous resolutions on health conditions in the occupied Palestinian territory and other Arab occupied territories;

Recalling resolution EB124.R4, adopted by the Executive Board at its 124th session, on the grave health situation caused by Israeli military operations in the occupied Palestinian territory, particularly in the occupied Gaza Strip;

Taking note of the report of the Director-General on the health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan;

Noting with deep concern the findings in the report of the Director-General on the specialized health mission to the Gaza Strip;

Stressing the essential role of UNRWA in providing crucial health and education services in the occupied Palestinian territory, particularly in addressing the emergency needs in the Gaza Strip;

Expressing its concern at the deterioration of economic and health conditions as well as the humanitarian crisis resulting from the continued occupation and the severe restrictions imposed by Israel, the occupying power;

Expressing its deep concern also at the health crisis and rising levels of food insecurity in the occupied Palestinian territory, particularly in the Gaza Strip;

Affirming the need to guarantee universal coverage of health services and to preserve the functions of the public health services in the occupied Palestinian territory;

Recognizing that the acute shortage of financial and medical resources in the Palestinian Ministry of Health, which is responsible for running and financing public health services, jeopardizes the access of the Palestinian population to curative and preventive services;

Affirming the right of Palestinian patients and medical staff to have access to the Palestinian health institutions in occupied east Jerusalem;

Deploing the incidents involving lack of respect and protection for Palestinian ambulances and medical personnel by the Israeli army, which have led to casualties among Palestinian medical personnel, as well as the restrictions on their movements imposed by Israel, the occupying power, in violation of international humanitarian law;

Affirming that the blockade is continuing and that the crossing points are not entirely and definitely opened, meaning that the crisis and suffering that started before the Israeli attack on the Strip are continuing, hindering the efforts of the Ministry of Health of the Palestinian Authority to reconstruct the establishments destroyed by the Israeli military operations by the end of 2008 and in 2009;

Expressing deep concern at the grave implications of the wall on the accessibility and quality of medical services received by the Palestinian population in the occupied Palestinian territory, including east Jerusalem;

Expressing deep concern also at the serious implications for pregnant women and patients of restrictions on movement imposed by Israel on Palestinian ambulances and medical personnel,

1. DEMANDS that Israel, the occupying power:
 - (1) immediately put an end to the closure of the occupied Palestinian territory, particularly the closure of the crossing points of the occupied Gaza Strip that is causing the serious shortage of medicines and medical supplies therein, and comply in this regard with the provisions of the Israeli Palestinian Agreement on Movement and Access of November 2005;
 - (2) abandon its policies and measures that have led to the prevailing dire health conditions and severe food and fuel shortages in the Gaza Strip;
 - (3) comply with the Advisory Opinion rendered on 9 July 2004 by the International Court of Justice on the wall which, inter alia, has grave implications for the accessibility and quality of medical services received by the Palestinian population in the occupied Palestinian territory, including east Jerusalem;
 - (4) facilitate the access of Palestinian patients and medical staff to the Palestinian health institutions in occupied east Jerusalem and abroad;
 - (5) ensure unhindered and safe passage for Palestinian ambulances as well as respect and protection of medical personnel, in compliance with international humanitarian law;
 - (6) improve the living and medical conditions of Palestinian detainees, particularly children, women and patients, and provide the detainees who are suffering from serious medical conditions worsening every day with the necessary medical treatment;
 - (7) facilitate the transit and entry of medicine and medical equipment to the occupied Palestinian territory;
 - (8) assume its responsibility with regard to the humanitarian needs of the Palestinian people and their daily access to humanitarian aid, including food and medicine, in compliance with international humanitarian law;
 - (9) halt immediately all its practices, policies and plans, including its policy of closure, that seriously affect the health conditions of civilians under occupation;
 - (10) respect and facilitate the mandate and work of UNRWA and other international organizations, and ensure the free movement of their staff and aid supplies;

2. URGES Member States and intergovernmental and nongovernmental organizations:
 - (1) to help overcome the health crisis in the occupied Palestinian territory by providing assistance to the Palestinian people;
 - (2) to help meet urgent health and humanitarian needs, as well as the important health-related needs for the medium and long term, identified in the report of the Director-General on the specialized health mission to the Gaza Strip;
 - (3) to call upon the international community to exert pressure on the Government of Israel to lift the siege imposed on the occupied Gaza Strip in order to avoid a serious exacerbation of the humanitarian crisis therein and to help lift the restrictions and obstacles imposed on the Palestinian people including the free movement of people and medical staff in the occupied Palestinian territory, and to bring Israel to respect its legal and moral responsibilities and ensure the full enjoyment of basic human rights for civilian populations in the occupied Palestinian territory, particularly in east Jerusalem;
 - (4) to remind Israel, the occupying power, to abide by the Fourth Geneva Convention relative to the Protection of Civilian Persons in Time of War of 1949, which is applicable to the occupied Palestinian territory including east Jerusalem;
 - (5) to call upon all international human rights organizations, to intervene on an urgent and immediate basis vis-à-vis the occupying power, Israel, and compel it to provide adequate medical treatment to Palestinian prisoners and detainees who are suffering from serious medical conditions worsening every day, and urges civil society organizations to exercise pressure on the occupying power, Israel, to save the lives of detainees and ensure the immediate release of critical cases and to provide them with external treatment, and to allow Palestinian women prisoners to receive maternity care services and medical follow

up during pregnancy, delivery and postpartum care, and to allow them to give birth in healthy and humanitarian conditions in the presence of their relatives and family members and immediately to release all children detained in Israeli prisons;

(6) to support and assist the Palestinian Ministry of Health in carrying out its duties, including running and financing public health services;

(7) to provide financial and technical support to the Palestinian public health and veterinary services;

3. EXPRESSES deep appreciation to the international donor community for their support of the Palestinian people in different fields, and urges donor countries and international health organizations to continue their efforts to ensure the provision of necessary political and financial support to enable the implementation of the 2008–2010 health plan of the Palestinian Authority and to create a suitable political environment to implement the plan with a view to putting an end to the occupation and establishing the state of Palestine as proposed by the Government of Palestine, which is working seriously to create the proper conditions for its implementation;

4. EXPRESSES its deep appreciation to the Director-General for her efforts to provide necessary assistance to the Palestinian people in the occupied Palestinian territory, including east Jerusalem, and to the Syrian population in the occupied Syrian Golan;

5. REQUESTS the Director-General:

(1) to provide support to the Palestinian health and veterinary services including capacity building;

(2) to submit a fact-finding report on the health and economic situation in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan;

(3) to support the establishment of medical facilities and provide health-related technical assistance to the Syrian population in the occupied Syrian Golan;

(4) to continue providing necessary technical assistance in order to meet the health needs of the Palestinian people, including the handicapped and injured;

(5) to also provide support to the Palestinian health and veterinary services in preparing for unusual emergencies;

(6) to support the development of the health system in the occupied Palestinian territory, including development of human resources;

(7) to make available the detailed report prepared by the specialized health mission to the Gaza Strip;

(8) to report on implementation of this resolution to the Sixty-fifth World Health Assembly.

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

1. Resolution Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan	
2. Linkage to programme budget	
Strategic objective:	Organization-wide expected result:
5. To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.	5.3 Norms and standards developed, capacity built and technical support provided to Member States for assessing needs and for planning and implementing interventions during the transition and recovery phases of conflicts and disasters.

(Briefly indicate the linkage with expected results, indicators, targets, baseline)

If fully funded and implemented, the resolution is expected to have an impact on the targets for the second and third indicators for the expected result.

3. Budgetary implications**(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).**

US\$ 3 920 000 over the one-year period of the resolution, including staff, travel, training activities, technical assistance, health supplies, security and operational equipment. The breakdown of the estimated cost of operative paragraph 5 is as follows:

Subparagraph (1)	US\$	100 000
Subparagraph (2)	US\$	70 000
Subparagraph (3)	US\$	50 000
Subparagraph (4)	US\$	200 000
Subparagraph (5)	US\$	500 000
Subparagraph (6)	US\$	3 000 000
Total	US\$	3 920 000

(b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)

US\$ 2 250 000.

(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?

Seventy-five per cent of US\$ 2 250 000 at headquarters, Regional Office and Jerusalem Office levels.

4. Financial implications**How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?**

A substantial proportion of these resources has been raised as humanitarian voluntary contributions through the Consolidated Appeal Process (CAP) for addressing humanitarian health needs, implementing life-saving interventions, re-establishing the functionality of disrupted health services and rolling out the Interagency Standing Committee (IASC) health cluster.

5. Administrative implications**(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant).**

The activities will be primarily implemented through the WHO Office in Jerusalem responsible for WHO's cooperation programme with the Palestinian Authority. WHO's country-level efforts will be supplemented by support from the Regional Office for the Eastern Mediterranean, and by the headquarters clusters working in the areas of polio eradication, emergency preparedness and response, and country focus, health security and environment.

(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.

It will be necessary to sustain beyond May 2011 the actual presence at country level of the national and international staff recruited to implement humanitarian health activities and interventions in the occupied Palestinian territory.

(c) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile).

Not applicable.

(d) Time frames (indicate broad time frames for implementation of activities).

One year.

Dr DAYRIT (Secretary) said that the cosponsors of the draft resolution had proposed that, in lines 1 and 2 of subparagraph 2(5), the phrase “particularly the International Committee of the Red Cross” be deleted.

Ms RIACHI ASSAKER (Lebanon), introducing the draft resolution on behalf of the Arab Group, said that the report contained in the annex to document A64/27 shed light on the deteriorating situation in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan, due mainly to the occupation by Israel and its use of force. The situation was catastrophic, particularly in the Gaza Strip, and the international community needed to act decisively against such repressive measures as the blockade and the closure of crossing points. Preventing the circulation of ambulances and delivery of medical products violated human rights principles and the tenets of international humanitarian law, and the ramifications of the separating wall were clear. The report by the Ministry of Health of the Palestinian Authority showed that its efforts had been in vain. The international community needed to put pressure on Israel to fulfil its commitments under international humanitarian law; WHO, in particular, had an obligation to support the Palestinian people. Medical coverage in the occupied Syrian Golan, where living standards were low, was both inadequate and costly. Its citizens were entitled to enjoy good health and the international community had an obligation to make that possible. The draft resolution would be a step in the right direction and she therefore called on Member States to support it.

Dr MOGHLI (Palestine) expressed appreciation to the international community for its past generous assistance and its support for both the Palestinian people and the Palestinian Authority, which had made it possible to survive the Israeli occupation.

Considered to be the backbone of health care, the primary health care system in the occupied Palestinian territory had undergone modernization in recent years in an effort to achieve the Millennium Development Goals. A network of primary health care centres had been created in all towns and villages except those classified as “Area C”. Hospitals had also been constructed and a plan drawn up for strengthening the technical capacity of medical staff. As a result, there had been improvements in some general health indicators; for example, maternal mortality ratios and under-five mortality rates had declined and vaccination coverage was 100%. Progress had also been made in eliminating some communicable diseases. Unfortunately, the blockade prevented any further progress and the separation wall hindered the circulation of goods and individuals and stopped medicines from reaching their destination. Even though two years had passed since the military action in the Gaza Strip, the blockade had made it impossible to rebuild the hospitals, homes, medical centres and dispensaries that had been destroyed.

Health was a universal right; politicians and health-care professionals needed to ensure that services were available to all. The Israeli occupation was the biggest obstacle to development of effective and universal health care, and to implementation of the ambitious health-care strategy devised by the Ministry of Health of the Palestinian Authority. In addition to facing restricted access to medical treatment in their own country, many sick people had been prevented from seeking treatment abroad, at times with fatal consequences. The Palestinian people wanted unimpeded access to health services. He therefore welcomed the repeated calls for the creation of a Palestinian State; that would be a means of ensuring that all citizens exercised their right to health.

It was to be hoped that the draft resolution would be adopted unanimously despite certain reservations on the part of some Member States.

Professor ALI (Bangladesh) expressed dismay at the bleak scenario outlined in the reports in document A64/27, particularly with regard to the Gaza Strip. Despite some modest progress, the structural and systemic challenges remained the same, undermining improvements in the health sector as a whole. He therefore urged WHO to continue providing policy and technical support, with particular attention to capacity building for health-related disaster management and emergency response.

The stagnation in moves towards achieving the Millennium Development Goals in the occupied territories must be reversed and progress made rapidly, especially in relation to Millennium Development Goal 4. Persistently high poverty and fertility rates, particularly in the Gaza Strip, heightened the challenges, and the prevalence of anaemia remained a major threat to women's health.

The key to addressing the health situation in the occupied territories was ensuring unrestricted access to health-care services for the entire population. For example, people had to have unhindered access to specialized hospitals in east Jerusalem and treatment abroad. The blockade and restriction of movement had severely undermined the effectiveness of the health system, making it all the more important for the international community to press for comprehensive and sustainable change in the territories. He fully supported the draft resolution and hoped that it would be adopted by consensus.

Dr AL-JALAHMA (Bahrain) commended the Secretariat's report (document A64/27), but expressed disappointment that it did not refer to measures taken by the Director-General in the occupied Syrian Golan. Another working group should be established to review the health situation in that zone. Deterioration of the health situation in the occupied territories as a whole was impeding progress towards achieving the health-related Millennium Development Goals and eliminating communicable and noncommunicable diseases. People in poor health were entitled to have access to health care and everything possible should be done to raise health standards in the region. She supported the draft resolution.

Dr RASAE (Yemen) supported the draft resolution and the comments made by the previous speaker. The draft resolution focused on the humanitarian aspects of health care, such as the right to medicines and the right to be treated in properly-functioning health facilities. He urged the Director-General to continue providing support to health services in the occupied territories, particularly to the health workforce in the occupied Syrian Golan, and to report back to the Sixty-fifth World Health Assembly through a second fact-finding report.

Mr KHABBAZ-HAMOUI (Syrian Arab Republic) recalled that every year the Health Assembly heard a description of the suffering inflicted on the Palestinian people in contravention of international resolutions. The practices of the Government of Israel undermined the basic right to health care and restricted access to such services to the few who could afford health insurance. There were no health clinics, or even primary health care centres, in the occupied Syrian Golan despite the efforts of his Government, which was working with international organizations, under the auspices of the Syrian Arab Red Crescent, to establish health facilities in the territory and to alleviate the suffering of its citizens, including those detained in Israeli prisons who were subjected to torture and exposed to disease, leading, in some cases, to premature death. Others, including children, had died or been disabled as a result of Israeli mines. Further, contamination of soil and water by nuclear waste had negative implications for health. WHO needed to investigate the health situation in the occupied Syrian Golan, and the international community should seriously consider exerting pressure on Israel to respect international humanitarian law.

Although information had been provided to the Secretariat on deteriorating health conditions in the occupied Syrian Golan, the fact-finding report (document A64/27, annex) failed even to mention the region. He sought an explanation for that omission. The Director-General had been asked to establish a working group to devise a mechanism for implementing subparagraph 5(3) of resolution WHA63.2, which requested the Director-General to support establishment of medical facilities and provide health-related technical assistance to the Syrian population in the occupied Syrian Golan. The

working group should visit the occupied Syrian Golan in order to obtain additional information, including eye-witness accounts.

He called on all Member States to support the draft resolution in order to demonstrate WHO's concern over the deteriorating health situation in the occupied Syrian Golan.

Dr QIAN Bo (China) commended WHO's efforts to improve the health situation in the occupied territories, which continued to cause concern. Referring to recent clashes between Israeli military forces and Palestinian demonstrators, he said that he feared a further escalation of violence and called on both sides to remain calm. The stalling of peace talks on the Middle East had been detrimental to peace and stability in the region and he urged the international community to call for timely resumption of the talks. He favoured providing assistance to the Palestinian people and called on the parties concerned to take proactive measures to improve the humanitarian situation in the region. He endorsed the draft resolution.

Dr BHUTTO (Pakistan) expressed deep concern at the health situation in the occupied territories. High levels of poverty and unemployment continued to adversely affect the Arab population, and deaths and injuries resulting from the occupation had markedly increased in 2010 and 2011. The situation, aggravated by chronic malnutrition and associated micronutrient deficiencies, as well as noncommunicable diseases, was causing major public health problems. The Gaza Strip continued to be isolated from the outside world owing to the policy of external closure, resulting in restricted access to secondary and tertiary health care. The lack of essential consumables and medicines further weakened the health-care delivery system. The economic siege of the Gaza Strip had led to degradation of the overall health infrastructure and adversely affected the performance of the health sector. It had caused essential primary health-care programmes, such as immunization and maternal and child care, to deteriorate.

She appreciated the health-related support provided by WHO to the Palestinian people. The Organization should, however, broaden the scope of its technical assistance to UNRWA and use its influence with donors to ease the funding crisis faced by that Agency.

The assault on a Gaza-bound humanitarian aid flotilla in May 2010 had been strongly condemned by the international community. The Health Assembly, too, should send a strong message calling for an end to the economic and political repression that continued to jeopardize access to, and provision of, health services for the Palestinian people.

She supported the draft resolution and urged the international community to make a concerted effort to attain a just, comprehensive and lasting peace.

Dr EL SAYED (Egypt) affirmed that human health was a precondition for peace and international security. Member States had a moral obligation to adopt all international resolutions on the subject and the draft resolution, which he supported, should be seen as part of WHO's efforts to safeguard the health of the Palestinian people. Financial support was also needed to allow the implementation of national plans for improving health care. A second fact-finding report should be prepared by a specially convened working group. Endorsement of the draft resolution might have an impact on Israeli practices that contravened international resolutions and would allow WHO to carry out its humanitarian mission in accordance with those resolutions.

Ms EKEMAN (Turkey) welcomed the report contained in document A64/27 and noted its findings with deep concern, particularly with regard to restriction of movement and its impact on access to medical services. Similar worrying conclusions had been reached by the Director of Health, UNRWA, in his report (document A64/INF.DOC./3). Restriction on the free movement of UNRWA's staff and supplies was also a matter of serious concern.

The intransigence of the Government of Israel continued to undermine efforts to establish peace and security in the Middle East and was also having a devastating social, economic and humanitarian impact on people living in the occupied territories. It was tragic that Palestinian children subjected to

violence, arrest and imprisonment by Israeli forces suffered from mental health disorders; Member States had a moral obligation to protect them. Her Government urged the international community to exert pressure on the Government of Israel to lift the blockade, remove the restrictions imposed on the Palestinian people and fulfil its legal obligations. Such steps were essential to resolving the health and humanitarian crisis. She reiterated her Government's support for a two-State solution under which a State of Palestine would be established, with east Jerusalem as its capital, living side by side, within secure borders, with the State of Israel. Turkey would continue to support any measures aimed at reaching a comprehensive agreement for a lasting peace in the Middle East and, to that end, wished to sponsor the draft resolution, which she called on all Member States to support.

Mr MARTIN (Cuba) said that the Government of Israel was continuing its aggressive policy towards the occupied Palestinian territory and the occupied Syrian Golan. The attacks on the Gaza Strip and the building of further illegal settlements in east Jerusalem were a deliberate affront to the international community. The blockade imposed on the Gaza Strip exemplified the policy of genocide being pursued against the Palestinian people. His Government roundly condemned such actions. It demanded an immediate end to the building of new settlements and confiscation of Palestinian land which, in conjunction with the separation wall, were altering local demographics, not least through the arbitrary restrictions placed on free movement. The blockade must be lifted immediately in order to prevent the situation from deteriorating even further. The actions of the Government of Israel hindered access to health services and were preventing attainment of the Millennium Development Goals. Although hospitals and primary health-care facilities in the Gaza Strip continued to function, they were facing obstacles, such as shortages of essential medicines and vaccines.

The occupation of the Syrian Golan violated human rights, including the right to health. The Government of Israel must comply with the relevant resolutions, including those adopted by the Health Assembly, and withdraw from the territory.

His Government reaffirmed its full support for the Palestinian people and their legitimate desire for an independent State of Palestine within the 1967 borders and with east Jerusalem as its capital. It supported the just claims of the people of Syrian Arab Republic, Lebanon and other Arab countries similarly occupied or threatened by Israel. He endorsed the draft resolution.

Dr YOUNOUS (Chad) said that, for numerous years, the Health Assembly had adopted resolutions condemning the Israeli occupation and its effect on health services and the most vulnerable groups such as women and children. The Gaza Strip gave particular cause for concern and the Secretariat should be congratulated on preparing such an unbiased report on the catastrophic situation of the Palestinian people.

He supported the draft resolution and called on Member States to adopt it by consensus.

Dr NICKNAM (Islamic Republic of Iran) commended the Secretariat's report, but asked that, in future, documents of similar importance could be made available in a timely manner. He thanked WHO for its ongoing contribution to improving health conditions in the region, including the provision of medical supplies. However, the occupation continued to cause economic and social hardship for Palestinians. The long-term restrictions on the movement of people, goods and services had severely weakened the local economy, led to high rates of unemployment and poverty, and undermined the health of the population. The desperate situation described in the report had impeded progress towards achievement of the Millennium Development Goals and could deteriorate into a humanitarian crisis fuelled by chronic malnutrition, anaemia and micronutrient deficiencies. A rise in noncommunicable diseases and increasingly unhealthy life styles were additional sources of concern. The refusal of the Government of Israel to allow unrestricted access to the six hospitals in east Jerusalem further aggravated the situation. He called on Israel to ease restrictions on medical supplies, and on WHO and other organizations to continue providing technical assistance and health services. He also urged the international community to find a solution that would lead to a lifting of the siege of the Gaza Strip and end decades of occupation.

Ms COOK (United States of America) expressed disappointment that once again the Health Assembly was being asked to consider a draft resolution on health conditions in the occupied territories. The draft resolution contained a political dimension that was not conducive to progress in the search for peace, to which her Government and President were deeply committed. Neither would it serve to improve the health of Palestinians. Her Government was committed to finding a two-State solution to the Israeli–Palestinian conflict as part of a comprehensive regional peace plan in the Middle East.

Her Government, the largest contributor to UNRWA, had provided about US\$ 267 million in 2010 to support core health, education and social services, including primary health care dispensed through clinics and subsidized hospitals, for 4.7 million refugees in the Gaza Strip, Jordan, Lebanon, Syrian Arab Republic and the West Bank, as well as emergency operations in the Gaza Strip and West Bank. In addition, support was provided to ensure access to adequate water and sanitation services for refugee communities, and to counselling and mental health services for vulnerable refugees, particularly children and young people.

Through the United States Agency for International Development, her Government supported programmes that improved the quality of life for Palestinians while strengthening their capacity in such areas as infrastructure development, agribusiness expansion, employment generation, health sector development, community-driven projects and democratic governance. In 2010, the Agency had provided a total of US\$ 400.4 million in assistance to the West Bank and Gaza Strip.

Her Government remained concerned about the humanitarian situation in the Gaza Strip, which had nonetheless improved over the past year. It would continue to work with Israel, the Palestinians and others to ensure that the needs of the people of the Gaza Strip were being met. Nevertheless, it questioned the overtly political nature of the draft resolution, which failed to recognize existing and potential cooperation between Israel and the Palestinians and was likely to increase tensions rather than build bridges within the health sector, where peace might be consolidated. Her Government's opposition to the draft did not diminish in any way its commitment to improving the welfare of the Palestinian people. She requested that a decision on the draft resolution be taken by a recorded vote.

Mr TERLYGA (Kyrgyzstan) said that the checkpoints, lack of medicines, poor health-care services and severe food shortages in the occupied territories were unacceptable in terms of both achieving the Millennium Development Goals and respecting WHO's Constitution, and viewed from the perspective of human rights. He therefore fully supported the draft resolution.

Mr KAMAPRAPIPTA ISNOMO (Indonesia) expressed deep concern at the deteriorating health situation in the occupied territories. Israel's continuing occupation had clearly restricted the Palestinian people's access to adequate health care and treatment. The situation had been worsened by the persistent and stifling blockade imposed on the Gaza Strip and the continued closures and checkpoints in the West Bank. The acute shortage of essential materials, food, energy, electricity and other necessities had further compounded the problem, giving rise to a situation that was not only hazardous but also a violation of the right to life and to health of all those living under occupation, and more particularly of vulnerable groups, such as women, children and the elderly.

He urged the international community to demand an end to those inhumane measures and practices. Israel, as the occupying power, must fulfil its obligations under the international agreements to which it was party, for the safety and well-being of all people under occupation. The international community should provide support to the Palestinian Ministry of Health and assist it in carrying out its duties.

He favoured the creation of an independent State of Palestine, existing side by side with Israel in peace and security, with east Jerusalem as its capital. He supported the draft resolution and urged all Member States to do likewise; the international community could not stand by while the health situation in the territories deteriorated.

Dr AL-THANI (Qatar) said that the Palestinian people were subjected to unequal treatment and lacked access even to the most basic health-care services. He supported the draft resolution and urged Member States to adopt it unanimously as a clear mark of their refusal to accept the continuation of that state of affairs and the suffering it was inflicting. He expressed concern at remarks that the draft resolution was biased and asked how that was possible when it simply requested that health care should be provided to all those in need.

Dr GONZÁLEZ (Nicaragua) said that the Secretariat's report established a direct link between the blockade and the aggressive policies towards the populations under occupation. What would be the future impact of those policies on the most vulnerable groups, which needed the most attention? What would have become of those populations without the support of humanitarian organizations, friendly countries and WHO? How had that situation arisen when all governments were committed to ensuring the right to security, food and health? Stifling human development would have a major impact in the long term.

He fully supported the draft resolution and invited all Member States to do the same as it was impossible for the international community to remain indifferent. His country had been left impoverished by imperialist aggression, the deep wounds of which were still being felt 20 years on.

Mr CHEBIHI (Algeria), endorsing the statement made by the delegate of Lebanon, encouraged the Director-General to continue monitoring the health-care situation in the occupied territories. He regretted that the Secretariat's report had provided no information on the occupied Syrian Golan and expressed deep concern at the deteriorating situation and continuing suffering there, resulting from Israeli occupation. The separation wall, burial of nuclear waste and erection of roadblocks compounded the problem, limiting freedom of movement and the entry of medicines, thus preventing individuals from enjoying their right to high-quality health care.

The Palestinian Authority had fulfilled its duties towards its people; the time had come for the international community to follow suit and see to it that Palestinians fully exercised their right to health care. WHO, too, should continue assisting people in the occupied territories in gaining access to health care. His country was doing its utmost to meet the needs of the Palestinian people and to support UNRWA, and urged others do likewise, so that the Agency could continue its work. He called on all Member States to adopt the draft resolution by consensus, in the name of impartiality and the right to health care for all, which was universally recognized.

Dr AL-SHAMMARI (Saudi Arabia) reaffirmed the right of those in the occupied territories to health care. She expressed the hope that all Member States would vote in favour of the draft resolution, for humanitarian and moral reasons.

Dr MOHAMED FIKRI (United Arab Emirates) thanked the Director-General for her efforts to provide the necessary assistance to the populations in the occupied territories. He supported the draft resolution.

Mr MOHAMMED (Sudan) fully supported the draft resolution, which was impartial and apolitical, focusing solely on the right to health care of the Syrian and Palestinian people living in the occupied territories. He thanked the Director-General and UNRWA for their efforts to improve access to health care in those regions and called on all Member States to vote in favour of the draft resolution, in the name of peace and justice.

Mr RAM (Israel) said that the draft resolution was blatantly political, deliberately misleading, and unrelated to health and, as such, had no place in the Health Assembly's discussions. It was probably for that reason that health issues in countries such as the Libyan Arab Jamahiriya, Syrian Arab Republic and Yemen had not been debated. Palestinians consistently abused international forums

for the advancement of their political interests, at the expense of health and humanitarian crises around the world.

Ranked 72 out of 194 in UNDP's Human Development Index in terms of health indicators, the Palestinian territories enjoyed a higher position than 60% of the world, including most other Arab countries. Furthermore, according to the United Nations report to the Ad Hoc Liaison Committee in 2011, the health-care system of the Palestinian territories was "well developed". Those facts made it clear that the draft resolution was politically motivated and not based on a genuine concern for the Palestinian health situation.

There was no "special health situation" for the non-Jewish population of the Golan Heights, as suggested in the draft resolution. On the contrary, all residents enjoyed full access to comprehensive and high-quality health coverage under the Israeli National Health Insurance Law. Israel fully cooperated with the Secretariat and assisted with the integration of WHO experts into the Palestinian Authority when necessary. In addition, Israel directly assisted the Palestinian population by providing medical care for Palestinian patients in Israel and medical training for Palestinian health professionals.

Negative, biased and polemic resolutions such as the present one were counterproductive. He urged Member States to oppose it in order to keep the Health Assembly free of all politicization.

Dr SEITA (Director of Health, UNRWA) said that the situation of the two million Palestine refugees in the occupied Palestinian territory – representing almost half its population – was serious and put their health at risk. UNRWA provided comprehensive care to those refugees and helped to improve their health status, in extremely difficult conditions. Supported by host countries, donors and the international community, it had developed and would continue to develop measures to mitigate the effects of conflict, occupation and violence on the health of Palestinian refugees.

The health status of those refugees had significantly improved, thanks to the support of UNRWA and governmental and other health-care providers. For example, although progress had recently halted, the infant mortality rate was still comparable to, if not better than, rates in other countries of the Near East. At the same time, the Agency's curative services were overstretched, owing to increased demand for care and limited human and financial resources. Its overall health services needed to be modernized, its preventive services expanded, and care for noncommunicable diseases, the primary health problem among the refugees, further developed. If the Agency failed in its mission, the progress achieved, particularly in maternal and child health, could be lost.

Palestinian refugees were victims of conflict, violence, occupation, political instability, poverty, and inequality in access to health care. In the Gaza Strip, border closings and severe restrictions on the movement of people and goods had posed serious challenges. The blockade, despite being eased by the Israeli Government in mid-2010, continued to hamper the Agency's reconstruction projects, including urgent work on health centres. In the West Bank, many Palestinians, refugees and non-refugees alike, continued to be severely restricted in their movement. All such restrictions, particularly those concerning east Jerusalem, limited UNRWA's capacity to meet the health needs of increasingly vulnerable communities in that region.

The international community must renew its support to UNRWA so that it could pursue its mission, which was as critical now as when the Agency had been created.

Dr AYLWARD (Assistant Director-General) thanked Member States for their recognition of the Organization's contribution to the multifaceted strategy for improving the health situation of the Palestinian people, and for their statements of intent to assist in that regard.

Concerns regarding the information gaps in the Secretariat's report had been noted, and Member States could rest assured that the Secretariat would continue seeking information in order to provide a full report. Likewise, in response to concerns regarding the timeliness and availability of both the report and the supporting documents, he reassured Member States that those documents would be distributed in a timely manner in future.

He thanked Member States once again for giving the Organization detailed guidance with respect to the implementation of resolution WHA63.2.

The CHAIRMAN recalled the proposal to proceed to a roll-call vote.

At the invitation of the CHAIRMAN, Mr BURCI (Legal Counsel) explained the procedures for the roll-call vote. The Member States whose right to vote had been suspended by virtue of Article 7 of the Constitution, or which were not represented at the Health Assembly, and would therefore be unable to participate in the vote were: Antigua and Barbuda, Belize, Central African Republic, Comoros, Dominica, Grenada, Guinea-Bissau, Kyrgyzstan, Libyan Arab Jamahiriya, Niue, Saint Lucia, Saint Vincent and the Grenadines, Seychelles, Somalia, Suriname and Tajikistan.

A vote was taken by roll-call, the names of the Member States being called in the English alphabetical order, starting with Republic of Korea, the letter R having been determined by lot.

The result of the vote was:

In favour: Afghanistan, Algeria, Angola, Argentina, Azerbaijan, Bahrain, Bangladesh, Belarus, Bolivia (Plurinational State of), Brazil, Brunei Darussalam, Burkina Faso, Burundi, Cape Verde, Chad, Chile, China, Congo, Costa Rica, Cuba, Democratic Republic of the Congo, Djibouti, Ecuador, Egypt, Ghana, Guatemala, Guinea, Indonesia, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Malaysia, Maldives, Mauritania, Mexico, Morocco, Mozambique, Namibia, Nicaragua, Niger, Nigeria, Oman, Pakistan, Paraguay, Peru, Philippines, Qatar, Russian Federation, Saudi Arabia, Senegal, South Africa, Sri Lanka, Sudan, Syrian Arab Republic, Tunisia, Turkey, United Arab Emirates, United Republic of Tanzania, Uruguay, Viet Nam, Yemen, Zimbabwe.

Against: Australia, Canada, Israel, New Zealand, United States of America.

Abstaining: Andorra, Armenia, Austria, Belgium, Benin, Bhutan, Bosnia and Herzegovina, Bulgaria, Cameroon, Colombia, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Honduras, Hungary, Iceland, Ireland, Italy, Jamaica, Japan, Latvia, Lithuania, Luxembourg, Malawi, Malta, Monaco, Netherlands, Norway, Poland, Portugal, Republic of Korea, Republic of Moldova, Romania, Samoa, San Marino, Serbia, Singapore, Slovakia, Slovenia, Spain, Sweden, Switzerland, Thailand, Ukraine, United Kingdom of Great Britain and Northern Ireland.

Absent: Albania, Bahamas, Barbados, Botswana, Cambodia, Cook Islands, Côte d'Ivoire, Democratic People's Republic of Korea, Dominican Republic, El Salvador, Equatorial Guinea, Eritrea, Ethiopia, Fiji, Gabon, Gambia, Georgia, Guyana, Haiti, India,¹ Kazakhstan, Kenya, Kiribati, Lao People's Democratic Republic, Lesotho, Liberia, Madagascar, Mali, Marshall Islands, Mauritius, Micronesia (Federated States of), Mongolia, Montenegro, Myanmar, Nauru, Nepal, Palau, Panama, Papua New Guinea, Rwanda, Saint Kitts and Nevis, Sao Tome and Principe, Sierra Leone, Solomon Islands, Swaziland, The former Yugoslav Republic of Macedonia, Timor-Leste, Togo, Tonga, Trinidad and Tobago, Turkmenistan, Tuvalu, Uganda, Uzbekistan, Vanuatu, Venezuela (Bolivarian Republic of), Zambia.

The draft resolution, as amended, was therefore approved by 64 votes to 5, with 51 abstentions.²

¹ India subsequently sent a statement for the record that it would have voted in favour of the resolution.

² Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA64.4.

Mr PAPP (Hungary), speaking in explanation of vote on behalf of the European Union and of Norway, Andorra and Iceland, who had associated themselves with his statement, said that the European Union remained concerned about the health situation in the occupied Palestinian territory, including east Jerusalem. The draft resolution contained elements relating to political issues, which might be considered to lie outside the remit of the Health Assembly. A shorter, more balanced text would have been preferable, with a sharper focus on health issues and greater reliance on the Secretariat's findings and on specific facts and data. The draft resolution should have been more up-to-date and more reflective of the broader context, in order to represent the current situation more accurately.

Although the European Union had abstained during the vote, it would continue to be active in efforts to improve health conditions in the occupied territories and to address the humanitarian needs of the Palestinian people. An approach that took into account the impact of the conflict on all sides would be welcome.

Mr PANG (Singapore), speaking in explanation of vote, said that his country's abstention was not a measure of the merits or demerits of the case. Singapore had consistently supported efforts to bring about a just and lasting peace in the Middle East, firmly believing in the right of the Palestinian people to a homeland and in the two-State solution, and backing United Nations resolutions to that effect. It recognized the difficult health situation facing the Palestinian people, but had abstained because of its conviction that Health Assembly resolutions should not contain political elements.

Ms HINTON (New Zealand), speaking in explanation of vote, echoed the concerns raised in the draft resolution regarding the poor health and economic conditions in the occupied territories, particularly in the Gaza Strip. She welcomed the moves by some governments, including Israel and Egypt, to ease restrictions on the movement of humanitarian goods and people. She called on Israel and the Palestinian Authority to ease such restrictions even further and to work together to foster lasting improvement in the health situation of the Palestinian people. The draft resolution was not confined to addressing humanitarian needs, but sought also to apportion blame, in an unbalanced way, and to address political issues outside the mandate of the Health Assembly. Her country had therefore voted against it.

Mr OYARCE (Chile), speaking in explanation of vote, said that his Government was concerned about the complex health situation of all people living in the occupied territories, and had therefore voted in favour of the draft resolution. It would have been preferable if the draft resolution had been approved by consensus and biased political debate avoided, as that might have an impact on the Organization's humanitarian and health-care efforts, which were backed by all Member States. He called on Palestinians and Israelis to continue efforts to reinvigorate the negotiation process, with the support of the international community, with a view to achieving a comprehensive and lasting peace.

Mr HIGGINS (Australia), speaking in explanation of vote, said that his country's decision to vote against the draft resolution, as it had done with similar resolutions in the past, did not reflect a lack of concern over the poor health conditions facing Palestinians in the West Bank and the Gaza Strip. Rather, it demonstrated his country's strong opposition to introducing political issues into the Health Assembly agenda. The draft resolution did not contribute constructively to the goal of a negotiated solution to the conflict or to improving the situation on the ground.

His country had strongly supported efforts to achieve a comprehensive and enduring peace, based on a two-State solution, as it was all countries' responsibility to do. Through a multi-donor trust fund, it was contributing to the development of Palestinian institutions and providing humanitarian aid. Since 2007, his country had channelled nearly 250 million Australian dollars into aid activities, and was the tenth largest contributor to UNRWA. In that way, it was helping to build capacities in schools and health clinics, assist the Palestinian Authority in meeting recovery and reconstruction needs, and construct the institutions necessary for statehood.

Ms HAMILTON (Canada), speaking in explanation of vote, said that her country remained concerned about the health situation of the Palestinian people, in particular in the Gaza Strip. It therefore continued to provide humanitarian aid via nongovernmental and multilateral organizations. Since 2008, her country had approved or disbursed 69 million Canadian dollars in support of food security for the Palestinian people.

Important changes had been sweeping the Arab world, such as the opening of the border between the Gaza Strip and Egypt. The draft resolution, however, did not recognize that change, nor its impact on the availability of medical care and medicines in the Gaza Strip, and the possibility of seeking treatment elsewhere. Nor did the draft resolution, in its demand that Israel lift its blockade of the Gaza Strip, take into account Israel's legitimate security concerns in the face of repeated terrorist attacks against it and its civilian population.

As in the past, her country was concerned about including an overtly political draft resolution in the Health Assembly's discussions. The text had singled out one side for harsh criticism, leaving the responsibilities of the Palestinian Authority and the authorities in the Gaza Strip unscrutinized. Furthermore, it called for Member States to engage in inappropriate political lobbying. Her country was therefore unable to vote in its favour.

Dr YOUNOUS (Chad), speaking in explanation of vote, said that his country had voted in favour of the draft resolution as a mark of support for the population of the occupied Palestinian territory, who lacked basic health care. He welcomed the approval of the draft resolution.

The meeting rose at 18:05.

SECOND MEETING

Thursday, 19 May 2011, at 09:20

Chairman: Dr M.T. VALENZUELA (Chile)

1. FIRST REPORT OF COMMITTEE B (Document A64/55 (Draft))

Mr TUITAMA LEAO TUITAMA (Samoa), Rapporteur, read out the draft first report of Committee B.

The report was adopted.¹

2. FINANCIAL MATTERS: Item 17 of the Agenda

Appointment of the External Auditor: Item 17.8 of the Agenda (Documents A64/35 and A64/35 Corr.1)

At the invitation of the CHAIRMAN, who said that she took it that the Committee wished to proceed as in previous elections of the External Auditor, Mr BURCI (Legal Counsel) outlined the process of presenting candidatures and voting by secret ballot.

The CHAIRMAN noted that, as indicated in document A64/35 Corr.1, the Auditor-General of Ghana had withdrawn his candidature for the post of External Auditor. The five remaining candidates, nominated by France, Germany, Malaysia, the Philippines and Spain, were to be considered by the Health Assembly for the position of External Auditor.

Mr PELLET (France) drew attention to Attachment 3 of document A64/35 Corr.1, which contained an updated version of Annex 8. In order to ensure a fair comparison, it should be noted that the offer of the French Court of Audit included 36 auditing months at WHO headquarters, regional offices and associated entities and an additional 30 months at the Court of Audit in Paris, which were not mentioned in the Annex. Thus, the total offer consisted of 66 auditing months.

The CHAIRMAN invited the candidates to make their personal presentations to the Committee.

Mr PICHON (France), on behalf of the First President of the French Court of Audit, Mr Didier Migaud, presented his proposal for the post of External Auditor. Mr Migaud's extensive experience in public financing had given him a clear understanding of WHO Member States' expectations with regard to the work of the External Auditor, which included the principle of sincerity in accounting, financial control and measures to ensure more efficient management. Such understanding would be pertinent in view of WHO's double challenge: to meet the growing global health needs and to guarantee funding for its priorities.

The judicial status of members of the Court of Audit guaranteed the independence of their audits and recommendations. The Court intervened extensively in the health sector and certified the

¹ See page 339.

accounts of the social security administration. Its mandate had been extended following the budgetary reforms of 2001, which bore certain similarities to the Director-General's reform programme for improving WHO's management. The Court's role as External Auditor would be to promote reform, by verifying procedures, ensuring the sincerity of the accounts, providing accurate information on the financial state of the Organization, conducting risk assessment and, where necessary, giving advice.

Although the Court would remain totally independent and would not seek to interfere with the day-to-day running of the Organization, it would nevertheless maintain dialogue with the Secretariat. The Court's extensive experience with other international organizations would enable it to make a significant contribution to modernizing the Organization, sharing best practices and ensuring compliance with the strictest international standards. The Court complied with international auditing standards, such as those set by the International Organization of Supreme Audit Institutions, and played an active role in developing those standards. The Court had also been involved in setting the International Public Sector Accounting Standards (IPSAS), with which WHO would have to comply as of 2012. The Court's candidature took into account the difficulties that WHO would face during the transition to that system, and the Court would assist WHO in making the necessary changes, as it had done for other international organizations. The Court would ensure continuity through close contact with the outgoing External Auditor. It had a large, well-qualified staff and maintained close links with other supreme auditing institutions. Experienced colleagues from Bangladesh, Indonesia, Morocco and Tunisia regularly collaborated with its teams of auditors.

The French proposal represented particularly good value for money and a high-quality service, as the audit fee covered only the Court's costs for audits carried out on-site at WHO headquarters and did not include the supporting work in Paris, estimated at about 30 auditing months per year.

Mr HAUSER (Germany) said that one of the merits of the German offer was the long track record of the Supreme Audit Institution (*Bundesrechnungshof*) in auditing United Nations organizations, with field work in many parts of the world. Members of the Institution had chaired the United Nations Panel of External Auditors and its technical group since 2008.

He recalled that the term of office of the current WHO External Auditor would end just before the accounts were to be certified under IPSAS for the first time. The Institution's staff was experienced in making such transitions. It had invited key IPSAS staff from India to join the German team during the first year, in order to guarantee a smooth handover. The staff of the Institution understood the challenge for WHO of implementing both its reform programme and the changeover to IPSAS and proposed to meet that challenge jointly with the Organization.

The proposed German audit approach was proactive, going beyond compliance and value for money. It would also include constructive recommendations to prevent unnecessary expenditure and to meet goals more efficiently. The aim was to ensure that savings were made before any money was spent, by examining auditing issues before projects and programmes were implemented. The approach depended on an excellent working relationship with the client, which was based on trust and respect for the client's concerns, and included extensive reporting.

The auditing team consisted of an Audit Director, who had been part of the United Nations IPSAS Task Force, three audit managers and about 20 auditors, providing expertise in the fields of law, accountancy, economics, information technology, and engineering; it would therefore be able to cover all WHO activities. As the team was based in Bonn, it could carry out regular missions at WHO headquarters, with some members operating in Geneva. In order to add value to the proposal, the Institution had also submitted an application to audit PAHO.

The German proposal was comprehensive and based exclusively on the recovery of direct costs. In addition to 54 auditing months in Geneva or in the field, it offered an additional 20 months for analytical and preparatory work in Bonn, for a total of 1480 auditing days per year.

Dr CHONG Kee Kheong (Malaysia), speaking on behalf of Mr Ambrin Buang, the Auditor-General of Malaysia, described his qualifications for the post of External Auditor. He had extensive experience in the public sector, including as Secretary-General of the Ministry of Education. Having

been appointed Auditor-General of Malaysia in 2006, he had introduced several changes, including the introduction of a special audit sector within a departmental restructuring programme in 2008 and a “financial management accountability index” for ministries, departments and agencies responsible for managing public funds. He had been a member of the Governing Board of the Asian Organization of Supreme Audit Institutions and was involved in the work of the International Organization of Supreme Audit Institutions.

Ms PULIDA-TAN (Philippines) described her current role as Chairperson of the Philippine Commission on Audit, an independent constitutional body, as well as her previous experience as Commissioner of Good Government, Under-Secretary of Finance and consultant to development agencies and other partners. She also described the professional experience and core competences of her two commissioners, who had worked for many years in both the public and private sectors and with United Nations agencies.

The Commission on Audit had extensive experience in auditing international bodies. It also had close links with other auditing bodies, as a member of the Panel of External Auditors of the United Nations, the specialized agencies and IAEA and the International Organization of Supreme Audit Institutions, and was a founding member of the Asian Organization of Supreme Audit Institutions. The Commission’s collaborative activities with those bodies included standard-setting and exchanges of best practices.

The Commission would put together an audit team comprising highly qualified auditors who were fluent in both spoken and written English and had training and experience in working with the United Nations system and international development agencies. It would therefore be familiar with the resource planning systems of United Nations agencies. As State-run companies in the Philippines already used IPSAS, the auditing team would also be familiar with the International Financial Reporting Standards and IPSAS systems.

The Commission’s auditing approach consisted of four stages. The first involved defining expectations, in order to achieve established goals in line with the mandate and vision of WHO. The preparatory work would involve collaboration with the Internal Auditor. The planning stage involved understanding WHO and its operations, processes and information systems in order to identify and prioritize risks; that analysis would define the types of audits required. The implementation stage included continuous assessment of risk management strategies, managing residual audit risks and reducing them to an acceptable level, and assessing the vulnerability of programmes. The final stage, the communication of audit results and follow-up, would go beyond the submission of audit reports: the Commission would prepare specific risk-mitigation measures, provide other value-added recommendations, measure satisfaction and ensure the follow-up of audit recommendations.

The scope of the proposed external audit services would conform with that defined in WHO’s Financial Regulations and other relevant documents. The risk-based audit approach of the Commission on Audit complied with standards set by the International Organization of Supreme Audit Institutions and constituted best practice with regard to value-for-money audits. WHO could be confident that the approach would not only be in line with its reform agenda but would also include steps to track the mobilization and implementation of resources and recommendations on measures to mitigate risk.

The proposal represented good value for money. It included 21 auditing months at the Commission’s headquarters in Manila, covering a multi-level review and a range of other services.

Ms DE LA FUENTE and Ms FERNANDEZ ESPINOSA (Spain), on behalf of Mr Manuel Núñez Pérez, President of the Spanish Court of Audit, jointly presented his proposal for the post of External Auditor. Both the Court of Audit and its President were committed to serving the field of health, Mr Núñez Pérez having served as Minister of Health and having attended many WHO meetings.

One of the Court’s main assets was its independence, which was vital to ensure impartial, objective work. The Spanish Constitution had granted the Court of Audit a broad mandate, covering

accounts for the entire public sector, and it undertook all types of auditing, including compliance, performance and management systems. One of the Court's seven departments, which dealt exclusively with health, had submitted some 15 reports on health-related issues in the previous year. The Court of Audit had highly qualified staff and a strict code of professional ethics. The institution's procedures complied with the standards set by the International Organization of Supreme Audit Institutions. The Court recognized the importance of establishing a good relationship with the auditee and had extensive experience of reporting, which involved providing not only opinions on the financial state of a body, but also recommendations for improving administrative and legislative practices.

The Spanish Court of Audit had a wealth of experience at the international level, within the framework of the International Organization of Supreme Audit Institutions, the European Organization of Supreme Audit Institutions and the Organization of Latin American and Caribbean Supreme Audit Institutions. It was also involved in the setting of both national and international auditing standards and had carried out audits for several international organizations

In the Court's view, the main aim of the audit and subsequent recommendations was to improve the administration of the Organization. Its offer comprised 82 auditing months, 26 of which would be spent at WHO headquarters and the regional offices, covering all six offices over the course of four years. The Court considered that 82 auditing months would be sufficient for an organization the size of WHO. The team would consist of 10 highly qualified auditors, with wide international experience and knowledge of languages, managed by a coordinator and supported by officials of the Court with respect in particular to information technology.

The proposal was highly competitive and concordant with WHO's Financial Regulations. The focus of the proposal was risk analysis, and it would be based on an audit plan that would provide sufficient flexibility to address unforeseen contingencies. As the Court of Audit was not a profit-making institution, no additional daily expenses would be claimed for work done at the Court's headquarters.

The CHAIRMAN, in accordance with Rule 78 of the Rules of Procedure of the World Health Assembly, invited the Committee to proceed to a secret ballot to appoint the External Auditor. She proposed that, in order to save time, the Committee should use ballot papers on which the names of the countries presenting candidates were already printed in alphabetical order.

It was so agreed.

Ms Creelman (Australia) and Mr Van Schalkwyk (South Africa) were appointed as tellers.

Mr BURCI (Legal Counsel), responding to a request for clarification from Dr REN Minghui (China), explained that ballot papers were distributed only to delegations represented at the Health Assembly and entitled to vote. Those Member States whose voting rights had been suspended or that were not represented at the current Health Assembly were Antigua and Barbuda, Belize, Central African Republic, Comoros, Dominica, Grenada, Guinea-Bissau, Kyrgystan, Libyan Arab Jamahiriya, Niue, Saint Lucia, Saint Vincent and the Grenadines, Seychelles, Somalia, Suriname and Tajikistan.

A vote was taken by secret ballot.

The result of the secret ballot was as follows:

Members entitled to vote	177
Members absent	42
Abstentions	0
Papers null and void	0

Members present and voting	135
France	29
Germany	32
Malaysia	24
Philippines	41
Spain	9
Number required for a simple majority	68

Mr BURCI (Legal Counsel) said that, as no candidate had obtained the required majority, in accordance with Rule 79 of the Rules of Procedure, the second ballot to appoint the External Auditor would be restricted to the two candidates who had obtained the largest number of votes in the first ballot: those nominated by Germany and the Philippines.

A second vote was taken by secret ballot.

The result of the secret ballot was as follows:

Members entitled to vote	177
Members absent	39
Abstentions	0
Papers null and void	2
Members present and voting	136
Germany	62
Philippines	74
Number required for a simple majority	69

Having obtained the required majority, the Philippines' candidate for the position of External Auditor was elected.

The draft resolution contained in paragraph 8 of document A64/35, completed in accordance with the result of the secret ballot, was approved.¹

The meeting rose at 12:50.

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA64.23.

THIRD MEETING

Thursday, 19 May 2011, at 14:50

Chairman: Dr M.T. VALENZUELA (Chile)

1. AUDIT AND OVERSIGHT MATTERS: Item 16 of the Agenda

Report of the Internal Auditor (Documents A64/28 and A64/48)

Dr MOHAMED (Oman), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, introduced the Committee's sixth report (document A64/48).

Dr GULLY (Canada) sought reassurance that the reduction in human resources within the Office of Internal Oversight Services would not hamper its work. Referring to the Committee's sixth report, he concurred that regional and country audit reports should be fully disclosed to the extent possible, as they were a useful source of information.

Mr KÜMMEL (Germany) noted the importance of strengthening internal controls, attitudes and practices within the Secretariat, especially in the context of reform. The limited resources available should be used effectively, rationally and strategically and be protected from abuse. The report of the Internal Auditor (document A64/28) highlighted the professionalism and commitment of the Office of Internal Oversight Services and its staff, but made clear the need for additional resources. He asked whether the number of staff members was sufficient to enable the Office to carry out its functions effectively; international organizations of comparable size had up to five times as many staff. Immediate action should be taken to increase the resources of the Office. Of particular concern was the fact that the average delay to implementation of the Office's recommendations was 1.3 years. Remarking on the need to increase efficiency, effectiveness and accountability across the Organization, he said that internal oversight had a key role to play and should be given due priority. He noted with appreciation the Secretariat's response to the concerns raised during the discussions on the subject at the fourteenth meeting of the Programme, Budget and Administration Committee.

Mr STORBEKKRØNNING (Norway) said that WHO had to have a supervisory body with a broad mandate, independence and sufficient human and financial resources to carry out the full range of tasks within that mandate. The report of the Internal Auditor highlighted weaknesses within the Organization, in particular with regard to the insufficient funding allocated to the Office of Internal Oversight Services and the delays, sometimes of several years, in following up the recommendations in previous reports. He requested timely resolution of the issues raised by the Internal Auditor and submission of a report to the Executive Board and its Programme, Budget and Administration Committee that clarified the procedure for following up the recommendations contained in audit reports and reporting progress made. Sufficient resources and capacity should be made available so that the recommendations could be followed up expeditiously.

Miss PASSAWEE TAPASANAN (Thailand), recognizing the importance of internal audits and risk management for the effective functioning of any large organization, commended the comprehensive work of the Office of Internal Oversight Services. She expressed concern, however, about the inadequate level of staffing of the Office, which could compromise its work, especially in

view of the increasing demands for internal oversight throughout the Secretariat. Concerted efforts had been made to synergize the internal and external auditing mechanisms, but the Office's capacity was not commensurate with the demands put on it.

It was also a matter of concern that 73% of the recommendations made by the Internal Auditor during the period 2006–2011 were still open, despite their significance; timely implementation of all recommendations should be facilitated.

She welcomed the coming into force of the Policy on the Prevention of Harassment at WHO and noted that two claims had already been closed; she looked forward to finalization of the remaining claims and requested clarification about the outcome of the investigations mentioned in paragraphs 27, 28 and 31 of document A64/28. Immediate action should be taken in all cases of misconduct or fraudulent action; regional directors had a vital role to play in that connection. Transparent and ethical conduct of all WHO staff members was the key to the effective functioning of the Organization.

Mr CHATELUS (France) said that internal controls should be viewed in the context of the operating budget and reform. He referred to the tripartite audit and monitoring mechanisms, consisting of external and internal audits and the Independent Expert Oversight Advisory Committee; any ensuing recommendations should be ranked in terms of priority, distinguishing between those that were urgent and those of a structural nature. The latter should form the basis for future discussions and influence broader reform within the Organization, in particular with regard to funding.

Given the multiple levels and the complexity of the Organization, internal audit was essential, and adequate resources should be made available to support it. He requested that internal audit reports be disclosed to Member States, with emphasis on the main problems and corresponding solutions, especially with regard to financial and human resources and evaluations of regions, countries and partner organizations.

Dr REN Minghui (China) said that internal audits were essential for ensuring that the Organization operated with transparency, accountability and efficiency. Strengthening of internal audits should be an integral part of the WHO reform agenda. Attention should be given to the problems and issues highlighted in the Internal Auditor's report, particularly with regard to irregularities in compliance with WHO's rules and regulations, and additional training should be given in that respect. The long-outstanding recommendations listed in the report should be implemented in a timely manner. He asked for adequate resources to be made available to the Office of Internal Oversight Services in order to allow it to accomplish the wide range of tasks in its mandate.

Ms BLACKWOOD (United States of America) concurred with the delegate of France about the themes common to the internal audits, external audits and the Independent Expert Oversight Advisory Committee. She thanked the Office of Internal Oversight Services for its report and its work. She urged the Organization to implement the audit recommendations without delay and to put in place follow-up procedures to ensure that their implementation was sustained. She expressed concern at the number of issues and problems identified in document A64/28, particularly in the areas of procurement contracts and personnel administration in regional and country offices, and encouraged the Secretariat to resolve them expeditiously. Deadlines should be established for implementation of recommendations by the respective offices, and any difficulties encountered in their implementation should be detailed in future reports. Echoing the comments made by previous speakers, she drew attention to the insufficiency of human resources for the Office, which could affect its capacity to fulfil its mission. Staffing levels, including support staff to maintain risk management services, should be reviewed.

Mr RUSH (United Kingdom of Great Britain and Northern Ireland) said that he shared the concerns expressed by previous speakers. It was essential that the Office of Internal Oversight Services had enough staff to discharge fully the tasks entrusted to it. With regard to the recommendations in the Internal Auditor's report, it was important to identify those responsible for

implementing the outstanding recommendations, in order to improve accountability, and to set clear deadlines for that action. He expressed deep concern at the findings and recommendations in the Internal Auditor's report, which reflected poor compliance throughout the Organization. Given sufficient resources, the Office could tackle the problems identified and help to improve the overall performance of the Organization. He commended the Director and staff of the Office for their work and their response to the concerns voiced by Member States.

Mr WEBB (Office of Internal Oversight Services) thanked Member States for their comments on the work of the Office of Internal Oversight Services and their calls to increase its resources; extra staffing would help the Office to fulfil its mandate effectively. He reminded Member States that, in the risk model used by the Office, priorities for the allocation of resources were set according to the level of perceived risk to the Organization. During the biennium 2010–2011, after the reduction in staff, the Office had used external resources to complement the fixed-term staff in order to cover areas in which technical expertise was lacking and to meet urgent requests, such as for investigatory work, the volume of which had increased in 2010, especially for alleged cases of harassment. A pilot study had been conducted to test various efficiency measures, particularly at country level, including desk-based reviews and other short-form reporting. It had proved successful, and the measures would be continued. The Office was supported in its work by PAHO in the Region of the Americas, and it worked closely with the External Auditor in order to maximize coverage and avoid duplication of work. He confirmed that the Office had been allocated a slight increase in funding for the biennium 2010–2011.

Responding to the concerns about the follow-up of recommendations, he reported that a new database had been set up to facilitate management of their follow-up at a more detailed level, which would be reflected in future reports to the Health Assembly. Use of the database would allow the Office to report to the Director-General, Assistant Directors-General and regional directors on a quarterly basis regarding outstanding recommendations and would allow identification of the responsible officers. Follow-up of recommendations was an important part of the internal audit process, and the Office worked directly with the directors of administration and finance in the Regional Offices to ensure that issues were addressed and common solutions were found and implemented.

The Office was aware of the recurring weaknesses in internal controls, referred to in the report as "dilution of the accountability framework". The new model for internal controls in the Global Management System was not yet in place, but action had been taken to accelerate its implementation and to strengthen the enterprise risk-management system.

The Office had only one staff member for investigating alleged cases of harassment, and, in view of the growing workload in that area, had had to rely on external consultants or had diverted resources from other activities for urgent cases. Although delegates had requested clarification of actions taken in relation to specific investigations, the Office of Internal Oversight Services was an independent body and not involved in disciplinary action; its primary function was to determine the facts of a case. The Director-General and the regional directors were responsible for deciding on the appropriate course of action. Referring to the delegate of Thailand's request for clarification in connection with paragraph 27 of the Internal Auditor's report, he confirmed that disciplinary action had been taken when the staff member involved had retired. The Regional Director had taken measures against the member of staff involved in the investigation referred to in paragraph 31.

In line with due process and respect for the confidentiality of the parties involved, investigation reports were not fully disclosed. Reports covering operational, independent and performance audits could, however, be openly reviewed. He would report the outcome of discussions on full disclosure of internal audit reports to the Executive Board at a subsequent session.

The Committee noted the report.

2. FINANCIAL MATTERS: Item 17 of the Agenda

Unaudited interim financial report on the accounts of WHO for the year 2010: Item 17.1 of the Agenda (Documents A64/29, A64/29 Add.1, A64/49 and A64/49 Corr.1)

Dr MOHAMED (Oman), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, introduced the Committee's second report (documents A64/49 and A64/49 Corr.1).

Mr JONES (Canada) underlined the importance of the unaudited interim financial report, which provided a good overall indication of the financial health of the Organization and formed a basis for sound governance decisions. He noted the relatively high collection rate of assessed contributions, but expressed concern about the effect of the expected shortfall in income for the biennium, in particular, the underfunded liability of US\$ 90 million for staff entitlements. It was essential that adequate funding be ensured. He urged the Secretariat to work with the Independent Expert Oversight Advisory Committee on identifying and exploiting opportunities to improve the financial management of the Organization through enhanced cash management and reduced currency exposure.

Mr JEFFREYS (Comptroller) reassured Member States that the US\$ 90 million shortfall in future staff entitlements was a future, not a current, liability; all current liabilities for staff entitlements were fully covered. Measures would be taken over 15 years to ensure that the shortfall in future staff entitlements would be fully funded.

The CHAIRMAN drew attention to the draft resolution contained in document A64/49.

The draft resolution was approved.¹

Interim report of the External Auditor: Item 17.2 of the Agenda (Documents A64/30 and A64/50)

Mr AWASTHI (representative of the External Auditor), presenting the interim results of the external audit of WHO for the financial period 2010–2011 on behalf of the External Auditor, said that audits had been conducted in the first year of the current financial period in the regional offices for Africa and the Western Pacific and in one country office in each of those regions. The report also contained in-depth reviews of the Office of Internal Oversight Services and the Income and Award Management unit at headquarters. In the second year of the financial period, the remaining regional offices and selected country offices would be audited, with detailed reviews of selected areas of WHO, including the information technology used by the Global Management System, and an audit opinion on the financial statements for the financial period 2010–2011 would be expressed. The interim report and the recommendations contained therein had been accepted by the Director-General, who had given assurances that the necessary actions would be taken.

With regard to the introduction of International Public Sector Accounting Standards, the External Auditor considered that WHO risked not meeting the target date of 1 January 2012. The standards still to be implemented were key ones. In the area of management reform, the External Auditor had recommended strengthening financial management by synchronizing the Comptroller's responsibilities and powers. The External Auditor had noted that WHO had made no provision for uncollected income from voluntary contributions; the situation should be reviewed in accordance with the United Nations System Accounting Standards. The review of the Income and Award Management unit had shown that better coordination was needed with the Department of Finance to ensure that award funds were fully disbursed and that delays in creating awards, due to incomplete

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA64.18.

documentation, were minimized. The External Auditor had recommended that WHO continue to make concentrated efforts to review and reduce outstanding receivables.

The review of the Office of Internal Oversight Services had shown that its human and financial resources should be increased, in line with its increased activities, the management's expectations and additional responsibilities assigned to it. Its mandate should be amended accordingly. The insufficient resources had led to a reduction in the number of audits in the regions and countries. The audit of regional and country offices had revealed gaps with respect to budgetary control and use of funds. Assurances had been received from the regional directors concerned that action would be taken to implement the Programme budget. Delays in bank reconciliations had also been observed in the two regional offices audited, and the External Auditor had recommended that unreconciled items in the e-Imprest account be reconciled. Cases of salary and travel advances that had been outstanding for more than a year had been observed.

The implementation of significant recommendations would be noted in the final report on the current financial period. The External Auditor would continue to work towards bringing value to WHO and its stakeholders through the external audit process.

Dr MOHAMED (Oman), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, introduced the Committee's seventh report (document A64/50).

Dr SHONGWE (Swaziland), speaking on behalf of the Member States of the African Region, commended the External Auditor's interim report. Some of the weaknesses identified were being addressed at WHO headquarters and in the regional and country offices concerned. It should be noted that, at the time audits were being conducted, the Global Management System was being introduced, which had been a learning experience for all staff members. He requested an update on progress made in responding to the main findings and urged the Organization to implement the External Auditor's recommendations. He asked the Director-General to strengthen the Office of Internal Oversight Services.

Mr MÉSZÁROS (Hungary), speaking on behalf of the European Union, said that the candidate countries Turkey, Croatia, The former Yugoslav Republic of Macedonia, Montenegro and Iceland, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Serbia, as well as Ukraine, the Republic of Moldova and Armenia aligned themselves with his statement. He thanked the External Auditor for the informative report. The external audit was a necessary complement to the internal audit and the Independent Expert Oversight Advisory Committee. The European Union considered that the current levels of financial and human resources of the Office of Internal Oversight Services were not commensurate with its important responsibilities and strongly supported the External Auditor's recommendation that the Secretariat reassess the resources available to the Office. The European Union noted with concern the findings on practices in the financial management and internal controls of the Organization and welcomed the reassurances made to the Programme, Budget and Administration Committee in that regard. Building trust included the way in which the Secretariat dealt with its limited financial resources, and improvements made in that area would contribute to its future role in global health. It remained a clear priority to strengthen internal control systems and routines and to improve attitudes and practices in order to prevent, detect and resolve any financial irregularities. He looked forward to a progress report on follow-up of the External Auditor's recommendations.

Mr SATPATHY (India) welcomed the presentation of the interim results for 2010–2011 and the proposed audit of the information technology used by the Global Management System, WHO's resource planning system. He was aware of the difficulties in implementing International Public Sector Accounting Standards by 2012, but encouraged the Secretariat to continue to do so. He supported the recommendation to strengthen the Office of Internal Oversight Services in order to improve financial

management. Audit was an activity that had the benefit of hindsight and should serve to prevent repetition of past mistakes. He looked forward to the final report, to be submitted to the next Health Assembly, and encouraged the Secretariat to cooperate with the External Auditor to ensure productive examination of the existing systems.

Dr WANICHA CHUENKONGKAEW (Thailand) expressed concern regarding two points in the interim report of the External Auditor. According to paragraph 76, overpayment of salaries had been due mainly to delays in the submission and approval of documents for leave without pay. That showed a weakness in human resource management and should be investigated by the Director-General or the responsible Assistant Director-General. Referring to paragraph 89, she suggested that, rather than increasing the proportion of the budget allocated to the Office of Internal Oversight Services to 0.5% of the total resources available to the Organization, budgetary support could be increased gradually, with prioritization of the work of the Office.

Mr KÜMMEL (Germany) said that his Government was alarmed by the findings of the External Auditor, including the high number of personal advances, as already discussed during the meeting of the Programme, Budget and Administration Committee. The External Auditor had raised the same issue in his report of April 2009 and had recommended that the outstanding balances be settled.¹ Although the External Auditor had at that time noted that regional and country management had given assurances that exercises were under way to comply with his recommendations, it was clear that due attention had not been paid to his recommendations. That was a shared responsibility of the Secretariat's senior management and Member States. His Government was concerned about the findings on the Organization's financial management and internal controls, but was even more preoccupied by the failure to implement serious recommendations and the resulting potential financial losses. Furthermore, there was an apparent lack of efficient monitoring, with considerable consequences for non-compliance. The Secretariat must take the External Auditor's findings and recommendations seriously. Given the findings, his Government strongly supported closer oversight of the regions and clear sanctions for future non-compliance. It wanted a strong WHO that made sure that the available financial resources resulted in the greatest health outcomes.

Mr JEFFREYS (Comptroller) welcomed the observations of the External Auditor, the detailed comments of Member States and the scrutiny of the Programme, Budget and Administration Committee. Maintenance of good internal control was indeed essential, and reinforcement of accountability of compliance with controls was central to the Organization's objectives for reform. The introduction of the Global Management System had been a period of significant change. The system provided an excellent means of monitoring income, expenditure, assets and liabilities throughout the Organization. It increased efficiency by integrating transactions for travel, procurement, human resources and finance, which had formerly been treated separately, and it was a powerful tool for increasing transparency. Its implementation had transformed the control environment, however, and some of the new controls were not yet fully understood or as effective as they should be. He was taking strong measures in conjunction with the directors of finance and administration in the regions to ensure that system controls were working properly and that those controls were clearly linked with the accountability of individual managers. He was also working to ensure stronger enforcement in cases of breaches of controls.

Regarding cases of leave without pay, he said that, since the report had been written, three-quarters of the advances had been recovered and the rest would be recovered soon. In response to the concern expressed regarding salary advances, he reassured delegates that in most cases they were not advances on salary, but legitimate salaries paid to people who had not yet been registered in the General Management System.

¹ See document A62/29.

Dr SAMBO (Regional Director for Africa), responding to the concerns expressed about outstanding advances, said that substantial progress had been made since January 2011. Of 5978 outstanding salary advances reported by the External Auditor at end-2010, nearly 90% had been cleared by April 2011. Most of the remaining 671 advances involved inactive or superannuated staff; he was following up the outstanding cases and expected the write-offs to be limited. Regarding outstanding travel advances, of the 2986 cases cited in the report, only 180 remained. Paragraph 79 of the report referred to full recovery of advances by May 2011, and that had largely been achieved. The high number of advances stemmed mainly from the fact that the figures had been produced during a vulnerable period for the African Region, when it was in transition to the Global Management System. The first four months of applying that System had required a new environment and culture as well as staff training in the 46 Member States of the Region. Unfortunately, during the transition, many active staff had gone unpaid when their personal information had been registered in the System late or incorrectly; other regions had experienced similar difficulties. As he could not hold the affected staff responsible for system problems or withhold their salaries, he had decided to make manual salary payments. He recognized that important work remained to be done, but the situation had largely been resolved. Some of the advances had been due to weaknesses in internal control, which had been identified and were being addressed. He would continue to report on progress until a final settlement was achieved. Any required write-offs would be reported to the Comptroller together with details of measures taken for recovery. Only then would a decision be made on the amount to be written off in the 2010–2011 financial statement. The African Region was fully accountable for the funds it received. The audit reports had been improving, and he considered that the Global Management System would add to the transparency of operations and improve financial and programme monitoring and oversight.

The Committee noted the report.

Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution: Item 17.3 of the Agenda (Documents A64/31 and A64/51)

The CHAIRMAN drew attention to the fifth report of the Programme, Budget and Administration Committee (document A64/51), which included an amended draft resolution. She had been advised by the Secretariat that Afghanistan had subsequently paid a sufficient amount, so that Article 7 need no longer be invoked. She invited the Committee to consider the draft resolution, with the deletion of the reference to Afghanistan.

The draft resolution, as orally amended, was approved.¹

Special arrangements for settlement of arrears: Item 17.4 of the Agenda (Documents A64/32 and A64/51)

The CHAIRMAN invited the Committee to consider the draft resolution contained in document A64/32, concerning the special arrangements for Ukraine to settle its arrears.

The draft resolution was approved.²

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA64.19.

² Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA64.20.

Scale of assessments for 2012–2013: Item 17.5 of the Agenda (Documents A64/33 and EB128/2011/REC/1, and resolution EB128.R2)

Professor MPHANDE (Malawi), speaking on behalf of the Member States of the African Region, welcomed the use of the latest United Nations scale of assessments for contributions of Member States. He noted that the latest scale remained at the level adopted for 2010–2012. The African Region therefore supported the draft resolution contained in resolution EB128.R2 on the scale of assessments for 2012–2013. The importance of using the latest available United Nations scale could not be overemphasized.

The CHAIRMAN invited the Committee to consider the draft resolution recommended by the Executive Board in resolution EB128.R2.

The draft resolution was approved.¹

Amendments to the Financial Regulations and Financial Rules: Item 17.7 of the Agenda (Documents A64/34 and EB128/2011/REC/1, and resolution EB128.R3)

Miss PIMPAVADEE PHAHOLYOTHIN (Thailand) said that, as audits were to be conducted annually at the request of the United Nations Panel of External Auditors, the proposed amendments were necessary. She therefore supported the draft resolution in resolution EB128.R3 amending Financial Regulations 14.1, 14.8 and 14.9. She requested assurance, however, that the additional benefit of one more external audit per biennium would outweigh its additional cost.

Dr YANSANE (Guinea), speaking on behalf of the Member States of the African Region and noting that the United Nations Panel of External Auditors required an annual audit of all organizations in the United Nations system in order to guarantee maximum credibility and transparency, recommended adoption of the amendments to WHO's Financial Regulations.

Mr JEFFREYS (Comptroller) said that annual externally audited accounts would increase the transparency and accountability of the Organization's financial results and its internal control framework. Referring to his response to concerns about the Organization's control mechanism expressed during the discussions on external and internal audits, he said that annual certification by the External Auditor would bring a heightened level of external scrutiny to the Organization's financial performance and internal controls. It would be difficult to quantify the value of the exercise. The costs for the next biennium would be established once the resolution on the appointment of the new External Auditor had been adopted by the Health Assembly.

The CHAIRMAN invited the Committee to consider the draft resolution recommended by the Executive Board in resolution EB128.R3.

The draft resolution was approved.²

The meeting rose at 16:50.

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA64.21.

² Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA64.22.

FOURTH MEETING

Friday, 20 May 2011, at 09:50

Chairman: Dr M.T. VALENZUELA (Chile)
later: Dr A.-Z. GOLEM (Croatia)

1. SECOND REPORT OF COMMITTEE B (Document A64/58 (Draft))

Mr TUITAMA LEAO TUITAMA (Samoa), Rapporteur, read out the draft second report of Committee B.

The report was adopted.¹

2. STAFFING MATTERS: Item 18 of the Agenda

Human resources: annual report: Item 18.1 of the Agenda (Document A64/36)

Dr GULLY (Canada) noted with appreciation WHO's progress with respect to gender balance, and encouraged continued efforts to achieve parity within the coming decade. The Secretariat needed also to remain vigilant so that the gains made in gender equality, and within the Organization, were maintained and indeed furthered. WHO had other challenges to face, among them the unequal distribution of professional and higher-category posts between developed and developing countries, and an ageing workforce.

Noting the significant reduction between 31 July and 31 December 2010 in the number of temporary staff largely due to budgetary constraints, he asked for clarification about the extent to which WHO's core business, including standard-setting work and technical cooperation, was being strategically modified to adapt to those reductions.

Mr RUSH (United Kingdom of Great Britain and Northern Ireland) observed that there was general recognition of the significant human resources difficulties that the Organization faced, as had been outlined in the documents on the future of financing and the human resources strategy introduced the previous year. A key element of the strategy was to embed human resources thinking and strategies within the organizational culture, rather than letting that aspect remain a separate management issue. A progress report should be provided on some key performance targets, now that the strategy had been in force for a year.

He welcomed the significant efforts and resources invested in ensuring that the Global Management System would help the Organization to target better its resources for decision- and policy-making in the human resources area. However, he highlighted the wider corporate risks attaching to the System, notably the manufacturer's cessation of support for the current software in 2013, which would pose substantial difficulties for the Organization, particularly financial problems. How did the Organization plan to respond?

¹ See page 340.

Member States and the Secretariat had to have a set of strategic objectives that were specific, measurable, achievable, realistic and timely, and which would be applied throughout the Organization, from top-level corporate strategic objectives down to individuals' objectives, with clear synchronization of those objectives.

As the documents on the future of financing for WHO made clear, there was currently a mismatch within the Organization's staffing model, in terms both of short- and long-term contracts and of the related mix of skills and experience. The Organization must have a staffing model that was fit for purpose.

Many Member States had not taken due account early enough of the important role played by the International Civil Service Commission in making recommendations on human resource issues, with the result that, once those recommendations had been endorsed by the United Nations General Assembly, they had become a *de facto* reality for all organizations in the United Nations system, imposing constraints on the Organization that made it difficult to implement flexible policies. He sought information on the level of the Secretariat's engagement with that Commission in terms of influencing the discussions before it made recommendations.

Ms ALTMAIER (Human Resources Management) said that she appreciated the support expressed for the progress in achieving gender balance. Headquarters was working closely with the regions, and the Secretariat had just launched a new web site and an outreach activity toolkit that should make it possible to close the gender gap, especially in the higher categories, in less time than the 10 years mentioned in the report.

With regard to staffing levels, the process of decreasing staff numbers was continuing, with a further 300 people affected across the Organization (144 of them in headquarters) since the beginning of the year as a result of the mismatch between funding and staffing levels.

The Secretariat had already implemented 28 standard operating procedures for human resources. The implementation of the "make and check process", effective from 1 June 2011, under which all transactions with payroll implications would have to be signed off by a National Professional Officer or professional staff member would help to mitigate the risk. Those standard operating procedures had been aligned with WHO's rules and regulations in order to achieve consistent and harmonized processes across the Organization. The next stage would be to undertake an exercise, in collaboration with the Global Service Centre, to determine the cost of each transaction. A major project to clean up the data, which had involved examining all the personnel assignment details in the Global Management System, was drawing to its close. More than 10 000 data fields that had been identified as erroneous or empty had been rectified or completed, and a policy had been instituted to prevent data corruption and attain further data quality in future. The Secretariat could now fully rely on the data in the System, which was a major step forward. Further work was in hand to automate human resource reports.

With regard to performance management, the compliance rate had increased from 55% two years earlier to 77% at the present time; the target remained 100%. The Organization was investing heavily in training in performance management and evaluation. Objectives were being refined and an Organization-wide workplan was being prepared. Further, over the past two years, the recruitment time had been reduced from nine to five months; the goal was four months, but that would need greater availability of recruitment panel members. As another step towards more rapid deployment, several rosters had been or were being developed for specific categories of personnel, including potential WHO Representatives, administrative officers, and epidemiologists. She would be able to submit further information to the Executive Board at its 130th session in January 2012, including data on some main performance indicators, as baselines were established against which progress could be measured.

Specific, measurable, achievable, realistic and timely objectives for human resources staff had been disseminated widely so that all offices could increase their efficiency and effectiveness and improve results. In the area of skill mix, work had to be completed on a fully functioning performance

management system that would detect competency gaps and enable the Secretariat to determine how to close them through training and learning focused on the strategic priorities.

Funding and staffing were mismatched. In January 2012 a new staffing model would be submitted to the Board, one that not only differentiated between ongoing and project-based functions but also defined the allocation of contract types. That would help in the identification of what changes in contracts and contracting might subsequently be needed. The revised staffing model would also link functions and funding more closely, with clear descriptions of all posts so that projects could be readily expanded or shrunk depending on Member States' strategic needs.

Overall, a holistic approach was being taken to human resources management, in order to foster the creation and establishment of a high-performance culture. Islands of high-performance culture already existed, but that concept was not yet uniformly distributed throughout the Organization. Only when that culture was fully in place would it be possible to impose accountability, and apply a policy of rewards and sanctions which was currently being developed with the countries and regions.

With regard to the involvement of the International Civil Service Commission in human resources policy-making, it was true that the Organization felt somewhat isolated and neglected, with decisions all being taken in New York, and the needs of the outlying specialized agencies not apparently being taken seriously. WHO was working with the United Nations system on performance management, classification, organizational design and policies for streamlining and implementation. However, with more support and guidance from Member States, WHO could be more effective in shaping the agenda and improving policies.

Mr CHATELUS (France) stressed his country's readiness to help the Organization in any way possible in its dealings with the United Nations Secretariat, in particular through a dialogue in which the Members States could participate. Human resources issues and questions of contract types were crucial for WHO, in the context of its search for a more balanced funding model and above all for a staffing model that would both be in harmony with the Organization's mission and allow the staff to be fully associated with the universally supported reform of the United Nations system.

Ms ALTMAIER (Human Resources Management) replied that it was in the Organization's interest to have as much information exchange as possible. She welcomed such exchanges, and would be organizing round-table meetings in order to share information with all Member States. As part of the Organization's reform, a task force would be established comprising staff from the regions and headquarters to review all the Staff Rules and, by January, to come up with a comprehensive package of what needed to be changed in the light of the revised staffing model to be presented. That process would require dialogue and exchange with all Member States.

The Committee noted the report.

Report of the International Civil Service Commission: Item 18.2 of the Agenda (Document A64/37)

The Committee noted the report.

Amendments to the Staff Regulations and Staff Rules: Item 18.3 of the Agenda (Documents A64/38 and EB128/2011/REC/1, resolution EB128.R5)

The CHAIRMAN invited the Committee to consider the draft resolution recommended by the Executive Board in resolution EB128.R5.

The draft resolution was approved.¹

Report of the United Nations Joint Staff Pension Board: Item 18.4 of the Agenda (Document A64/39)

The Committee noted the report.

Appointment of representatives to the WHO Staff Pension Committee: Item 18.5 of the Agenda (Document A64/40)

The CHAIRMAN proposed the nomination of Dr Ebenezer Appiah-Denkira (Ghana) as a member and Mrs Palanitina Tupuimatagi Toelupe (Samoa) as an alternate member of the WHO Staff Pension Committee for a three-year term until May 2014.

Dr DAHN (Liberia), speaking on behalf of the Member States of the African Region, supported that proposal.

The CHAIRMAN proposed the nomination of Dr Viroj Tangcharoensathien (Thailand) as a member of the WHO Staff Pension Committee to complete the remainder of the term of office of Dr A.A. Yoosuf (Maldives), namely until May 2013.

Mr PRASAD (India), speaking on behalf of the Member States of the WHO South-East Asia Region, supported that proposal.

It was so decided.²

Interim progress report of the Working Group on the Election of the Director-General of the World Health Organization: Item 18.6 of the Agenda (Document A64/41)

Ms QUACOE (Côte d'Ivoire) speaking on behalf of the Member States of the African Region, observed that the agenda item concerning the election of the Director-General raised issues of improving the procedures for doing so. The matter had been under examination since 2006, and was one of considerable importance for the African Region.

Since the creation of WHO, its Directors-General had come only from three of its six regions. With a view to ensuring equality of opportunity to all the regions, the countries of the African Region requested that the World Health Assembly incorporate the principle of balanced geographical representation into the criteria for nominations to the post of Director-General set forth in resolution EB97.R10. Improving the rules for selecting the Director-General would involve increasing the participation of all Member States in the process and enhancing the role of the World Health Assembly by proposing more than one candidate for its consideration. There was also a need to define more objective selection criteria in the interests of transparency, given that certain of the criteria contained in resolution EB97.R10, such as "sensitiveness to cultural, social and political differences" or "a strong commitment to the work of WHO" seemed difficult to measure.

Ms BLACKWOOD (United States of America) expressed appreciation for the constructive spirit shown by the members of the working group at its first meeting. The United States welcomed the challenge by the chair of the working group, to both sides, to take the discussion beyond its past boundaries in a spirit of flexibility and openness. The efforts of the working group had to lead to

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA64.25.

² Decision WHA64(8).

durable solutions that would strengthen the Organization. The role of the Director-General, whether in overseeing response to pandemic outbreak, promoting best practices among Member States, or managing a global organization, had never been more crucial to all of WHO's Member States.

The Committee noted the report.

3. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS: Item 19 of the Agenda (Document A64/42)

Mr QUINTANILLA (Cuba) drew attention to the Organization's collaboration with the United Nations in the preparation, in particular, of the High-level Plenary Meeting of the General Assembly on the Millennium Development Goals, of September 2010, and the forthcoming high-level meeting on the prevention and control of noncommunicable diseases, to be held in September 2011.

Despite such successful collaboration, however, much remained to be done. The United Nations system's operational activities for development must be universal, voluntary, neutral and multilateral, responding flexibly to the development needs of the countries in which they were carried out. They must be implemented for the benefit of the recipient countries, at their request and in line with their development policies and priorities.

Ms CHAVANICHKUL (Thailand) commented that the report seemed to be a "business-as-usual" type of document, which merely outlined the collaborative process between WHO and other agencies and organizations but failed to highlight the benefits and challenges of those various collaborations, especially the implications for health of the United Nations reform agenda. She hoped that the Secretariat would be able to provide a more analytical report, one that would include mechanisms for efficient business operations among United Nations and other intergovernmental agencies.

Ms DJANGANI (Equatorial Guinea), speaking on behalf of the Member States of the African Group, said that 18 countries in the African Region had received joint technical assistance from United Nations bodies, which had enabled them, inter alia, to prepare medium-term expenditure frameworks, mobilize donors and draw up health plans. Within that framework, the WHO Regional Office for Africa was working with the African Union in various areas of common interest, including implementation of the Africa Health Strategy 2007–2015, prevention and treatment of HIV/AIDS, preparation and administration of traditional medicines and reduction of maternal mortality.

Despite such positive undertakings, challenges remained. They included the high transaction costs of collaborative efforts, the need for harmonization of working methods, the differing areas of competency and different programmes of the various organizations involved, the search for new sources of funding in emerging countries, the fragmentary nature of development assistance at national level and the major efforts that would be needed nationally and internationally to achieve the Millennium Development Goals by the target date of 2015.

Mr CHATELUS (France) considered that in the present period of reform and transition, it was no great drawback that the report was not very detailed and might be considered a "business-as-usual" document. The matter of collaboration within the United Nations system was key to WHO's reform and its future financing system. It should therefore be developed further and incorporated into all aspects of the reform process, for which it would act as a key indicator.

Dr MANSOOR (Iraq) said that the report should be more detailed, in its description both of collaborative efforts and of the outcomes that such efforts were intended to achieve. He stressed the need for coordination among the different organizations of the United Nations system and for

harmonization of plans and programmes. A framework for coordination among the regional offices should be established, and national resources needed to be developed to further cooperation among the various organizations.

Mr SAMIEI (International Atomic Energy Agency) said that the Agency was pleased to be a partner in the WHO-IAEA Joint Programme on Cancer Control established in March 2009. Nuclear and radiation techniques were often the sole means of diagnosing and treating many diseases, especially cancers and heart diseases. The Agency had more than 40 years of field experience in assisting Member States to develop the use of radiation techniques for health and medicine. Capacity-building and training provided by the Agency had enabled some 115 low- and middle-income Member States to establish basic nuclear medicine clinics to provide radiation therapy to at least a portion of their cancer patients. However, existing resources were much too small to address the enormous and growing needs in such countries, which had led the Agency in 2005 to launch its Programme of Action for Cancer Therapy (PACT), which targeted developing countries and in which WHO was a key partner. A joint IAEA/WHO programme, launched in 2008, was aimed at assessing cancer control infrastructures and developing national cancer control plans in low- and middle-income countries.

The IAEA and WHO had also initiated several joint country projects on cancer control to demonstrate the synergies that could be achieved by international and national partners in cancer capacity-building. The IAEA was honoured to have contributed its expertise to WHO's global efforts against cancer.

Dr WORNING (Executive Director, Office of the Director-General) took note of the wish of Member States to have a more detailed report and of the suggestion that collaboration within the United Nations system and with other intergovernmental organizations should become an integral part of the broad reform agenda proposed by the Director-General.

Harmonization of efforts, alignment with national priorities, and national ownership were key features of the Organization's intervention strategy at country level and she hoped the strategy would ensure that the health priorities of all the countries concerned were recognized and supported within the United Nations system as a whole.

The increasing prominence of health matters in the debates within the United Nations General Assembly represented an enormous opportunity, but had also necessitated some changes in WHO's way of working. For example, headquarters and the regional offices had needed to devise a seamless methodology to draw as much attention as possible to the topic of noncommunicable diseases.

The Committee noted the report.

4. INTERNATIONAL AGENCY FOR RESEARCH ON CANCER: AMENDMENTS TO STATUTE: Item 20 of the Agenda (Document A64/43)

The CHAIRMAN invited the Committee to consider the draft resolution in document A64/43.

The draft resolution was approved.¹

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA64.26.

5. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)**Infant and young child nutrition: implementation plan:** Item 13.13 of the Agenda (Document A64/22)

Dr RUBERU (Sri Lanka), speaking on behalf of the Member States of the WHO South-East Asia Region, observed that the Region accounted for over 70% of the world's malnourished children. The rate of exclusive breastfeeding up to the age of six months varied widely from country to country, but averaged out at no more than 25%. All the countries in the Region had adopted the global strategy for infant and young child feeding, although to differing extents, and funding was often a constraint on implementation. Application of the International Code of Marketing of Breast-milk Substitutes needed to be strengthened in most of the countries, which would entail training of health staff and enforcement of legislation.

The countries of the Region were tackling the question of infant and young child nutrition with a common approach. The four main areas of attention were low birth weight, reduction of anaemia prevalence, management of severe acute malnutrition and childhood obesity. In reducing low birth weight, the focus was on adolescent and pre-pregnancy nutrition, and pregnancy weight gain was used as an indicator. In addition, attention was focused on care for low-birth-weight children.

Fortification of food was one strategy used to combat anaemia, but most fortification was based on wheat flour, which did not meet the needs of the large number of countries of the Region where the staple food was rice. Rice fortification needed to be given priority, or else suitable alternative foods needed to be found for each country. In the area of complementary feeding, the countries promoted therapeutic feeding using indigenous, locally available and culturally acceptable foods, rather than ready-to-use therapeutic foods, wherever possible.

Management of severe acute malnutrition was centred on community-based programmes that also included developing locally produced therapeutic foods. Recent surveys had revealed the rapidly increasing prevalence of child obesity. To raise the profile of that health problem at the global level, the countries of the Region urged Member States, and requested the Director-General, to collaborate in initiating a global programme to tackle obesity.

Mr PRASAD (India) said that the Government of India had consistently promoted exclusive breastfeeding for the first six months and introduction of complementary foods thereafter, with continued breastfeeding up to two years. National guidelines on infant and young child feeding had been prepared to foster that approach. In 2004 the Indian Government had revised its legislation to extend the age of exclusive breastfeeding to six months and to place infant foods on a par with infant milk substitutes in the areas of advertising and promotion. India now had one of the strongest laws to protect breastfeeding from commercial influence, with the ultimate aim of eliminating all forms of commercial promotion of complementary foods as being suitable for children under two years of age. Ready-to-use therapeutic foods were not accepted by the Government of India, which instead promoted therapeutic feeding with indigenous, locally available and culturally acceptable foods.

Under its strategic plan for child survival, the Government had set a number of goals, the implementation of which was expected to contribute to the achievement of the health-related Millennium Development Goals. The overarching aim was to provide universal access to basic quality care while taking into account the social determinants of health.

Dr AL HAJERI (Bahrain) said that her country was implementing a range of measures to promote maternal, infant and young child nutrition. It had developed guidelines based on the International Code of Marketing of Breast-milk Substitutes, and implemented the global strategy for infant and young child feeding. It was also monitoring iron levels in infants, young children, pregnant women and breastfeeding mothers in order to prevent iron deficiency anaemia. A committee had been established to monitor the marketing of breast-milk substitutes and foods designed specifically for infants and young children, and to ensure compliance with relevant WHO resolutions. In 2010, the

Ministry of Health had launched a programme that used different health indicators to prevent diseases caused by malnutrition among infants, adolescents and breastfeeding mothers.

Professor ARSLAN (Bangladesh) said that the first section of the comprehensive implementation plan might be divided into three subsections: maternal, infant and young child nutritional status; the scope of the nutritional issues to be tackled by governments and development partners; and progress in the implementation of policies to reduce maternal, infant and young child malnutrition. The second section of the implementation plan might set out a universal strategy to implement maternal, infant and young child nutrition policies, which each Member State could adapt in accordance with its nutritional status and concerns. The third section might provide guidelines for the development of action plans for individual countries, setting out objectives, indicators, targets, activities, time frames, and monitoring and evaluation strategies.

Dr WARUNEE PUNPANICH VANDEPITTE (Thailand) urged the Director-General and Member States to support the enactment of new laws and strengthen existing measures to ensure that the marketing of breast-milk substitutes complied with the International Code of Marketing of Breast-milk Substitutes and relevant Health Assembly resolutions. Thailand strongly supported the fifth action contained in the second section of the implementation plan concerning monitoring and evaluation of the implementation of policies and programmes, which should include indicators on adoption and implementation of the Code.

In Thailand, the prevalence of overweight children was rapidly increasing, and a national obesity tracking strategy had been formulated. She hoped that WHO would collaborate with others in launching a global programme to tackle obesity. Iodine deficiency remained problematic, particularly among pregnant women and breastfeeding mothers in impoverished areas, and salt iodization remained a significant technical challenge. WHO must work closely with its partners to make developing countries aware of the importance of universal salt iodization and folate supplementation and to provide them with technical support in those areas.

Ms BLACKWOOD (United States of America) said that the United States supported the recommendations to develop further the issues relating to overnutrition and to increase the references to maternal nutrition in the implementation plan. The plan should also differentiate more clearly between optimal maternal feeding practices and the interventions necessary to promote those practices. More supporting evidence should be provided in the background papers to demonstrate the impact of national nutrition policies, and countries should be advised that the implementation of nutritional interventions would require prioritization and need to be tailored to the national context. The implementation plan should include a section clarifying paragraph 1.4 of resolution WHA63.23, which urged Member States “to end inappropriate promotion of food for infants and young children, and to ensure that nutrition and health claims shall not be permitted for foods for infants and young children, except where specifically provided for in relevant Codex Alimentarius standards or national legislation”. There were few such relevant Codex standards, and many Member States lacked legislation regulating the labelling and use of foods for older infants and young children. The implementation plan provided an opportunity to clarify guidelines on the promotion of foods for infants and young children, in particular concerning complementary feeding between six and 24 months. A reference to foods in national policies, rather than in national legislation, would give governments more flexibility to meet changing public health priorities.

Dr AYDINLI (Turkey) said that the WHO Child Growth Standards were an important tool in reducing malnutrition and helping to control the obesity epidemic. Food safety and nutrition programmes were essential, as was collaboration between civil society and the private sector.

Turkey had achieved considerable success in the area of maternal, infant and young child nutrition, and implemented a number of programmes at the national and regional level including the promotion of breastfeeding and complementary feeding; iron and vitamin D supplementation for

infants and pregnant women; the promotion of iodized salt programmes; ensuring access to and availability of healthier foods, including fruit and vegetables; and the provision of primary education for girls, all of which contributed significantly to reducing obesity.

Ms SHI Qi (China) said that China attached particular importance to maternal, infant and young child nutrition, and had incorporated a number of nutrition indicators in its national plan for economic and social development. It was establishing a number of baby-friendly hospitals and providing folate supplementation for pregnant women and mothers. China would welcome increased international cooperation and the sharing of experience and results in the area of maternal and young child nutrition. It hoped that WHO would continue to play an active role in that field, including by providing financial and technical support and working with Member States to select the strategy best adapted to their national circumstances.

Dr MOMAH (Nigeria) said that, following from her country's firm commitment to address the urgent problem of undernutrition, its strategic plan to ensure optimum feeding of infants and young children, including those with HIV/AIDS, had been mainstreamed into the national strategic health development plan for 2010–2015. Nigeria had enacted into law the International Code of Marketing of Breast-milk Substitutes. It had also adopted the ILO Maternity Protection Convention C183, and legislation was in place to extend maternity leave to 14 weeks. Her country was taking various steps to promote infant and young child nutrition, including building capacity for training infant and young child feeding counsellors; updating the nutrition information surveillance system; producing individual child health record cards incorporating the new WHO Child Growth Standards; and holding a maternal and newborn child health week twice a year.

In 2008, an assessment of infant and young child feeding in Nigeria had been undertaken using WHO tools. Challenges remained, including support for scaling up interventions at every level, inadequate human resources, and low levels of support from partners for nutrition activities. Plans to establish a nutrition council in Nigeria had received attention at the highest level.

Dr DIXON (Jamaica) welcomed the proposed objective of the implementation plan to address the double burden of malnutrition in children from the earliest stages of development. She agreed with the suggested five-year period for short-term assessments and ten-year period for long-term assessments; milestones might however be included to mark progress over shorter time periods.

With regard to the priority interventions, sectoral policies and indicators listed in the appendix to the implementation plan, she said that vitamin A supplementation was not needed in Jamaica as vitamin A deficiency was not prevalent. An additional survey would have to be carried out in order to ascertain the prevalence of anaemia among under-five-year-olds and whether supplementation was indicated. The policy of using salt as a vehicle for iodine and fluoridation might have to be revised in the light of her Government's efforts to reduce the consumption of sodium.

Jamaica recognized the importance of exclusive breastfeeding in the first six months of life and of continued breastfeeding for two years or more. A national breastfeeding week was held every September, the Baby-friendly Hospital Initiative was implemented across the island, and a good network of international agencies and local food industries was in place. However, available data showed that while the majority of mothers were aware of the benefits of breastfeeding, few reported sustained exclusive breastfeeding after the first six weeks of life.

Dr GULLY (Canada) said that Canada welcomed WHO's development of a comprehensive implementation plan for infant and young child nutrition, and supported the recent expansion of its scope to include maternal nutrition. Canada continued to support resolution WHA63.23, which urged Member States to expedite, strengthen and expand implementation of the global strategy for infant and young child feeding, and underscored the need for flexibility to meet the unique needs and circumstances of each Member State in that regard. Canada also supported the International Code of

Marketing of Breast-milk Substitutes, which should be adapted by countries to suit their specific political, economic and social conditions.

Canada was concerned about the fiscal vulnerability of WHO's Department of Nutrition for Health and Development. The equivalent of 1% of the total budget for the biennium had been allocated to strategic objective 9 (To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development), and Canada wondered whether that amount would be sufficient to meet the existing requirements of the Department as well as the activities included in the implementation plan.

Dr MANSOOR (Iraq), speaking on behalf of the Member States of the WHO Eastern Mediterranean Region, expressed support for the Director General's efforts in the area of maternal, infant and young child nutrition. Statistics published by UNICEF showed that some 30% of under-five-year-olds in the Region, in particular in heavily populated areas, suffered from poor growth as a result of malnutrition. The situation had deteriorated further in a number of countries following the global financial crisis. With support from WHO, 17 countries from the Region had so far implemented relevant international standards and strategies, and he hoped all other countries of the Region would have done so by the end of the year. The global strategy for infant and young child feeding formed the basis for nutrition efforts in his own country.

Efforts to promote maternal, infant and young child nutrition in the Region, although essential, were limited and should be evaluated and strengthened. Steps should be taken to strengthen breastfeeding and complementary feeding programmes. Monitoring and follow-up activities should be undertaken, and technical assistance provided to facilitate the implementation of measures to combat undernutrition and malnutrition. Efforts should also be made to establish partnerships with stakeholders from other sectors to facilitate the further development of nutrition programmes.

Dr KOSHY (Malaysia) commended WHO's efforts to develop a comprehensive implementation plan. Her country had succeeded in improving maternal, infant and young child nutrition using a multifaceted approach spearheaded by the Ministry of Health. The National Nutrition Policy of Malaysia and the National Plan of Action for Nutrition of Malaysia for 2006–2015 had provided the strategic framework; implementation of the Baby-friendly Hospital Initiative had also had a positive impact.

Malaysia agreed in principle with the comprehensive implementation plan, which addressed both undernutrition and obesity. Examples of initiatives and interventions should be included in the plan as lessons to be learnt. As some of the proposed interventions might overlap with those under the 2008–2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases, good coordination and careful planning were required at the national level to ensure the optimum use of all available resources.

Dr AILLON (Plurinational State of Bolivia) recalled that the International Code of Marketing of Breast-milk Substitutes had been adopted 30 years earlier in response to the marketing practices of certain international companies which used aggressive publicity campaigns to promote breast-milk substitutes, endangering the health of breastfeeding mothers and infants all over the world. The Latin American region had made much progress in implementing the Code, although the extent varied from country to country. As a result of the zero malnutrition programme in Bolivia, chronic malnutrition had been significantly reduced in less than five years. As part of that programme, mother and baby-friendly hospitals had been established, where breastfeeding support groups had been set up and the promotion of breast-milk substitutes was prohibited. In 2006, Bolivia had enacted legislation intended to encourage exclusive breastfeeding for the first six months of life, extend the breastfeeding period for up to two years, and regulate the promotion, distribution, marketing and sale of breast-milk substitutes. His country would continue its efforts to ensure that the International Code of Marketing of Breast-milk Substitutes was implemented fully.

Dr MPONDA (United Republic of Tanzania), speaking on behalf of the Member States of the WHO African Region, said that vitamin A, iodine and iron deficiencies were major underlying factors in over 50% of the cases of morbidity and mortality among children under five years of age and pregnant women in Africa. Owing to the limited use of exclusive breastfeeding and inappropriate feeding practices, more than 43% of children in Africa suffered from stunted growth and 23% were underweight. Malnutrition in all its forms, which threatened lives, health, growth and development, and was linked to the rise in noncommunicable diseases, was slowing Africa's progress in achieving economic growth and reducing poverty.

The African Region welcomed the decision to include maternal nutrition – a factor critical to both maternal and child survival – in the implementation plan and suggested that it should also include a focus on adolescent girls. The Region was pleased to note that the double burden of malnutrition was being addressed. It welcomed the decision to begin consultations in the African and South-East Asia Regions, where the burden of malnutrition was high, and trusted that, as the plan was developed further, there would be adequate consultation to ensure relevant inputs from countries. The plan should give priority to interventions to strengthen breastfeeding, including implementation of the International Code of Marketing of Breast-milk Substitutes. It should also provide guidance on strengthening growth monitoring, using the new WHO Growth Standards, and on improving the management of severe acute malnutrition at health centre and community levels.

The African Region welcomed the fact that one of the five actions envisaged under the plan concerned the provision of sufficient human resources. The plan should also include cost-effective approaches to improving the skills and knowledge of service providers and other frontline workers involved in maternal, young child and infant nutrition. The Region welcomed the inclusion in the plan of non-health interventions that had an impact on nutrition. The plan should provide specific guidance to Member States on strengthening multisectoral coordination and implementation, which remained a challenge in many countries of the Region. The African Region was grateful for all the assistance it had received in support of its efforts to improve the well-being of women and children.

Ms CREELMAN (Australia) outlined some of Australia's recent achievements in the area of maternal, infant and young child nutrition, including the agreement reached by health ministers on the Australian national breastfeeding strategy 2010–2015 and the establishment of a national breastfeeding committee composed of senior government officials. Among the items on Australia's current agenda were: reporting on a 2010 national infant feeding survey, finalizing a set of core national breastfeeding indicators, revising infant feeding guidelines, and reviewing its response to the International Code of Marketing of Breast-milk Substitutes.

It was important that the implementation plan met international development needs while taking into account the different contexts that existed in various countries. Australia would welcome more information on the time frames and procedures for developing and finalizing the background papers and implementation plan, and on their relation to a global multisectoral nutrition framework. It also sought clarification on the timing and coordination of the proposed regional and national stakeholder consultations.

Mr GARCIA DE ZUÑIGA (Paraguay) welcomed the holistic approach being taken with respect to nutrition, and noted that an intersectoral approach involving civil society was also important to ensure success. Precise indicators for monitoring the implementation of policies, plans and programmes were needed in order to measure impact and ensure that the substantial investment of financial and human resources was justified. It would be useful to develop measurement indices and health interventions for women of reproductive age, so that nutritional deficits, low weight or anaemia could be detected and prevented before pregnancy when such interventions would be the most effective.

If further progress was to be made in the area of nutrition, steps had to be taken to improve information generation and monitoring, empower local human resources and implement basic strategies such as the promotion of breastfeeding. The main challenge was to ensure that nutrition was

regarded as an inalienable right that encompassed not only the provision of foodstuffs but also the establishment of basic conditions that enabled all human beings to realize their potential from the very beginning of life.

Dr AL HAMAD (Kuwait) said that the implementation plan must be sufficiently flexible to respond to the cultural, political and social context of each country. A mechanism should be devised to monitor the implementation of the plan in all countries.

Dr BOKENGE (Democratic Republic of the Congo) said his country shared the Organization's concerns about the continuing decline in the resources available to the developing countries, and sub-Saharan Africa in particular, for tackling problems linked to nutrition, including vitamin A and iron deficiency, obesity, diabetes and cardiovascular disease. He called on WHO to intensify its efforts to mobilize funds and promote local foods, and urged it to appoint a nutrition counsellor in its regional offices.

Mr LAHLOU (Morocco) said that malnutrition could have an adverse impact on a country's economic and social development. The causes of malnutrition should be identified and the quality of services enhanced, including obesity prevention.

The Moroccan Government had developed a strategy for 2012–2019 to improve the health of its citizens. The strategy was consistent with the content of the implementation plan and sought, *inter alia*, to encourage breastfeeding, promote the marketing of good quality and healthy products, and increase awareness of the importance of nutrition.

Dr KAZIHISE (Burundi) said that his Government attached great significance to maternal, infant and young child nutrition and was implementing a programme to combat malnutrition, which was a reality for many people in Burundi. With heightened awareness and a commitment to tackle the issue of nutrition at the global level, more tangible and rapid results could surely be achieved. He welcomed the support provided to his country by its financial and technical partners.

Dr MINAROO (Indonesia) said that, in accordance with its national development plan, Indonesia had launched a food nutrition action plan every five years. The plan addressed five areas, namely ensuring sustainable access to food; infant and young child feeding; food safety; healthy lifestyles; and capacity building, and was used to guide the development of nutrition programmes. In line with the WHO Child Growth Standards, Indonesia had enacted health legislation in 2009 that promoted exclusive breastfeeding for the first six months. It was also undertaking various priority activities, including integrated counselling on breastfeeding, complementary feeding and growth, and case management of severe acute malnutrition. Reductions in the prevalence of vitamin A deficiency, iron deficiency anaemia and iodine disease disorders confirmed that the nutritional status of infants and young children in Indonesia continued to improve.

Dr Shin-Lan KOONG (Chinese Taipei), welcomed the preparatory process used in the development of the comprehensive implementation plan. Chinese Taipei welcomed in particular the inclusion in the plan of actions aimed at establishing a supportive environment and fostering the implementation of non-health interventions. Breastfeeding rates had increased in Chinese Taipei following the introduction of the Baby-friendly Hospital Initiative. However, obesity was a growing problem. To tackle it, legislation relating to the content of television, radio and satellite broadcasting had recently been amended and a law was being drafted that would place restrictions on the advertising of foods linked to obesity and hypertension. She hoped that statutory regulations on the marketing of foods, non-alcoholic beverages and breast-milk substitutes would be established in her country in the near future.

Ms ARENDT (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN, welcomed the fact that the implementation plan would also address maternal nutrition, which was intrinsically linked to the health of mother and child. The plan raised one concern: a focus on nutrition might result in less attention being paid to breastfeeding and maternity protection. The positive impact on health and poverty reduction of interventions related to improved early, exclusive and continued breastfeeding, as well as their cost-effectiveness, had been repeatedly underscored in medical journals. Moreover, the effects of breastfeeding on child survival, growth, health and development were not limited to settings where resources were scarce.

The many resolutions on infant and young child nutrition passed by the Health Assembly over the past 30 years provided clear guidance with respect to the basic elements of the implementation plan, which should include the International Code of Marketing of Breast-milk Substitutes, the Baby-friendly Hospital Initiative, complementary feeding after six months and training of health professionals. The rules concerning the obligations and responsibilities of commercial enterprises, as set out in the global strategy for infant and young child feeding, should be applied during consultations on the implementation plan.

She sought reassurance from the Secretariat that the biennial reporting on the global strategy for infant and young child feeding, the Baby-friendly Hospital Initiative and the International Code of Marketing of Breast-milk Substitutes would be maintained.

Ms ALLAIN (Consumers International), speaking at the invitation of the CHAIRMAN, commended the Secretariat's work on the implementation plan. However, as a result of the shift in focus towards nutrition in general, the importance of protection, promotion and support for breastfeeding and complementary feeding might be minimized. It was vital that the plan be developed within the framework of human rights, social justice and the principles of the Alma-Ata Declaration.

Although important progress in achieving optimal infant and young child feeding had been made over the past 30 years, much remained to be done. For example, the International Code on the Marketing of Breast-milk Substitutes had yet to be implemented fully: only 33 countries had enacted all of its provisions into law, and some 500 violations by 22 companies in 46 countries had recently been reported.

The participation of industry in regional and national consultations on the implementation plan was a matter of great concern as no provision appeared to have been made for managing conflicts of interest. The effectiveness of recommendations for policy and programme implementation would be compromised at all levels if the role of industry was expanded to include policy setting.

Ms GIULIANI (Churches' Action for Health), speaking at the invitation of the CHAIRMAN and on behalf of the People's Health Movement, said that both undernutrition and obesity were linked to the increasing dependence of poor countries on high-income countries for food security. Nutrition strategies should therefore address the complex socioeconomic and political determinants of malnutrition, and governments and international bodies like WHO must advocate regulation of the trade and marketing of unhealthy foodstuffs to protect consumers against aggressive corporate influence.

It was alarming that WHO had shifted its focus to nutrition in general, to the detriment of breastfeeding and complementary feeding. Breastfeeding was a major safeguard against early childhood malnutrition and should be protected, promoted and supported as part of comprehensive primary health care. Reports of ongoing violations of the International Code of Marketing of Breast-milk Substitutes made it clear that much remained to be done to protect breastfeeding.

In order to prevent inadequate nutrition in early childhood, regulations controlling marketing practices should be strictly enforced, particularly in schools. Binding regulations were crucial, as voluntary agreements by corporations were inadequate and often disregarded, particularly in the South.

The plan to allow industry to participate in the development of the implementation plan, in the absence of any guidance on the prevention and management of conflicts of interest, was a matter of

concern. Any consultation process should be made transparent through the publication on a web site of all submissions and the clear identification and disclosure of any conflicts of interest.

To make nutritional interventions sustainable in local contexts, the implementation plan must be aligned with primary health-care systems, with strong community participation. Ready-to-use therapeutic foods should be restricted to the treatment of severe acute malnutrition, and local production of such foods should be accelerated and information provided on their basic ingredients.

The definitive elimination of malnutrition in the long-term depended on coherent efforts to tackle its structural determinants. WHO must insist on the fact that food security and sovereignty were essential for good nutrition; the measures taken to promote them must be supported by other sectors and institutions.

Dr COSTEA (International Special Dietary Foods Industries), speaking at the invitation of the CHAIRMAN, said that the active engagement of stakeholders, particularly those in official relations with WHO, was critical to the success of the implementation plan. The International Special Dietary Foods Industries were well positioned to provide expertise on the development of new products delivering nutrient-rich foods for infants and young children and on the deployment of products in accordance with national and international guidelines, and to offer educational support to families on appropriate complementary feeding practices.

Inappropriate complementary feeding remained a challenge. Country data showed that even where breastfeeding rates had improved, stunting and wasting at two years of age remained a problem, and that after six months of age, children were at increased risk of malnutrition because of suboptimal feeding practices and the fact that complementary foods did not always fully meet their nutritional needs. Positive nutrition and health outcomes for infants and young children could be achieved by incorporating evidence-based policies on complementary feeding in the implementation plan. She recommended that consideration be given to providing nutrition counselling to all women during pregnancy and lactation.

Dr ALWAN (Assistant Director-General) said that he had taken note of the comments of the delegate of Thailand regarding the need to accord greater priority to strengthening the implementation of the International Code of Marketing of Breast-milk Substitutes and to achieve universal iodization. Efforts to monitor overweight and obesity trends at the global level were considered a priority within WHO's programmes on nutrition and noncommunicable diseases. The Global status report on noncommunicable diseases 2010 contained specific estimates of overweight and obesity for the 193 Member States of WHO, which would serve as the baseline for future monitoring of overweight and obesity and other noncommunicable disease trends.

Noting that several Member States had called for the scaling up of technical support to countries, he pointed out that technical collaboration was a key strategic direction under WHO's nutrition programmes.

Responding to the comment from the delegate of Australia regarding the time frame and process for development of the implementation plan, he said that working papers had already been drafted and had been posted on the WHO web site. A draft of the comprehensive implementation plan would be prepared by August 2011, circulated to members for comment in September, and submitted to the Executive Board for consideration in January 2012. A regional consultation had already taken place in Harare and consultations would be held in Burkina Faso in July and Sri Lanka in August. Consideration was also being given to holding a regional consultation in the Region of the Americas.

Replying to the question from Canada regarding the budgetary allocation, he said that the approved programme budget for 2012–2013 contained the possibility of scaling up the resources for strategic objective 9 by 23% as compared to expenditure in the 2008–2009 biennium. Action was being taken to restructure the Department of Nutrition for Health and Development and to strengthen coordination between headquarters and country and regional offices.

He wished to assure the delegate of the United States that WHO had invested considerable resources in updating the evidence base for nutrition programmes. Several guidelines on

micronutrients had also been recently updated. Additional efforts had been made to define adaptation methodologies to guide Member States in choosing priority interventions.

Turning to the comments from civil society, he said that WHO would continue to apply the guidelines concerning interaction with commercial enterprises during the consultations on the implementation plan and in other areas of work. Biennial reporting on the global strategy for infant and young child feeding and the International Code on the Marketing of Breast-milk Substitutes would continue.

He thanked Member States for their guidance and excellent input, which would assist in the finalization of the implementation plan, and looked forward to receiving further comments on the plan later in the year.

Dr Golem took the Chair.

The Committee noted the report.

The meeting rose at 12:45.

FIFTH MEETING

Friday, 20 May 2011, at 15:05

Chairman: Dr A.-Z. GOLEM (Croatia)

later: Dr M.T. VALENZUELA (Chile)

1. STAFFING MATTERS: Item 18 of the Agenda (continued)

Interim progress report of the Working Group on the election of the Director-General of the World Health Organization: Item 18.6 of the Agenda (Document A64/41) (continued from the fourth meeting, section 2)

Mr JAZAÏRY (Algeria) said that the current procedure for electing the Director-General theoretically allowed Member States to nominate for consideration by the Executive Board one or more qualified candidates for the post. However, in practice, the system was less straightforward. In fact, during the Organization's 63 years of existence, only three of the six regions had nominated successful candidates. The current rules needed to be made more transparent and equitable in order to ensure that all WHO's regions were adequately represented. Certainly, candidates must be competent and of a high calibre, according to the criteria set out in resolution EB97.R10, and the relevant provisions must be upheld of paragraph 3 of Article 101 of the Charter of the United Nations, which referred to the importance of recruiting staff on as wide a geographical basis as possible. Limiting recruitment of Directors-General to half the regions represented, however, hardly met that criterion. As a specialized agency of the United Nations system, WHO was bound to comply with the Charter. Moreover, paragraph 1 of Article XII of the Agreement between the United Nations and WHO stipulated that they should develop as far as practicable common personnel standards. The criteria of competence, expertise and experience should not then override the principle of equitable geographical representation.

Greater involvement by the Health Assembly in the nomination of the Director-General would make the selection process more democratic and transparent. The Board was presently responsible for nominating candidates, but, because of its limited membership, it was not in a position to reflect the views of all Member States. It was time for the system to change: the Health Assembly should be empowered to nominate the Director-General itself, on the basis of a list presented to it by the Board, instead of merely "rubber-stamping" the Board's candidate.

He had welcomed the Board's decision in resolution EB128.R14 to establish a working group on the process and methods of the election of the Director-General, as it showed that Member States were committed to improving the current situation. The Working Group had held its first meeting in April 2011, in a spirit of cooperation that contrasted with previous discussions on the subject. It was to be hoped that the next meeting, to be held in October 2011, would produce recommendations for submission to the Board at its 130th session.

He trusted that Member States would avoid becoming embroiled in the political considerations that had led to a vote on a similar draft resolution at the Sixty-third World Health Assembly,¹ and he urged them to redouble their efforts to reach a consensus based solely on practical considerations and equity

¹ Document WHA63/2010/REC/3, summary record of the first (section 6), third, fifth, sixth and seventh meetings of Committee B.

The CHAIRMAN said that that statement had been noted.

2. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued)

Child injury prevention: Item 13.14 of the Agenda (Documents A64/23 and EB128/2011/REC/1, resolution EB129.R15)

Dr MOHAMED (representative of the Executive Board) said that the Executive Board, at its 128th session, had considered a report and a draft resolution on child injury prevention. He summarized the Board's discussion and proposed amendments that had led to the adoption of resolution EB128.R15, which recommended the Health Assembly to adopt the draft resolution contained therein.

Dr AL HAJERI (Bahrain), speaking on behalf of the Member States of the Eastern Mediterranean Region, expressed appreciation for WHO's work on a strategy on child injury prevention and endorsed the recommendations contained in the joint WHO/UNICEF *World report on child injury prevention*, particularly with regard to primary prevention. However, mainly for economic reasons, it was difficult for low- and middle-income countries to implement such a strategy. In the Region, many children living in poverty, who were particularly prone to injury, had limited access to health-care services. WHO had been an active contributor to the United Nations Secretary-General's Study on Violence against Children, which documented the many forms of violence to which children were subjected. It was important to differentiate between intentional and unintentional injuries and to take into account social, cultural and other factors in individual countries.

As child injury prevention involved many sectors of the Organization and other organizations in the United Nations system, intersectoral action was needed. Most interventions to prevent childhood injuries were made in developing countries, and WHO should invest more in capacity building and training at national and subnational levels and encourage countries to strengthen measures to prevent child injury. Such prevention should be mentioned specifically under the relevant Millennium Development Goal and accorded the same level of support as noncommunicable diseases. Measures taken to tackle child injury prevention should also be regularly evaluated. The number of injuries suffered by children under the age of 15 years had to be reduced. The Member States of the Region were committed to giving priority to child injury prevention activities in their health programmes and to allocating the necessary resources for their implementation. She supported the draft resolution and called on other Member States to adopt it.

Mrs MALTA (Brazil) commended the joint WHO/UNICEF *World report on child injury prevention*, but noted the need for recommendations on public policies and programmes and on strengthening health systems in order for the problem to be tackled effectively. Morbidity and mortality profiles for children and young people showed that most causes of child injury were external and therefore were a public health matter that should be dealt with by governments. Most deaths among children and young people were preventable, especially those caused by road traffic injuries which, in her country, were the main cause of death among children, followed by drowning, burns, falls and intoxication. Her Government had passed a law prohibiting drinking and driving that had reduced road traffic deaths and injuries. Legislation had also been enacted to regulate the use of seatbelts and child safety seats, and a mobile pre-hospital emergency system had been set up. Data on accidents and violence were regularly monitored. In addition to the health sector, various other sectors were involved in preventing child injury, including education, transport, law enforcement, environment and agriculture, so a multisectoral approach was needed. Since falls were a major cause of morbidity in children and mainly happened in the home, family-oriented health education and risk

prevention should be promoted. She endorsed the draft resolution and encouraged Member States to adopt it.

Mr BROU (Côte d'Ivoire) pointed out that the increase in child injuries stemmed mainly from a rise in road traffic accidents, a failure to use child-restraint and protection devices, and violence, whether intentional or not. In 2001, a total of 6540 road traffic accidents, 34% involving pedestrians, had been recorded in Côte d'Ivoire, caused, in order of frequency, by: imprudence on the part of pedestrians, driver carelessness, excessive speed, loss of control, dangerous parking and mechanical failure. Therefore, his Government had decided to focus attention on children, within the context of noncommunicable diseases. He thanked WHO for its efforts to step up the campaign to prevent child injury.

Ms WAKEFIELD (United States of America) said that her Government was committed to reducing the burden of child injury and therefore endorsed the report's emphasis on the need to prioritize and fund child injury prevention through appropriate legislative, administrative, social and educational measures. It supported the recommendations for preventing and controlling child injury contained in the report as well as the recommendations and best practices outlined in the joint WHO/UNICEF *World report on child injury prevention*.

Child injury prevention should be integrated into public health and child survival programmes by collecting global data on the burden and cost of injury, and developing and implementing an action plan that included legislation, public education and greater emergency and rehabilitative capacity. There was a need for more investment in programme activities as well as for applied research in low- and middle-income countries where the child injury burden was the greatest. Reliable data were needed as data systems tended to underestimate the burden of injury by including only children who were treated in public health facilities. Injury prevention should be an integral part of countries' child and adolescent health plans. Children's health should be addressed through prevention policies and programmes and through improved trauma response, emergency and hospital care, and rehabilitation. Health ministries could help nongovernmental and research organizations to identify, implement and evaluate prevention programmes that targeted the most common causes of child injury.

She proposed two changes to the draft resolution: in the first line of subparagraph 1(2), the word "commitment" should be replaced by "the fulfilment of their obligations"; and at the beginning of subparagraph 1(6), the word "ensure" should be replaced by "assure".

Dr BOKENGE (Democratic Republic of the Congo), speaking on behalf of the Member States of the African Region, said that, according to international statistics, the burden of child injury was highest in the African Region, where 95% of child deaths due to injury occurred. However, the inadequacy of country-level statistics in the Region partly explained why child injury was not seen as a public health problem and not always included in health policies and programmes. Injuries suffered by children undermined the progress being made towards achieving Millennium Development Goal 4 (Reduce child mortality). To counteract that trend, he recommended three actions. The Secretariat should increase its support to countries to enable them to conduct national studies to identify the magnitude of the problem and determine its underlying causes, and to implement multisectoral policies and programmes that prioritized basic prevention measures. Secondly, Member States should adopt a holistic approach to the prevention of children's health problems, bearing in mind the multisectoral nature of the causes of child injury. Thirdly, the Secretariat should provide Member States with an opportunity to share their experience and knowledge with a view to improving and consolidating national policies on child injury prevention. He encouraged all Member States to support the draft resolution.

Ms SHI Qi (China) said that a survey on the causes of child deaths conducted in China between 2004 and 2005 showed that injury accounted for 42.2% of deaths among children aged between 1 and 4 years, 58.8% of deaths among those aged between 5 and 9 years, and 51.1% of deaths among young

people aged between 15 and 19 years. Her Government recognized that preventing child injury was a shared responsibility requiring multisectoral cooperation. WHO should therefore endeavour to integrate child injury prevention into the public health agenda. Governments and national health departments should provide information on injuries internationally and nationally in order to enhance awareness in schools and among manufacturers of children's products, play area operators, and families. She endorsed the draft resolution.

Dr MANSOOR (Iraq) said that the prevention of child injury, an important factor in improving maternal and child health, should be included among the Millennium Development Goals. It was necessary to engage all stakeholders, including manufacturers of children's products and families, in raising awareness and promoting training, in order to ensure that children grew up in a safe environment. Children should also be taught to recognize danger and avoid injury. A strategy for dealing with emergencies, including administering first aid, should be developed and integrated in the school curriculum, and teachers and parents should be trained to act appropriately and in a timely manner. Children's playgrounds should be made safe and children trained to use playground equipment. The capacity of health-care professionals to diagnose child injuries also needed to be improved.

The prevention of child injury was an important element within the framework of the United Nations Decade of Action for Road Safety (2011–2020) and, with that in mind, he urged Member States to support the draft resolution.

Dr BRENNEN (Bahamas) supported the draft resolution. His Government recognized that deaths among children aged between one and four years contributed disproportionately to child mortality rates and that reducing those deaths was crucial for attaining Millennium Development Goal 4. The population of the Bahamas was small and its social and economic development depended on its young people. The loss of even a small number of that group could have a devastating long-term effect. Attention had been drawn to the issue of child injury prevention through improved public service announcements, lectures, health-care provider education and increased emphasis on enforcing laws on seatbelt and child safety-seat use. However, the WHO/UNICEF *Report on child injury prevention* had made it clear that the incorporation of other evidence-based initiatives for reducing child injury could lead to further programme improvement. The designation of a focal point within health ministries to provide health-sector and intersectoral leadership was of paramount importance. The active involvement of sectors such as education, transport, environment and law enforcement would be essential in defining and meeting country-specific needs and targets for reducing injury. His Government recognized the need for particular improvement in its provision of trauma and emergency care, and welcomed guidance from the Organization in that regard.

Mrs HANJAM SOARES (Timor-Leste), speaking on behalf of the Member States of the South-East Asia Region, said that the WHO/UNICEF *Report on child injury prevention* urged countries to keep children safe by promoting evidence-based injury prevention interventions and sustained investment by all sectors. In the South-East Asia Region, injury was a major cause of death. In 2004, the Region recorded the second highest rate of unintentional child injuries. Road traffic injuries, drowning, burns and self-inflicted injuries were the leading causes of death among children. Despite the efforts of some Member States in the Region, many challenges remained, including the persistent belief that injuries were caused by fate, as well as difficulties in data gathering and programme implementation, limited human and financial resources and inadequate political commitment. Timor-Leste was committed to reducing child mortality and morbidity related to injury. She therefore supported the draft resolution and urged other Member States to do the same.

Dr SAIPIN HATHIRAT (Thailand) said that the WHO/UNICEF *Report on child injury prevention* confirmed that child injury was preventable through better public health and social policies; sustainable commitment; concerted intersectoral and intercountry efforts; citizen

empowerment; and a proactive approach that involved tackling the root causes and determinants of the problem. Children everywhere were being increasingly exposed to risk, including heavy traffic, lack of safe spaces and inadequate child-care facilities. There was also a contradiction between the increasing risk to which children were exposed and the fact that safety products for children, including safety helmets and safety seats, were either unavailable, unaffordable or of poor quality in low- and middle-income countries.

She proposed three amendments to the draft resolution. A new fifth preambular paragraph (bis) should be inserted to read: "Recognizing that the five leading causes of child unintentional injury deaths include road traffic injury, drowning, fire-related burns, falls and poisoning, particularly drowning, which is responsible for about half of total child injury deaths, context-specific preventive measures, including a safe environment, safety products, safety management and awareness raising are crucial". In the fourth line of subparagraph 1(7), the word "transportation" should be inserted between "spaces" and "construction". In line 2 of subparagraph 1(11), the words "as well as all members of society" should be inserted between "groups" and "about". She supported the draft resolution.

Mrs TZIMAS (Germany) said that unintentional injuries could be prevented by effective and simple interventions, including enforcing speed limits, especially near schools, residential areas and play areas; formulating and enforcing laws on drinking and driving; wearing bicycle and motorcycle helmets and using seatbelts; and setting up poison control centres. The prevention of child injuries was a multisectoral issue linked to the principle of health for all. Therefore, injury prevention programmes should be an integral part of children's health strategies. In the event of injury, it was essential that all necessary measures were taken to limit the long-term effects on children and their families. It would be helpful for data on child injury prevention to be collected and made available on the Internet. Additionally, national strategic goals had a positive effect and were well received by the public. For example, her Government had set a target of reducing accidents involving children by 20%.

She supported the draft resolution and called on Member States to take effective measures to prevent child injuries and death.

Mr PRASAD (India) concurred that child injuries were a major public health concern. About 30% of the Indian population was aged under 15 years: a group at high risk for injury. The nature of child injuries varied according to the stage of development; for example, road traffic injuries were common among schoolchildren and adolescents. Many children worked in jobs that exposed them to injury. Socioeconomic disadvantage was closely correlated with child injury, and its prevention was crucial to attaining Millennium Development Goal 4 (Reduce child mortality). Resources allocated to child injury prevention should be commensurate with the breadth of the problem. This was particularly the case in the South-East Asia Region, which would also benefit from the development of appropriate protocols and technical tools. Preventing childhood injuries required multisectoral coordination. The health sector could play a major role in child injury prevention, management and rehabilitation of the injured, and the development of injury prevention and control programmes by taking a number of steps: implementing appropriate emergency and pre-hospital care programmes; conducting trauma audits on the basis of minimum care guidelines; providing health-care delivery systems with adequate physical, technical and human resources; developing cost-effective, culture-specific and sustainable rehabilitation programmes; enhancing the skills of trauma-care professionals; and networking in order to develop an intersectoral approach. He endorsed the draft resolution.

Ms LAWLEY (Canada) said that the draft resolution was in line with her Government's commitment to child injury prevention. The principle of broadening the scope of data collection to include demographic, socioeconomic and economic factors was acceptable, but its practical application would depend on the resources available. The collection of basic injury data might be a more realistic first step in some settings.

She would be able to support the draft resolution with the following minor revision. In subparagraph 2(2), the text after "nongovernmental organizations" should be replaced to read: "to

establish an effective network to ensure effective coordination and implementation of activities for child injury prevention in low- and middle-income countries". The modified text placed emphasis on coordination and implementation of activities, instead of just information sharing. According to the report on the financial and administrative implications of the draft resolution,¹ there were insufficient funds to cover implementation costs fully over the next 10 years. Child injury prevention activities should therefore be prioritized so that some of them could be implemented while additional funding was being sought for those remaining.

Mr LAHLOU (Morocco) outlined the main causes responsible for the high level of child injuries and welcomed the draft resolution on child injury prevention. Any strategy to reduce the number of deaths from such injuries would require a multisectoral and multidisciplinary approach at several levels, including at school and in the home, that also took into account the cultural environment.

To prevent child injuries and limit their consequences, WHO should promote the use of targeted research to expand existing knowledge with regard to interventions, and should assess such interventions in conjunction with its partners. Research outcomes could then be used to generate safe and affordable solutions. Technical assistance should also be provided for training health professionals in child emergency care and rehabilitation, and standards and criteria for those services needed to be defined, especially with regard to human resources.

Professor ARSLAN (Bangladesh) said that child injury was a national tragedy for Bangladesh. His Government was according priority to injury prevention programmes, taking new initiatives and strengthening existing programmes. With technical support from WHO and UNICEF, the Ministry of Health was preparing an injury prevention strategy, and priority was being given to child injury prevention activities in the next five-year health sector programme. Strengthening emergency medical services at national, district and subdistrict levels to improve management of injuries and injury-related disabilities was an existing priority. Bangladesh and other developing countries needed support in quantifying the economic impact of child injuries on families and the country as a whole, so that country-specific programmes could be devised. It was fostering coordination and collaboration among different sectors, including transport, health, law enforcement, education and environment, in order to achieve common injury prevention goals.

In Bangladesh, drowning was the major cause of injury-related mortality in children aged between one and four years. His Government had pioneered the development of simple, cost-effective drowning prevention techniques, and would share its experience and substantial research findings with countries facing similar problems. Burn injuries had also increased, but his country had yet to devise interventions to prevent them. WHO could play a key role in disseminating the experience of countries with successful programmes for preventing burn injuries in order to help other countries to develop similar programmes. More research into cost-effective, sustainable measures to prevent child injury, and increased investment in building institutional and individual capacity were required so that countries could develop appropriate interventions at national and regional level. He welcomed the draft resolution.

Mr JAZAÏRY (Algeria) endorsed the recommendations proposed by the delegate of the Democratic Republic of the Congo, as they would make the draft resolution more effective. He also welcomed the amendments proposed by the delegate of the United States, particularly the proposed amendment to subparagraph 1(2), which emphasized the fulfilment of Member States' obligations under the Convention on the Rights of the Child. He took that emphasis as a sign that the United States, which was the only country in the world not to have ratified the Convention, would do so in the near future.

¹ See document EB128/2011/REC/1, Annex 4.

Mr MANDABA (Central African Republic) said that unintentional injury to children was a major public health problem in his country as it was the main cause of child disability and death. In line with his Government's obligations under the Convention on the Rights of the Child and its commitment to achieving the Millennium Development Goals, child injury prevention had been placed at the centre of all its efforts to reduce child mortality and morbidity rates, including a programme devised by the health ministry to improve children's overall well-being. Despite progress having been made, significant challenges remained, mainly because of the shortage of human and financial resources and biomedical equipment, the absence of prevention programmes and emergency care services, and lax enforcement of child protection laws. Child injury prevention and care programmes needed to be set up, and measures taken to strengthen the health workforce and stem the exodus of health professionals. Technical capacity should be reinforced and the relevant laws rigorously applied, particularly those on child neglect, and drinking and driving. Emphasis should also be placed on helping children avoid injury by changing their behaviour.

He renewed his Government's request to the international community, and the Secretariat in particular, to support his country's efforts to control the scourge of childhood injury.

Dr KOSHY (Malaysia) recognized the need to prevent road traffic injuries, which were the main cause of injury in children aged between 12 and 19 years. Her Government had established a road safety department with a research section, within the Ministry of Transport, and had launched, with full participation of the Ministry of Health, a multisectoral road safety action plan, one priority of which was road safety education in schools. She endorsed the draft resolution.

Ms BENNETT (Australia) urged Member States to take specific measures to reduce injuries to children. Significant advances had been made in her own country through a range of programmes, particularly on water safety and road safety. She endorsed the draft resolution and supported the amendment to subparagraph 2(2) proposed by the delegate of Canada.

Dr SAIPIN HATHIRAT (Thailand) proposed a minor change to the new preambular paragraph it had previously proposed. The fifth preambular paragraph bis should instead read: "Recognizing that the leading causes of child deaths from unintentional injury include road traffic injury, drowning, fire-related burns, falls and poisoning. In some regions of the world drowning is responsible for about half of total child injury deaths, context-specific preventive measures, including a safe environment, safety products, safety management and awareness raising are crucial".

Dr Shin-Lan KOONG (Chinese Taipei) said that in Chinese Taipei the mandatory use of motorcycle helmets and child safety seats together with intersectoral efforts to improve child safety in the home, at school and during leisure hours had proved successful in reducing child injuries, which had dropped from 30 per 100 000 to 11 per 100 000 in the past 10 years. It was important to introduce child injury prevention strategies into existing child health services programmes. Injury prevention training was provided to parents and a household injury prevention checklist and a health education pamphlet had been issued to assist them in creating a safe home environment. Communities and schools were also being helped to reduce potential risks and improve safety.

Sound surveillance systems were vital to devising effective strategies for preventing child injury, and information from various sources, including a survey of adolescent behaviour and a health insurance database, was regularly monitored. Having developed a comprehensive child injury prevention system encompassing regulation, policy, health promotion, and a health-care network, Chinese Taipei would welcome the opportunity to share its experience and skills with Member States. She endorsed the draft resolution.

Dr ALWAN (Assistant Director-General) thanked Member States for their valuable contributions and for endorsing the draft resolution. The recommendations and requests would be taken into account. He looked forward to working closely with Member States in implementing the

draft resolution once it had been adopted. In response to a question from the delegate of India concerning new tools, he said that a document describing successful interventions for preventing burns would be issued that week.

The CHAIRMAN said that the Secretariat would prepare and circulate a revised version of the draft resolution containing all the proposed amendments.

It was so agreed.

(For approval of the draft resolution, see the summary record of the sixth meeting, section 2.)

Strategies for the safe management of drinking-water for human consumption: Item 13.15 of the Agenda (Document A64/24)

The CHAIRMAN drew attention to a draft resolution proposed by the delegations of Andorra, Armenia, Austria, Belgium, Brazil, Colombia, Denmark, Finland, France, Germany, Hungary, Italy, Japan, Monaco, Morocco, Netherlands, Portugal, Senegal, Slovenia, Spain, Switzerland and Yemen, which read:

The Sixty-fourth World Health Assembly,

PP1 Having considered the report on strategies for the safe management of drinking-water for human consumption;¹

PP2 Recalling the Declaration of Alma-Ata on Primary Health Care and the various resolutions stressing the role of improving safe drinking-water, sanitation facilities and hygiene practices in primary health care, environmental health, prevention of waterborne diseases, protection of high risk communities, infant and young child nutrition, including resolutions WHA39.20, WHA42.25, WHA44.28, WHA45.31, WHA35.17, WHA51.28 and WHA63.23, as well as resolutions EB128.R7 and EB128.R6 containing respectively draft resolutions on cholera: mechanisms for control and prevention, and on eradication of dracunculiasis;

PP3 Recalling further target C of Goal 7 (Ensure environmental sustainability) of the Millennium Development Goals, which calls for reducing by half the proportion of the population without sustainable access to safe drinking-water and basic sanitation by 2015, and the importance of this target for the achievement of other Goals, particularly Goals 4 (Reduce child mortality), 5 (Improve maternal health) and 6 (Combat HIV/AIDS, malaria and other diseases);²

PP4 Recognizing that between 1990 and 2008 an estimated 1.77 billion people gained access to improved sources of drinking-water and 1.26 billion gained access to improved sanitation, but deeply concerned that by the end of 2008 884 million people still lacked access to improved water sources and over 2.6 billion people did not have access to improved sanitation;

PP5 Noting the multiple health benefits and economic advantages of a broad public health approach through the expansion of access to safe drinking-water and sanitation, integrating household interventions, a more effective use of resources and the early incorporation of health considerations in the planning and design of water resources development, and recognizing the importance of pursuing these issues for the achievement of strategic objective 8 of the Medium-term strategic plan 2008–2013;

PP6 Recalling the International Decade for Action, “Water for Life” 2005–2015, proclaimed by the United Nations General Assembly in resolution 58/217; the International

¹ Document A64/24.

² See United Nations General Assembly document A/65/L.1.

Year of Sanitation, 2008, declared in resolution 61/192; as well as the follow-up resolution 65/153, calling upon all Member States to support the global effort to realize “Sustainable sanitation: the five-year-drive to 2015”; and also recalling that water quality was the theme of the United Nations World Water Day 2010;

PP7 Recalling further the United Nations General Assembly resolution 64/292, which recognizes the right to safe and clean drinking-water and sanitation as a “human right that is essential for the full enjoyment of life and all human rights” and the Human Rights Council resolution (A/HRC/RES/15/9) affirming that the “human right to safe drinking water and sanitation is derived from the right to an adequate standard of living and inextricably related to the right to the highest attainable standard of physical and mental health, as well as the right to life and human dignity”;

PP8 Noting with interest the efforts made to improve access to safe drinking-water, basic sanitation and to promote good personal and domestic hygiene practices that contribute to a sustainable approach to fight sanitation- and water-related diseases such as cholera and diarrhoea, which claimed the lives of 2.5 million people in 2008, among which 1.3 million children under the age of five;

PP9 Also noting the water, sanitation and hygiene components in the seven-point strategy agreed by WHO and UNICEF for comprehensive diarrhoea control, which include the promotion of hand washing with soap, household water treatment and safe storage and community-wide sanitation promotion;

PP10 Noting that millions of people are exposed to dangerous levels of biological contaminants and chemical pollutants in their drinking-water partly due to inadequate management of urban, industrial or agricultural wastewater;

PP11 Recognizing WHO’s major normative role in issues of water and health, its key role in monitoring progress regarding water supply and sanitation as well as its promotional and capacity-building roles for Water Safety Plans, Sanitation Safety Plans, water and sanitation in health care, schools and other public buildings and settings, and safe management of medical waste;

PP12 Noting that global driving forces, including population growth, urbanization and climate change, are expected to affect significantly the availability and quality of access to water and sanitation services and of freshwater resources and the need for water resources development for other purposes, which in themselves carry potential health risks, and noting that a response to these trends requires an intersectoral approach mainstreaming health and environmental issues in national sectoral policies through integrated water resources management and strengthened institutional arrangements to prevent and reduce the incidence of sanitation- and water-related diseases;

PP13 Noting that over the last decade almost two billion people were victims of natural disasters, including floods and droughts, that act as key contributors to sanitation- and water-related diseases; also recognizing the need, in emergency situations, to develop prevention tools and specific actions for supplying drinking-water and sanitation as well as the leading role of both WHO in the Health cluster and UNICEF in the Nutrition and WASH (Water, Sanitation and Hygiene) clusters in emergency operations,

1. URGES Member States:

- (1) to develop and strengthen, with all stakeholders, national public health strategies, so that they highlight the importance of safe drinking-water, sanitation and hygiene as the basis for primary prevention, based on an integrated approach of sectoral planning processes, policies, programmes and projects regarding water and sanitation, guided by an effective interministerial coordination mechanism at appropriate level, designating clear responsibilities across relevant ministries and institutions;
- (2) to promote new approaches to community education and awareness creation involving actively their leaders and civil society, with a view to having a specific impact,

particularly on women, children, youth, indigenous people and vulnerable and marginalized people, acknowledging and encouraging good practices;

(3) to ensure that national health strategies contribute to the realization of water- and sanitation-related Millennium Development Goals while coming in support to the progressive realization of the human right to water and sanitation that entitles everyone, without discrimination, to water and sanitation that is sufficient, safe, acceptable, physically accessible and affordable for personal and domestic uses;

(4) to strengthen the intersectoral policy frameworks and institutional mechanisms for integrated management of water- and sanitation-related health hazards and risks, including health impact assessment, strategic extension of drinking-water and sanitation systems and services, and environmental management to protect health in water resources and wastewater management projects;

(5) to mobilize their efforts, in consultation with bilateral and multilateral partners and in close coordination with responsible local authorities, to prioritize the reduction of disparities which exist between urban, periurban and rural areas as regards access to drinking-water at home as well as from other improved sources, improved sanitation facilities and hygiene;

(6) to offer appropriate facilities for access to safe drinking-water, sanitation and hand washing with soap in health care establishments, schools and other public buildings and settings, as well as advocacy and training tools on safe water, sanitation and hygiene practices for those who operate and use these establishments;

(7) to improve cooperation between the appropriate authorities and stakeholders, including in transboundary settings, to establish, implement and maintain efficient systems for assessing water quality, regularly communicating relevant, easily accessible information and responding to water quality issues;

(8) to ensure, in particular, the sustainability of comprehensive and harmonized national and/or local water and sanitation-related monitoring systems and early warning tools in order to prevent and control sanitation- and water-related diseases as well as to develop emergency preparedness and action plans, particularly in case of natural disasters and humanitarian emergencies;

(9) to work to strengthen, as necessary, the establishment, implementation and quality control of water safety plans and contribute to the development of sanitation safety plans, in collaboration with the WHO collaborating centres, WHO-hosted networks (drinking-water regulators, operation and maintenance, household water treatment and safe storage, management of small-community water supplies) and associations in official relations with WHO;

2. REQUESTS the Director-General:

(1) to continue calling the attention of the international community and decision-makers to the importance of primary prevention as a key goal, and the major impact of safe drinking-water, sanitation and hygiene on global public health, national economies, and the achievement of the Millennium Development Goals;

(2) to formulate a new, integrated WHO strategy for water, sanitation and health including a specific focus on water quality and monitoring issues, and on promotion of sanitation and hygiene behaviour change taking into account context-specific requirements with a view to encouraging the establishment of preventative measures as well as rapid analysis techniques to guarantee the quality of drinking-water and avoid adverse health impacts of water resources development;

(3) to strengthen WHO's collaboration with all relevant UN-Water members and partners, as well as other relevant organizations promoting access to safe drinking-water, sanitation and hygiene services, so as to set an example of effective intersectoral action in the context of WHO's involvement in the United Nations Delivering as One initiative,

and WHO's cooperation with the United Nations Special Rapporteur on the human right to safe drinking water and sanitation with a view to improving the progressive realization of the human right to water and sanitation;

(4) to strengthen the WHO/UNICEF Joint Monitoring Programme capacities to fulfil its mandate of monitoring progress towards the international drinking-water and sanitation development goals, and to serve as a platform for a generation of new sanitation and water indicators, including water quality and other relevant parameters at appropriate levels;

(5) to continue supporting existing regional initiatives such as the United Nations Economic Commission for Europe's Protocol on Water and Health which is an instrument of reference for safe water management and the protection of human health and encourage the creation of similar instruments dedicated to sustainable water management and reduction of sanitation- and water-related diseases in other regions, as well as continue to encourage relevant regional initiatives such as the WHO/UNEP Libreville Declaration on Health and Environment (2010) or the WHO Parma Declaration on Environment and Health (2010);

(6) to develop, in coordination with bilateral and multilateral partners, Member States' capacities by providing guidelines and technical support to develop, implement, monitor and evaluate national action plans for the sustainable management, operation and maintenance of safe drinking-water supply and sanitation systems and services;

(7) to further support Member States' capacities in building and maintaining adapted information and monitoring systems in order to facilitate the appropriate and streamlined reporting to relevant global monitoring mechanisms including the WHO World Health Statistics, the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation and the UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water;

(8) to increase technical assistance to countries by facilitating training and adult learning programmes for staff in charge of maintaining catchments, treatment and distribution facilities, water and sanitation networks and for staff and laboratories in charge of water quality monitoring, while encouraging the dissemination of best practices for household water treatment, especially where central water treatment or water supplies are deficient or not available;

(9) to promote partnerships for risk reduction in drinking-water installations and safe supply of drinking-water and methods to gather and disseminate the best practices and experiences in increasing access to safe drinking-water, sanitation and personal and domestic hygiene, in particular for the poorest populations, in health emergencies or during natural disasters;

(10) to report on progress in implementing this resolution, through the Executive Board, to the Sixty-sixth World Health Assembly.

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

1. Resolution Drinking-water, sanitation and health	
2. Linkage to programme budget	
Strategic objective:	Organization-wide expected result:
8. To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health.	8.1 Evidence-based assessments made, and norms and standards formulated and updated on major environmental hazards to health (e.g., poor air quality, chemical substances, electromagnetic fields, radon, poor-quality drinking-water and wastewater reuse).

8.2 Technical support and guidance provided to Member States for the implementation of primary prevention interventions that reduce environmental hazards to health, enhance safety and promote public health, including in specific settings (e.g. workplaces, homes or urban settings) and among vulnerable population groups (e.g. children).

8.4 Guidance, tools and initiatives created in order to support the health sector in influencing policies in other sectors to allow policies that improve health, the environment and safety to be identified and adopted.

8.5 Health-sector leadership enhanced for creating a healthier environment and changing policies in all sectors so as to tackle the root causes of environmental threats to health, through means such as responding to emerging and re-emerging consequences of development on environmental health and altered patterns of consumption and production and to the damaging effect of evolving technologies.

(Briefly indicate the linkage with expected results, indicators, targets, baseline)

Drinking-water, sanitation and health issues cut across the Organization-wide expected results for strategic objective 8, particularly 8.1 (risk assessment and management guidelines), 8.2 (primary prevention), 8.4 (intersectoral capacity-building) and 8.5 (monitoring). Strengthened work on the prevention of water- and sanitation-related disease is consistent with the expected results under the strategic objective, and implementation of the resolution would be reflected within the indicators and targets of expected results mentioned above.

3. Budgetary implications

(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).

In addition to the current programme, the estimated cost for the period 2012–2013 is US\$ 3.94 million. The estimated cost per biennium on a continuing basis thereafter is about US\$ 21 million.

(b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).

US\$ 985 000 (25% of US\$ 3.94 million for the last six months of the biennium).

Costs will be incurred at headquarters and at the regional office level in those offices currently lacking advisors who specialize in water, sanitation and health, namely, the regional offices for Africa, the Eastern Mediterranean and the Western Pacific.

(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?

No.

4. Financial implications

How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?

Additional voluntary funds are being sought; a number of parties have indicated interest.

5. Administrative implications

(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant).

Implementation will involve activities at global, regional and country levels. Headquarters will play a coordination and management role and provide guidance and standard-setting, and will support the implementation of activities.

The regional offices will support the work in monitoring, water-safety planning, capacity building and approaches in specific settings.

Projects with a strong country focus will require the involvement of country office staff for satisfactory implementation.

(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.

No.

(c) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile).

The following additional staff will be required: a Monitoring Manager at grade P.5; a Technical Officer at grade P.3 to support UN-Water's Global Analysis and Assessment of Sanitation and Drinking-Water; two Technical Officers at grade P.4, one to deal specifically with wastewater activities, and the other to deal with national health strategies to influence realization of the basic human right to water and sanitation; and three Regional Advisors on water, sanitation and health at grade P.4 (one in each of the regional offices for Africa, the Eastern Mediterranean and the Western Pacific).

(d) Time frames (indicate broad time frames for implementation of activities).

2010–2011. Following a broad consultation on developing a new generation of targets and indicators for post-2015 water and sanitation monitoring, a number of working groups will be activated as of 1 July 2011, with an incremental increase of staff to meet additional work requirements.

2012–2013. The start-up phase and coordination of strategic work should be completed; thereafter implementation of activities will be on a continuing basis.

Mr PELLET (France) said that the draft resolution, largely inspired by the Secretariat's report on the same subject, had been prepared by a working group composed of representatives of Member States from all WHO's regions, namely, Colombia, Hungary, Japan, Morocco, Senegal, Switzerland and Yemen. According to WHO statistics, 884 million people still did not have access to safe drinking-water and 2600 million people lacked basic sanitation. Safe drinking-water and access to basic sanitation were central to achieving Millennium Development Goal 7 (Ensure environmental sustainability), and a necessary condition for achieving Goal 4 (Reduce child mortality), Goal 5 (Improve maternal health) and Goal 6 (Combat HIV/AIDS, malaria and other diseases). Moreover, the right to safe drinking-water and sanitation had been recognized by the United Nations as being necessary for better physical and mental health, two essential components of the right to life and human dignity. The international community had to redouble its efforts to reach the Millennium Development Goals. In particular, the Secretariat needed to give fresh impetus to water-management activities and encourage Member States to do the same.

The draft resolution was the fruit of discussions at both the 127th and 128th sessions of the Executive Board, and broad consultations. Following meetings held in January and April 2011 to which all Member States had been invited, and the dissemination of the draft to stakeholders, many valuable contributions from both Member States and nongovernmental organizations had been integrated into the draft resolution.

The draft resolution set out three main areas of work for WHO, namely governance and the role of health authorities, promotion of operational approaches based on best practices, and primary

prevention. Within that framework, it outlined an integrated strategy for ensuring access to safe drinking-water and improved sanitation; promoting best practices in the area of hygiene; reducing the transmission of waterborne infections; and fostering institutional cooperation and a multidisciplinary approach.

The following Member States also wished to sponsor the draft resolution: Côte d'Ivoire, Norway, Republic of Moldova and Uruguay. All the sponsors wanted the draft resolution to be adopted by consensus as it pursued a commonly shared goal and complemented two other draft resolutions to be considered by the Health Assembly, namely those in resolution EB128.R3 (Cholera: mechanism for control and prevention) and resolution EB128.R6 (Eradication of dracunculiasis). It also formed part of the collective effort to meet the challenges of water management, one important aspect of which would be the Sixth World Water Forum due to be held in Marseille, France on 12–17 March 2012.

Dr Valenzuela took the Chair.

Dr DANKOKO (Senegal), speaking on behalf of the Member States of the African Region, said that improving access to safe drinking-water was a top priority for the African Region as the lack of that access was central to most public health problems. Many deaths among poor people in shanty towns and rural areas were caused by a lack of safe drinking-water. Inadequate or non-existent sanitation, combined with the lack of safe drinking-water, was frequently the cause of lethal epidemics, including major cholera outbreaks, that devastated people's lives. In sub-Saharan Africa, an average of 60% of the population had had access to improved drinking-water in 2008, but safe drinking-water coverage was not keeping pace with rapid demographic growth and urbanization. In many countries the conditions in which water was transported and stored reduced its quality.

Some countries in the Region had made progress, notably in implementing programmes that had increased access to safe drinking-water in urban areas. Governments in the Region were strongly committed to improving the quality of drinking-water and sanitation. Three countries had implemented safe drinking-water programmes, and four had adopted health frameworks to deal with health and environment problems.

The African Region was committed to evaluating national health and environmental priorities, in particular with reference to safe drinking-water. It was also collaborating with the International Network of Drinking-water Regulators to help countries to regulate the quality of drinking-water. It appreciated WHO's work on developing and field testing technologies for hand washing, household water treatment and safe water storage, and the Organization's support under the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation.

Limited access to safe drinking-water was an obstacle to reducing poverty, hunger and infant mortality, improving maternal health and controlling illness. A multisectoral approach to drinking-water, under the leadership of health ministers, was therefore indispensable and he called on the international community to support African governments in their efforts to that end.

He urged Member States to support the draft resolution.

Dr SAKAMOTO (Japan) said that it was a matter for regret that many people were still obliged to drink unsafe water, given its association with disease and poverty. Her country had been contributing its knowledge and technology to efforts to improve water quality and sanitation, in particular by promoting broad partnerships and through its work in the African Region, and was committed to advocating for that issue in international forums.

Water resources fit for human usage were scarce, a problem that was set to grow in importance owing to population growth, increases in food production, economic growth, urbanization, improvements in standards of living, and climate change. Discussion of the present resolution was likely to raise awareness of the scale of the problem.

The Secretariat had been advising Member States on water-quality management through its guidelines for drinking-water quality, based on the latest scientific advances in risk assessment and

management. It should give consideration to drawing up a new water-quality strategy, covering drinking-water, wastewater and recreation, and should regularly update its guidelines.

Mr AL KEHALY (Yemen), endorsing the statement by the delegate of France, noted that 60% of the population in most third world countries did not have access to drinking-water owing to severe shortages. Poor-quality drinking-water had been responsible for a widespread outbreak of diarrhoea in Yemen a few years previously. In response to an appeal from the country's health ministry, WHO had agreed to meet the affected population's basic development needs and a US\$ 10 000 plan had been implemented to sanitize, provide drinking-water to, and construct water-storage cisterns in seven regions.

He called on the Secretariat to support and encourage efforts to identify health determinants. He endorsed the draft resolution, and urged other Member States to do so.

Mr ROSALES LOZADA (Plurinational State of Bolivia) placed the utmost importance on drinking-water, sanitation and health. The "water war" of February 2000, in which Bolivian villagers had combated a water privatization plan, had sparked a series of actions demonstrating the importance of access to water, for the well-being of the population as well as for human life. His country, for example, had sponsored resolution 64/292, adopted in August 2010 by the United Nations General Assembly, which recognized access to water and sanitation as human rights. The right to water, which was an essential right on its own, and the right to health were mutually complementary and intrinsically linked. He welcomed the draft resolution, which not only reinforced that link but also gave timely impetus to WHO's activities in that area.

He proposed that, in the seventh preambular paragraph, only the reference to the United Nations General Assembly resolution be kept, as it was contradictory to refer to the rights to water and sanitation both as rights in themselves and as derived rights. In subparagraph 1(2), the word "marginalized", which was unclear, should be replaced by "the poorest". In subparagraphs 1(3) and 2(3), "progressive" should be deleted. He expressed the hope that those amendments, and the draft resolution as a whole, would be accepted by consensus.

Ms HELFER-VOGEL (Colombia) said that lack of access to water, sanitation and hygiene negatively affected people's health, safety, means of subsistence and quality of life. Despite the progress made, suggested by the significant increase in access to improved sources of drinking-water, millions still lacked access to such sources and to basic sanitation. Guaranteeing water and sanitation for all remained a global priority.

In her country, the ministries of social protection and the environment were working together on a public health policy that emphasized the importance of water quality. Nevertheless, much remained to be done to ensure the provision of drinking-water in remote, rural areas, and national environmental sanitation coverage.

An integrated approach to water, sanitation and hygiene would ensure that all countries met the Millennium Development Goals. Mortality and disease rates could be reduced by ensuring access to drinking-water and by fostering healthy environments in homes, schools, and workplaces. Ensuring access for all to drinking-water, basic sanitation and a healthy environment would help to improve quality of life, promote development and reduce costs related to pollution, environmental damage and illness. The availability of sufficient, safe and accessible drinking-water should be part of development plans and remain on the international agenda. She endorsed the draft resolution and expressed the hope that it would be approved by consensus.

Mr BROU (Côte d'Ivoire) affirmed the relevance of the Secretariat's report for the development of national policies on integrated management of water resources and environmental health. Implementation of the strategies put forward in the report would not only reduce the burden of sanitation- and water-related morbidity and mortality, but would also improve the well-being of people within the framework of sustainable development.

Mr TOSCANO VELASCO (Mexico) supported the draft resolution as his Government regarded the right to drinking-water and sanitation as fundamental for all countries. Mexico recognized access to drinking-water and sanitation as part of the human right to an adequate standard of living and the right to the enjoyment of the highest attainable standard of physical and mental health, as set forth in Article 25 of the Universal Declaration of Human Rights and Articles 11 and 12 of the International Covenant on Economic, Social and Cultural Rights. It interpreted subparagraph 1(3) of the draft resolution in that light.

Mexico would continue making all necessary efforts to adopt progressive measures, up to the limits of its available resources, to supply drinking-water and sanitation, as stipulated in its national legislation, to that part of its population that did not yet enjoy such services, in fulfilment of its international obligations and in line with the requirements of the Millennium Development Goals. The Constitution regulated ownership of the land and water lying within the limits of the national territory. His Government considered that equitable access to drinking-water and to basic sanitation should be guided by a national standard-setting framework. The draft resolution had therefore to be implemented in each country in line with its applicable legislation.

Mexico also considered that debate on the topic should be pursued in a constructive spirit within the framework established by the Human Rights Council.

Mrs TZIMAS (Germany) emphasized the importance in the developing world of access to safe drinking-water, and of sanitation and personal and domestic hygiene, along with awareness of health conditions. National health strategies should adequately reflect the burden posed by water-related diseases and the value for health of safe water and sanitation. Greater intersectoral cooperation was needed, especially between the health and water sectors, to boost efficiency and impact. Water and sanitation programmes should aim to raise awareness and provide hygiene education to induce behavioural change, while health programmes should focus more on education about waterborne diseases, promoting change in hygiene practices and creating demand for sanitation. Between 2008 and 2010, her country had spent about US\$ 900 million annually in development cooperation assistance relating to water and sanitation, and in particular to measures to control their impact on health. Such measures should be monitored more closely, with a view to ensuring a more systematic inclusion of water, sanitation and hygiene measures in health programmes, and hygiene and awareness-raising measures in water programmes.

She reaffirmed her country's support for the human right to safe drinking-water and sanitation.

Dr MANSOOR (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that water was becoming increasingly scarce in the Region; shortages were often the root cause of disease and insecurity, particularly in rural areas in low-income countries. Not having access to water made it impossible for people to meet even their basic needs in terms of hygiene. Even where water was available, sanitation tended to be inadequate. In order to attain the Millennium Development Goals people had to be aware of the need to conserve and manage water resources, and of the benefits to health of constructing wells rather than using groundwater. The WHO *Guidelines for drinking-water quality* needed revision and supplementing where necessary. A regional drinking-water strategy was needed that encompassed regulation and legislation and whose preparation included contributions from all relevant stakeholders. In Iraq, drinking-water was the key to public health. A lack of safe drinking-water had led people to use grey water that was meant for agriculture and was not fit for human consumption; measures to ensure proper use of wastewater were therefore needed.

Mr LINDGREN (Norway) said that, by improving the quality of water supplies, access to safe water, sanitation facilities and hygiene, the incidence of many diseases could be reduced. Water and sanitation were linked to the health-related Millennium Development Goals, and he recalled Human Rights Council resolution 15/9 on human rights and access to safe drinking-water and sanitation, adopted in 2010. Achieving the Goals required a holistic approach, the responsibility for which lay

with governments. WHO's leadership in the areas of safe drinking-water, basic sanitation and hygiene could further accelerate progress in that regard.

WHO was a driving force behind efforts to improve access to safe, clean water and to promote hygiene. He called on the European States to support the work being done jointly by WHO and the United Nations Economic Commission for Europe, under the Protocol on Water and Health to the 1992 Convention on the Protection and Use of Transboundary Watercourses and International Lakes. Setting national targets in accordance with Article 6 of the Protocol was particularly important. Given that nearly 140 million people in Europe still lived in homes unconnected to a safe drinking-water supply, the actions set out in the draft resolution would require a firm commitment for many years.

Professor ARSLAN (Bangladesh) emphasized water quality management, especially given the rapid urbanization in developing countries. It would be of benefit to both parties if countries in similar circumstances could share their experience and collaborate on developing practical and affordable interventions to raise water quality.

Bangladesh had made significant improvements in its response to natural disasters and emergencies through better management of water systems. However, for vulnerable countries like his, support from developed countries in reducing the adverse impact of climate change on water availability and water quality would be essential.

The draft resolution, which he endorsed, and that on the prevention and control of cholera, to be considered later by the Health Assembly, were complementary and mutually reinforcing. Together they would mark a significant step forwards in managing drinking-water quality and promoting hygiene and sanitation.

Dr GULLY (Canada) supported the draft resolution. His country was among those with the safest drinking-water in the world and had an effective governance model, with shared responsibility among national, subnational and local levels of government. However, it was still facing challenges in small, rural and remote communities.

Canada had provided 410 million Canadian dollars in assistance to the water and sanitation sector in developing countries, of which more than two thirds had gone to improve drinking-water supply and sanitation services, particularly for women, children and other vulnerable groups in rural areas.

He asked whether the "new, integrated WHO strategy for water, sanitation and health" mentioned in subparagraph 2(2) of the draft resolution would be separate from, or inclusive of, the initiatives outlined in subparagraphs 2(3) to 2(9).

Implementation of the draft resolution would put significant additional financial pressure on WHO. In view of the Organization's current financial situation, he asked the Secretariat to specify which activities could be carried out with existing funds and which would require additional funding, and to give priority to activities that would achieve maximum results with minimal costs.

Dr NIPUNPORN VORAMONGKOL (Thailand), speaking on behalf of the Member States of the South-East Asia Region, welcomed delegates' contributions to the draft resolution. She fully agreed that safe drinking-water could not be considered in isolation from other issues, especially from sanitation, water pollution and chemical contamination. She proposed that in subparagraph 1(2), the words "empowerment, participation" should be inserted, following a comma, after "education". In subparagraph 1(5), the words "and implement" should be inserted after "prioritize".

Mr ZHAO Yuechao (China) said that the text would help Member States to strengthen their water management programmes. Access to drinking-water of sufficient quality and quantity was a crucial determinant of health, and formed part of several of the Millennium Development Goals. His country attached great importance to the safety of drinking-water and had taken increasingly more stringent measures in that regard, revising water-quality standards, boosting monitoring and surveillance networks, and improving drinking-water management through reform of the national

health system. He looked forward to further opportunities to share his country's knowledge and experience on the global platform, and urged the Secretariat to provide greater guidance on risk assessments and improving the efficiency of water-safety management.

Mr WAHABI (Morocco) thanked the Secretariat for its efforts in the field of water, sanitation and health, which had helped Member States to improve their drinking-water standards and supply. Water-supply and sanitation facilities were of such importance that they should be considered as primary health services and be adequately funded, and national water-safety plans should be put in place.

The draft resolution laid the groundwork for a global strategy on water and sanitation, for which the report by the Secretariat provided all the necessary elements.

Mr CROTTAZ (Switzerland) affirmed that drinking-water provision, basic sanitation and sound resource-management were crucial to preventing waterborne diseases and protecting consumer health. The recent outbreaks of cholera in Haiti and Zimbabwe had been caused mainly by a lack of, or deterioration in the management of, sanitation facilities. Water and sanitation interventions should be focused and generate direct, measurable and sustainable results. His country's development aid had concentrated on water and health.

Member States must implement national strategies to improve hygiene through drinking-water usage and management, and run campaigns to sensitize and involve local communities, in particular in the remotest regions. Existing regional initiatives, in particular the Protocol on Water and Health, administered jointly by WHO and the United Nations Economic Commission for Europe, should be supported as potential models for improving access to drinking-water and sanitation. On a global level, the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation was doing remarkable work in the area of promotion and political dialogue and should be given the resources it needed. He invited WHO to strengthen its cooperation with all United Nations bodies active in the water sector and expressed his support for the draft resolution.

Dr KARAGULOVA (Kazakhstan) expressed strong support for the draft resolution, affirming that access to safe drinking-water was a global issue of the utmost importance. She welcomed the inclusion in the draft of the proposed amendment submitted by her country three weeks previously, namely the insertion, in the second preambular paragraph, of the words "Recalling the Declaration of Alma-Ata on Primary Health Care". That proposal had been based on the reference in the Declaration to "an adequate supply of safe water and basic sanitation" as one of the eight essential elements of primary health care. She asked for her country to be included as a sponsor.

Dr McMILLAN (Bahamas) supported the draft resolution. Her country was trying to improve water quality in a sustainable manner, through modern technology, improved water-management programmes, public-private partnerships and the renovation of its water infrastructure. Nevertheless, the challenge remained of developing a comprehensive water-safety plan to encompass all the archipelago's inhabited islands. Reform of the regulatory and legal framework, better use of human resources, new monitoring and evaluation tools, and a water-resource management plan – spanning the health, agriculture, energy and environment sectors – had helped to achieve nearly universal access to safe drinking-water and sanitation throughout the country, in line with Millennium Development Goals 7 and 10.

Dr AL HAJERI (Bahrain) said that Bahrain needed to develop a strategy on the safe management of drinking-water in conformity with international standards and to introduce laboratory testing of water. Public awareness should be raised about the importance of protecting water resources from pollution. She supported the draft resolution.

Ms GIBB (United States of America) said that her Government remained deeply committed to finding solutions to the world's water, sanitation and hygiene challenges. Governments and development partners had joined forces between 1990 and 2008, resulting in marked gains in access to improved sources of drinking-water, basic sanitation and hygiene. Significant work remained to be done, however. Member States must continue expanding their activities to ensure access to and effective maintenance of those essential systems, and strive to keep increased access to water, sanitation and hygiene high on the political and development agenda.

She drew attention to the need for precision in use of language. The report used a wide variety of terms to refer to water. In the interests of clarity, it would be helpful to use consistent terminology that stressed the difference between "clean" water, which generally referred to lake and river water, and "safe" water, which generally referred to water for drinking and other human consumption.

WHO might consider coordinating its activities with FAO, UNEP and the United Nations Forum on Sustainability Standards in order to develop an integrated strategy that acknowledged the linkages between water, food and climate.

Mr JAZAÏRY (Algeria) said that his country had been one of the first to enshrine in law the right to water and sanitation, through legislation enacted in 2005. A ministerial department was responsible for national policy on water resources and a regulatory authority had been created to monitor the quality and cost of water supply services. The rate of connection to the drinking-water supply network had risen from 78% in 1999 to 93% at present, and the rate of connection to the sewerage system had risen from 72% to 86% in the same period. Thus Algeria had already surpassed Targets 7.C of Millennium Development Goal 7 (Ensure environmental sustainability). It had an installed wastewater treatment capacity of 800 million cubic metres per year, and the daily average supply of water per inhabitant had increased from 123 litres in 1999 to 168 litres at present, thereby making it a leader among developing countries in the distribution of drinking-water and sanitation.

Apparently a breakdown in communication had caused Algeria to be omitted from the list of sponsors of the draft resolution, but it joined those who were calling for its adoption by consensus. At the same time, he suggested that the term "*eau de boisson*" in the title of the French version of the draft resolution be replaced by "*eau potable*."

Dr ST. JOHN (Barbados) recognized that the availability of potable water was the key to sustainable development: without it, all other development efforts were doomed to fail. Barbados, one of the world's most densely populated countries, was classified by the United Nations as a water-scarce country because it had 616 persons per square kilometre and renewable water resources estimated at 390 cubic metres per capita per year. Moreover, steady increases in population and in the tourism industry, and intensification of agriculture, were jeopardizing the quantity and quality of the island's groundwater reserves. In collaboration with the Inter-American Development Bank, the Government of Barbados had embarked on a 50-million-dollar project to improve the water distribution system and modernize the wastewater treatment system. The Government was also in the process of overhauling the groundwater protection zoning policy, and the water quality monitoring programme had been significantly strengthened. Barbados supported the draft resolution.

Mr PARRONDO BABARRO (Spain) observed that taking an "all-or-nothing" stand on the right to water and sanitation would not contribute to international recognition of that right. He therefore welcomed the inclusion in the draft resolution of language from United Nations General Assembly resolution 64/292 and Human Rights Council resolution 15/9, both of which presented the right as a component of wider essential human rights. He supported the draft resolution as both a contribution to improvement of access to drinking-water and sanitation and an appropriate response to environmental determinants of health. It should be adopted by consensus.

Dr WATT (United Kingdom of Great Britain and Northern Ireland) said that her Government was fully committed to supporting the achievement of the Millennium Development Goals and placed

a high priority on providing the poorest people in the world with clean water and sanitation. Since March 2008 its bilateral programmes had helped 1.8 million people in Africa and 25.5 million people in South Asia to gain access to basic sanitation, and safe water had been delivered to 2.7 million people in Africa and 3.1 million in South Asia.

Her Government recognized human rights that had a clear basis in international human rights law, thereby enabling each State to be aware of its obligations to its people, and each individual to know what his or her rights were. It recognized a right to water as an element of the right of everybody to an adequate standard of living, and acknowledged that inadequate sanitation undermined the protection of human rights. It did not, however, consider that a "right" to sanitation currently existed under international human rights law. Nor was there an internationally agreed definition of what such a right would comprise.

The United Kingdom's legal position did not lessen the importance it ascribed to adequate sanitation and to the drinking-water, sanitation and hygiene issues underlying the draft resolution. But the priority that all attached to improving sanitation should not lead to a misdirected effort to recognize a new legal right without due regard for the structure of international human rights law. Thus while she did not wish to block consensus on the resolution, she regretfully had to dissociate herself from subparagraph 2(3) therein.

Mr DJABBAROV (World Vision International), speaking at the invitation of the CHAIRMAN, endorsed the report and the draft resolution. Sanitation and safe drinking-water were vital elements in the fight to reduce preventable deaths; a common feature of the 30 countries with the highest death rate for children under five years of age was poor access to sanitation.

Drinking-water, sanitation and health issues, the control and prevention of cholera, and the eradication of dracunculiasis should be tackled with a coordinated approach and linked with the social determinants of health action plan to be developed later that year. At national level, public health strategies should be strengthened, intersectoral work reinforced, and planning and budgeting processes aligned.

He welcomed the inclusion in the draft resolution of the human right to water and sanitation and endorsed the request therein that the Director-General formulate a new, integrated WHO strategy for water, sanitation and health.

Dr NEIRA (Protection of the Human Environment) said that delegates' recommendations, observations and proposed amendments would be taken into account. In particular, she noted the requests for a more precise use of English and French terminology.

In response to the concern expressed by the delegate of Canada about the financial implications of the draft resolution, she said that the Secretariat planned to create synergies and merge programmes, in particular those related to risk assessment, risk management and water quality. At the same time, it recognized the need to extend its work on safety planning, particularly in the South-East Asia Region, and to look to the Asian Development Bank for investment. Monitoring also needed to be stepped up, particularly in view of the successful integration of indicators concerning the human right to water and sanitation. She was confident that major fundraising efforts would be successful as present-year results seemed promising; for example, donor pledges had been made at a recent meeting in Berlin to identify post-2015 water and sanitation indicators.

She confirmed that the Organization would be drawing up a new strategy on water, sanitation, hygiene and health, which would encompass all the elements mentioned in the draft resolution and be based on other successful strategies, such as the WHO/UNICEF Joint Monitoring Programme/Global Analysis and Assessment of Sanitation and Drinking-water.

She thanked the French delegation for strategic guidance and leadership during the consultations, not only on the draft resolution but also for the setting of priorities for the future.

Dr DAYRIT (Secretary) read out the proposed amendments to the draft resolution. Algeria, Cape Verde, Côte d'Ivoire, Kazakhstan, Maldives, Norway, Republic of Moldova and Uruguay should

be added to the list of sponsors. The delegate of Bolivia had proposed that in the seventh preambular paragraph, all text following “and all human rights” should be deleted. In subparagraph 1(2), the delegate of Thailand had proposed that “empowerment, participation” should be inserted, following a comma, after “community education”; and in the same subparagraph, the delegate of Bolivia had proposed that “marginalized” be replaced by “the poorest”. The delegate of Bolivia had proposed that in subparagraphs 1(3) and 2(3), “progressive” should be deleted. The delegate of Thailand had proposed that in subparagraph 1(5), “and implement” should be inserted after “prioritize”.

Mr PELLET (France) welcomed the solid support for the draft resolution, underlining that consensus was within reach. He could accept some of the proposed amendments, but found it difficult to accept the deletion of the last part of the seventh preambular paragraph. The reference to Human Rights Council resolution 15/9 had been included in order to accommodate the views of the majority and was extremely important as it recalled language that had been previously agreed. He asked whether the delegate of Bolivia was prepared to be flexible on that point, given that his other proposed amendment, to subparagraph 1(2), was acceptable. The proposal to delete “progressive” from subparagraphs 1(3) and 2(3) was also difficult to accept, especially since the wording echoed paragraph 8(a) of Human Rights Council resolution 15/9.

The remaining amendments could be adopted, leaving only the title of the draft resolution in need of further discussion.

Ms BLACKWOOD (United States of America) said that she could endorse several of the amendments to the draft resolution but echoed the concerns of the delegate of France regarding the deletions proposed by the delegate of Bolivia.

Mr JAZAÏRY (Algeria) asked whether Member States would agree to replacing “*eau de boisson*” with “*eau potable*” in the title and body of the French version of the draft resolution. Other language versions would not be affected.

Mr ROSALES LOZADA (Plurinational State of Bolivia) reiterated that access to drinking-water was a fundamental right and was vital for life itself, as had been confirmed at the highest political level. He therefore did not see why a reference to it being a derived right should be included in the seventh preambular paragraph. Nevertheless, in the interests of consensus he would withdraw his proposed amendment to that paragraph.

He asked that other delegates show the same spirit of flexibility in accepting the deletion of “progressive” in subparagraphs 1(3) and 2(3), noting that there was no mention of “progressive” in paragraph 3 of Human Rights Council resolution 15/9. In his view, that term was redundant within the context of the realization of a human right, and if it were to be deleted in those two subparagraphs, as proposed, he would be willing to endorse the draft resolution.

Mr PELLET (France) read out paragraph 8(a) of Human Rights Council resolution 15/9, which called upon States “... to achieve progressively the full realization of human rights obligations related to access to safe drinking water and sanitation ...”. He could accept the proposal to delete “progressive” from subparagraph 2(3) but not from subparagraph 1(3), which addressed Member States.

Ms BLACKWOOD (United States of America) said that, although human rights were universal, aspects of their implementation and realization could vary from place to place. That was especially true of economic, social and cultural rights, which were to be realized progressively, consistent with States’ available resources. It was therefore important, in her view, to retain the word “progressive”, in particular in subparagraph 1(3).

Mr PELLET (France) averred that a consensus had been reached, on the understanding that “progressive” would be deleted from subparagraph 2(3) only.

Mr ROSALES LOZADA (Plurinational State of Bolivia) said that retaining “progressive” in subparagraph 1(3) but deleting it in subparagraph 2(3) was a fair solution, which he accepted.

Mr JAZAÏRY (Algeria) said that the delegate of France had signalled to him his approval of the proposal to replace “*eau de boisson*” with “*eau potable*”. He therefore took it that his amendment would be included in the draft resolution, and would henceforth be integrated into general WHO terminology.

The draft resolution, as amended, was approved by acclamation.¹

The meeting rose at 18:20.

¹ Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA64.24.

SIXTH MEETING

Monday, 23 May 2011, at 09:15

Chairman: Dr M.T. VALENZUELA (Chile)

later: Mr Z. DUKPA (Bhutan)

1. **THIRD REPORT OF COMMITTEE B** (Document A64/57 (Draft))

Mr TUITAMA LEAO TUITAMA (Rapporteur) read out the draft third report of Committee B.

Mr LE GOFF (France) noted that the amendments, proposed by the delegates of Algeria and the Plurinational State of Bolivia to the draft resolution on drinking-water, sanitation and health and accepted during the course of the discussion,¹ did not appear in the version of the resolution reproduced in the Committee's draft third report. He sought assurances that they would be incorporated into the final text of the resolution.

The CHAIRMAN said that the Secretariat would ensure that all agreed amendments were included.

The report, as amended, was adopted.²

2. **TECHNICAL AND HEALTH MATTERS:** Item 13 of the Agenda (continued)

Child injury prevention: Item 13.14 of the Agenda (Documents A64/23 and EB128/2011/REC/1, resolution EB128.R15) (continued from the fifth meeting, section 2)

The CHAIRMAN drew attention to a revision of the draft resolution contained in resolution EB128.R15 incorporating amendments proposed by several Member States, which read:

The Sixty-fourth World Health Assembly,

Recalling resolution WHA57.10 on road safety and health, which affirmed that road traffic injuries constitute a major public health problem that required coordinated international efforts;

Recalling also that the Health Assembly in resolution WHA57.10 accepted the invitation by the United Nations General Assembly for WHO to act as a coordinator on road safety issues within the United Nations system, working in close collaboration with the United Nations regional commissions;

Further recalling resolution WHA60.22 on health systems: emergency-care systems, which recognized that improved organization and planning for provision of trauma and emergency care is an essential part of integrated health-care delivery, and resolution WHA58.23 on disability, including prevention, management and rehabilitation, which urged Member States

¹ See the summary record of the fifth meeting of Committee B, section 3.

² See page 340.

to take all necessary steps for the reduction of risk factors contributing to disabilities in childhood;

Acknowledging the responsibilities to ensure safety in the care and protection of children affirmed in the Convention on the Rights of the Child (1989), in the International Labour Organization Convention 182 (1999) and in the International Labour Organization Convention 138 (1973), and further acknowledging the responsibilities to protect persons with disabilities set out in the Convention on the Rights of Persons with Disabilities (2006) particularly in developing, low- and middle-income countries where there exists a significant burden of child injuries;

Recognizing that child injuries are a major threat to child survival and health, that they are a neglected public health problem with significant consequences in terms of mortality, morbidity, quality of life, social and economic costs, and that in the absence of urgent action this problem will hamper attainment of the Millennium Development Goals, particularly in developing, low- and middle-income countries, where there exists a significant burden of child injuries;

Recognizing that the leading causes of child death from unintentional injury include road traffic injury, drowning, fire-related burns, falls and poisoning. In some regions of the world, drowning is responsible for about half of total child injury deaths; context-specific preventive measures including safe environment, safety products, safety management and awareness raising are crucial [THAILAND];

Further recognizing that multisectoral approaches to preventing child injuries and limiting their consequences through implementation of evidence-based interventions have resulted in dramatic and sustained reductions in child injury in countries that have made concerted efforts;

Welcoming the joint WHO/UNICEF *World report on child injury prevention*¹ and its recommendations for public health policy and programming;

Considering that existing programmes on child survival and child health and development should introduce child injury prevention strategies, ensuring these are an integrated part of child health services, and that the success of child health programmes should not only be gauged by the use of traditional measures of infectious disease mortality but also by indicators of fatal and non-fatal injury,

1. URGES Member States:

- (1) to prioritize the prevention of child injury among child issues and ensure that intersectoral coordination mechanisms necessary to prevent child injury are established or strengthened;
- (2) to continue and, if necessary, to strengthen, **the fulfilment of their obligations** ~~their commitments~~ **[UNITED STATES OF AMERICA]** under the Convention on the Rights of the Child (1989) to respect, protect and fulfil the rights of children to the highest attainable standard of health and to take all appropriate legislative, administrative, social and educational measures to protect children from injury;
- (3) to ensure that funding mechanisms for relevant programmes, including health programmes, cover child injury and prevention, emergency care, pre-hospital care, treatment and rehabilitation services;
- (4) to implement, as appropriate, the recommendations of the WHO/UNICEF *World report on child injury prevention*, including, if not already in place, the assignation of a leadership role to a government agency or unit for child injury prevention and the appointment of a focal person for injury prevention, ensuring that such leadership facilitates collaboration between relevant sectors of government, communities and civil

¹ *World report on child injury prevention*, Geneva, World Health Organization, and New York, United Nations Children's Fund, 2008.

society; and, according to national needs, the key strategies identified in the *World report* as effective interventions for preventing child injury; and to monitor and evaluate the impact of these interventions;

(5) to integrate child injury prevention in national child development programmes and in other relevant programmes, and to establish multisectoral coordination and collaboration mechanisms, in particular ensuring that prevention of child injury is accorded appropriate importance within programmes for child survival and health;

(6) to ensure that national data collection across relevant sectors or surveillance systems quantifies the demographic, socioeconomic and epidemiological profile of the burden of, risk factors for, and costs of child injury, and to **assure ensure [UNITED STATES OF AMERICA]** that the resources available are commensurate with the extent of the problem;

(7) to develop and implement a multisectoral policy and plan of action, where necessary, that contain realistic targets for child injury prevention and include promotion of standards and codes on the prevention of child labour, as well as on legal adolescent employment, product safety, school and play spaces, **transportation, [THAILAND]** construction regulations and laws, and that either stand alone, or are incorporated within the national child health policy or plan;

(8) to enforce and, if necessary, strengthen the existing laws and regulations relevant to the prevention of child injury;

(9) to strengthen emergency and rehabilitation services and capacities, including first-response teams, acute pre-hospital care, management at health facilities, and suitable rehabilitation programmes for injured or disabled children;

(10) to define priorities for research, taking into consideration the WHO/UNICEF *World report on child injury prevention*, and working closely with research and development communities, including relevant manufacturers and distributors of safety products;

(11) to raise awareness and health literacy, in particular on child safety among parents, children, employers and relevant professional groups, **as well as all members of the society, [THAILAND]** about risk factors for child injury, especially transport, including the use of “cell” phones and other such mobile devices while driving, workplace hazards, water and fire hazards, and lack of child supervision and protection of children, and to advocate dedicated child injury prevention programmes;

2. REQUESTS the Director-General:

(1) to collaborate with Member States in improving data collection and analysis systems for child injuries and in establishing science-based public health policies and programmes for preventing and mitigating the consequences of child injury;

(2) to collaborate with organizations of the United Nations system, international development partners and nongovernmental organizations ~~in order~~ to establish **an effective network to ensure effective coordination and implementation of activities for child injury prevention in low- and middle-income countries** ~~a mechanism for the communication and sharing of information on child injury and of child injury prevention activities, so as to guarantee the cooperation and coordination of all parties concerned~~ **[CANADA]**;

(3) to encourage research that expands the evidence base for interventions to prevent child injuries and mitigate their consequences, and that evaluates the effectiveness of such interventions through collaborating centres and other partners, including translation into affordable safety products, policy interventions and effective implementation;

(4) to facilitate the adaptation and transfer of knowledge on measures and instruments to prevent child injury, from developed to developing settings;

- (5) to support Member States in developing and implementing child injury prevention measures;
- (6) to provide additional support to national injury prevention focal persons by organizing regular global and regional meetings and providing technical assistance;
- (7) to provide technical support for strengthening systems and capacities for emergency and rehabilitation services;
- (8) to collaborate with Member States, organizations in the United Nations system, and international development partners and nongovernmental organizations in order to mobilize resources and to augment the capacities needed to prevent child injury and undertake related rehabilitation programmes; to organize advocacy activities for governments of Member States; and to raise awareness that, in the absence of urgent action, this problem will hamper attainment of the Millennium Development Goals, particularly in developing, low- and middle-income countries where there exists a significant burden of child injuries;¹
- (9) to invest more in building institutional and individual capacities among Member States so that they are able to develop cost-effective interventions at national and subnational levels;
- (10) to report progress made in implementing this resolution, through the Executive Board, to the Sixty-seventh World Health Assembly.

The financial and administrative implications of the adoption of the resolution for the Secretariat were unchanged from those provided to the Board at its 128th session.²

Dr DAYRIT (Secretary) read out a revision proposed by the delegate of the United States of America to the amendment to subparagraph 1(2): after “to continue and, if necessary, to strengthen”, “their” should be replaced by “the”. In subparagraph 1(7) a comma should be inserted after the word “transportation”.

Ms LAWLEY (Canada) suggested that in subparagraph 2(2) the word “effective” before “network” should be deleted.

The CHAIRMAN said that, in the absence of any objections, she would take it that the Committee wished to approve the draft resolution, as amended.

The draft resolution, as amended, was approved.³

Youth and health risks: Item 13.16 of the Agenda (Document A64/25)

The CHAIRMAN drew attention to a draft resolution on youth and health risks proposed by the delegations of Finland, Hungary and Tunisia, which incorporated revisions proposed by an informal drafting group and read:

¹ Note from WHO Secretariat: The *World report on child injury prevention* provides the following data. Mortality for under 20 year-olds in the South-East Asia and African regions combined totalled 558 000 deaths out of the total of 950 366 deaths reported worldwide.

² See document EB128/2011/REC/1, Annex 4.

³ Transmitted to the Health Assembly in the Committee’s fourth report and adopted as resolution WHA64.27.

The Sixty-fourth World Health Assembly,

PP1 Having considered the report on youth and health risks,¹ which highlights the immediate and long-term effects of health risks on young people;

PP2 Recalling the resolutions **that directly address young people**: WHA38.22 on maturity before childbearing and promotion of responsible parenthood; WHA42.41 on the health of youth; WHA56.21 on the strategy for child and adolescent health and development, WPR/RC39.R12 Rev.1 on adolescent health; EM/RC43/R.11 on health education of adolescents; AFR/RC51/R3 on adolescent health: a strategy for the African Region; EUR/RC55/R6 on the European strategy for child and adolescent health and development; and CD48.R5 on the Pan American regional strategy for improving adolescent and youth health;

PP3 ~~Recalling the fundamental right of adolescents and youth to the enjoyment of the highest attainable standard of health~~ **the right of everyone, including adolescents and youth, to the enjoyment of the highest attainable standard of physical and mental health**, as set out in the International Covenant on Economic, Social and Cultural Rights, the United Nations Convention on the Rights of the Child, the United Nations Convention on the Elimination of All forms of Discrimination against Women and other international and regional human rights instruments, which, inter alia, reaffirm the equality of young women and men and respect for diversity;

[Alternative text proposed by UNITED STATES OF AMERICA] PP3: Recalling the right of everyone, including adolescents and youth, to the enjoyment of the highest attainable standard of physical and mental health, also recalling the International Covenant on Economic, Social and Cultural Rights, the United Nations Convention on the Rights of the Child, the United Nations Convention on the Elimination of All forms of Discrimination against Women and other international and regional human rights instruments, and emphasizing the need to promote the equality of young women and men and respect for diversity;

PP4 Recognizing that health is not only the absence of disease or infirmity, but a state of complete physical, mental and social well-being as articulated in the Constitution of the World Health Organization;

PP5 Acknowledging the fact that the 1800 million young people globally – one quarter of all people living in the world are ~~under the age~~ **between the ages of 10 and 24** years – make up the largest cohort in history, thereby representing an extraordinary opportunity to shape the world's social, economic and health futures;

PP6 Recognizing that the 2.6 million annual deaths among young people are generally preventable and that their current health behaviours and conditions can compromise both their existing and future health as well as the health of future generations;

PP7 Mindful that heterogeneity of the youth population and their circumstances renders some young people, for example adolescent girls, more vulnerable than others to negative health outcomes;

PP8 Emphasizing the importance of promoting healthy lifestyles, such as participation in physical activity and sport, eating a healthy diet, and physical education, for young people;

PP9 Acknowledging the attention given to young people in **resolutions dealing with the population at large**: the WHO Framework Convention on Tobacco Control (resolution WHA56.1); the Global strategy to reduce the harmful use of alcohol (resolution WHA63.13); the Global strategy on diet, physical activity and health (resolution WHA57.17); the recommendations on the marketing of foods and non-alcoholic beverages to children (endorsed in resolution WHA63.14); the action plan for the global strategy for the prevention and control of noncommunicable diseases (resolution WHA61.14); the strategy on reproductive health (resolution WHA57.12), the UNAIDS strategy in HIV for 2011–2015; the global strategy for

¹ Document A64/25.

the prevention and control of sexually transmitted infections (resolution WHA59.19); the global health sector strategy for HIV, 2011–2015; and the United Nations Decade of Action for Road Safety, 2011–2020; resolution WHA60.22 on health systems: emergency-care systems; and the recommendations contained in the *World report on violence and health* that were taken note of in resolution WHA56.24;

PP10 Recognizing the roles of the organizations **and programmes** in the United Nations system, such as ILO, UNESCO, UNICEF, UNHCR, UNFPA, and UNAIDS, and the International Organization for Migration, to address youth health risks and ~~in particular their comparative advantages~~ in influencing the determinants of youth health;

PP11 ~~Acknowledging~~ **Taking note of** the importance of addressing social determinants of youth health, social protection mechanisms that ensure the social inclusion, education and employment of youth, and the Guanajuato Declaration, resulting from the World Youth Conference (Leon, Guanajuato, Mexico, 25–27 August 2010) and which called for increased investments in policies and programmes across sectors and national development plans, with the meaningful participation of young people, following the World Programme of Action for Youth to the Year 2000 and beyond (United Nations General Assembly resolution 50/81);

PP12 Cognizant that the United Nations' World Programme for Action on Youth to the Year 2000 and beyond (United Nations General Assembly resolution 50/81) encourages governments to develop comprehensive sexual and reproductive health care services and provide young people with access to those services including, inter alia, education and services in family planning ~~consistent with the results of~~ **as set out in the programmes of action from** the International Conference on Population and Development (1994), the World Summit for Social Development (1995) and the Fourth World Conference on Women (1995); **ensuring that adolescents have information about, access to and the choice of the widest possible range of safe, effective modern methods of family planning; and to provide adolescents with comprehensive education on human sexuality, on sexual and reproductive health and gender equality so as to enable them to deal in a positive and responsible way with their sexuality;**

PP13 Mindful that meeting indicators and targets related to young people ~~will be~~ **are** crucial for attaining six of the eight Millennium Development Goals (Goals 1, 2, 3, 4, 5 and 6), and that paying specific attention to young people ~~will~~ **contributes** to achieving the aims of recent global health initiatives such as the United Nations Secretary General's Global Strategy for Women's and Children's Health and UNAIDS' Universal Access to HIV/AIDS ~~P~~**revention, T**~~r~~**eatment, C**~~e~~**are and support;**

PP14 Recognizing the opportunities to pay specific attention to the health needs of adolescents and youth during the forthcoming United Nations General Assembly high-level meetings on AIDS, on youth and ~~the planned United Nations General Assembly Special Session on~~ **the Prevention and Control of** Noncommunicable Diseases;

PP15 Acknowledging the ~~resource capacity that of~~ **resource capacity** ~~that of~~ young people ~~represent for to~~ **participate and lead in** health and development and the leadership ~~that~~ they demonstrate in ~~developing and using~~ **and developing** innovative technologies to meet **global and local and** global challenges ~~and act as agent of change to their health and development;~~

1. ~~ENDORSES REAFFIRMS~~ WHO's strategies that address the major health risks facing youth and include specific interventions for this age group;
2. ~~URGES~~ Member States to accelerate action, as appropriate, and develop a ~~coherent national policy~~ **policies and plans to address** the main determinants of health ~~in affecting~~ young people, including health-related behaviours and their impact on health at later stages in life **by:**

- (1) ~~ensuring that~~ **adopting** national health policies and strategies **that** contain specific targets and indicators on relevant determinants including assets, and outcomes of youth health and well-being;
 - (2) reviewing and revising policies in health and other areas with a view to including measures to protect young people from harm (e.g. early childbearing, sexual exploitation and violence, use of illicit substances and tobacco, harmful **use of alcohol use**, lack of physical activity, unhealthy diet and obesity, road traffic and other injuries, and mental **health problems**);
 - (2bis) reviewing and revising policies in health and other areas to eliminate all forms of discrimination experienced by youth;**
 - (3) ~~ensuring that~~ **putting in place** systems for health management information and vital registration **that** provide up-to-date age- and sex-specific data, given the existing gap in the data regarding young people's health;
 - (4) ~~ensuring~~ **promoting** the responsiveness of the health system to adolescents' needs, including health workforce development and financing in order to remove barriers to access to youth-friendly health **care services**;
 - (5) ~~ensuring~~ **providing** access to contraception; **reproductive health care during pregnancy and childbirth services**; prevention, treatment **and** care of HIV/AIDS and sexually transmitted infections and associated support; mental health services; and trauma care;
 - (6) ~~ensuring~~ **promoting** access to accurate information and evidence-based approaches that promote healthy behaviour, for example health information on sexual and reproductive health;
 - (7) ~~applying~~ **promoting collaboration a across sectorals approach at all levels on to** young people's health **and** including aspects related to health in sectors such as education, social inclusion, **social and physical environments**, employment, and the media **and with-including** civil society organizations **and the private sector, as appropriate;**
 - (8) involving different actors, such as families, ~~and~~ communities **and youth themselves**, in addressing determinants and health risks of young people, and mobilizing stakeholders in order to detect and help young people at risk or with a disadvantaged background;
 - (9) supporting the role of young people, with special attention to youth organizations, with a view to facilitating young people's empowerment and participation in influencing their immediate environments and shaping health public policy;
3. ~~CALLS on~~ **ENCOURAGES** multilateral and bilateral donors, ~~and~~ international financial institutions **and international development partners** to ~~direct~~ **support Member States to carry out these efforts including through the provision of specific** financial and technical resources ~~to the support of Member States in order to carry out these efforts, as appropriate;~~
 4. REQUESTS the Director-General:
 - (1) to ensure ~~harmonized attention to addressing the health risks of adolescents and young people in the next Medium-term strategic plan across programmes and levels of the Organization in order to ensure provision of sufficient technical support to Member States;~~ **appropriate Organizational priority, commitment, effective coordination and adequate resources in order to specify further and expand the implementation of existing strategies as they apply to young people and to regularly monitor the results for adolescents' health;**
 - (2) to ensure ~~appropriate oganizational priority, commitment, coordination and resources in order to specify further and expand the implementation of existing strategies as they apply to young people and to regularly monitor the results for adolescents' health~~ **address the health risks of adolescents and young people in the next Medium-term**

strategic plan across programmes and levels of the Organization in order to provide sufficient technical support to Member States;

(3) to ~~encourage~~ **identify knowledge gaps** and ~~conduct~~ **facilitate** research that will strengthen the evidence base needed to establish, deliver and monitor effective and age- and gender-appropriate programmes for adolescents and youth;

(4) to ~~sustain current productive~~ **continue to collaborate, as appropriate, with bodies organizations** in the United Nations system and civil society ~~organizations as well as those in order,~~ **and the private** sectors that have a bearing on young people's health;

(5) to ~~support~~ **strengthening the Organization's capacity of health ministries and to provide sufficient technical support on youth health to Member States, in particular health authorities, including strengthening capacity of WHO collaborating centres working to reduce risks to health such as the WHO Mediterranean Centre for Health Risk Reduction;**

(6) to ~~ensure~~ **promote** the participation and empowerment of young people as key stakeholders in health development, including in the ~~planned World Health Forum work of the Organization;~~

(7) to ~~provide biennial progress reports, through the Executive Board,~~ **periodically report on the health of young people and the implementation of this resolution** to the World Health Assembly, ~~on the health of young people and progress in the implementation of this resolution through the Executive Board,~~ **with the first occasion being the Sixty-seventh World Health Assembly.**

The financial and administrative implications for the Secretariat were as follows:

1. Resolution Youth and health risks	
2. Linkage to programme budget	
Strategic objective:	Organization-wide expected result:
2. To combat HIV/AIDS, tuberculosis and malaria.	2.1. Guidelines, policy, strategy and other tools developed for prevention of, and treatment and care for patients with, HIV/AIDS, tuberculosis and malaria, including innovative approaches for increasing coverage of the interventions among poor people, and hard-to-reach and vulnerable populations.
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment.	
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals.	4.6. Technical support provided to Member States for the implementation of evidence-based policies and strategies on adolescent health and development, and for the scaling up of a package of prevention, treatment and care interventions in accordance with established standards.
6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex.	
7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-	

responsive, and human rights-based approaches.

9. To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development.

(Briefly indicate the linkage with expected results, indicators, targets, baseline)

This resolution links directly to indicator 4.6.1. In addition, it links to several of the indicators and targets for strategic objectives as set out in the Medium-term strategic plan 2008–2013 (Amended (Draft)) (revised version, April 2009).¹ The following indicators and targets are concerned: strategic objective 2, second point; strategic objective 3, all three points; strategic objective 6, all three points; strategic objective 7, first point; and strategic objective 9, third point.

3. Budgetary implications

(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).

The lifetime of this resolution is estimated at 10 years (2011–2021). The estimated cost to the Secretariat for implementation of the resolution over this period at headquarters, the regional offices and country offices is US\$ 105 million.

(b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).

The estimated cost for the Secretariat at all levels during the remainder of the biennium would be US\$ 5.3 million.

(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?

Yes.

4. Financial implications

How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?

Existing funds are insufficient to support all these costs. The estimated additional funds needed are US\$ 530 000. The Secretariat will identify alternative sources of funding, to ensure sufficient funding levels to implement the resolution.

5. Administrative implications

(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant).

Implementation in all regions and countries.

(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.

No.

(c) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile).

Two additional regional staff are required at grade P4, one in each of the regional offices for Africa and the Western Pacific to ensure support for implementation of youth health in the region.

(d) Time frames (indicate broad time frames for implementation of activities).

2011–2021.

¹ Available online at http://apps.who.int/gb/ebwha/pdf_files/MTSP2009/MTSP3-en.pdf (accessed on 17 May 2011).

Mr BEN AMMAR (Tunisia), introducing the draft resolution, observed that, in the 22 years since the Health Assembly had last discussed youth health, a generation had been born and grown up. Despite the heavy morbidity and mortality, with many deaths caused by road-traffic injuries and suicide, relatively little attention had been paid to the health of young people because it had been assumed that they were healthier than young children and older people; the sobering statistics in the report told a different story. Improving the health of young people was crucial to achieving Millennium Development Goals 5 (Improve maternal health) and 6 (Combat HIV/AIDS, malaria and other diseases) and to stemming the tide of noncommunicable diseases. The draft resolution was intended to encourage the development of national policies and strategies for young people's health and risk reduction, ensure that health systems were responsive to the needs of young people and provided them with adequate health-care services; and drew attention to the need for more effective coordination, monitoring and technical support in order to strengthen capacity and address the social determinants that affected young people's health.

The current generation of young people was a tribute to the health sector's success in ensuring child survival. Countries must continue to invest in the health and education of young people of both sexes, bearing in mind that they were the key to social and economic development. He urged Member States to support the draft resolution.

Dr AL HAJERI (Bahrain) said that young people represented a large proportion of her country's population. In general, they enjoyed good health, but they faced various health risks and economic, social and cultural challenges. In order to assist them in facing those challenges, her Government had implemented several high-level strategies, including a national youth strategy, launched in 2005, which was a key initiative for promoting young people's health. With WHO's support, Bahrain had undertaken several other initiatives, including introducing a national school health programme and plans covering tobacco control, HIV prevention and physical education. Those initiatives demonstrated her Government's commitment to the health of young people in order to promote lifelong health. She supported the draft resolution.

Mr VIEGAS (Brazil), expressing support for the draft resolution, said that most deaths of young people were preventable, being attributable to external causes such as violence and accidents. Young people's health was therefore very much a public health issue. Behaviours that often began in adolescence, including alcohol misuse, tobacco use, physical inactivity and inadequate nutrition, contributed to chronic noncommunicable diseases in adulthood and vulnerability to accidents and violence. Brazil was monitoring such health problems and their consequences. The statistics showed the importance of early public health intervention to promote, for example, healthy eating habits at school and at home. They also pointed to the importance of joint action between health and education authorities. Brazilian young people had participated in designing school-based programmes for the prevention of HIV and other sexually transmitted infections, which had been successful and which highlighted the importance of promoting the active participation and leadership of young people in youth health programmes.

Mr IBRAHIM (Egypt) suggested that in paragraph 2 of the draft resolution the phrase "in accordance with their respective national laws and regulations" should be added after "URGES Member States".

Dr NYONATOR (Ghana), speaking on behalf of the Member States of the African Region, said that interventions addressing young people's health risks were already on the health policy agenda in many countries of the African Region. Young people in the Region contributed significantly to the economy and played an essential role in their families and communities. The adoption of policies and programmes promoting youth and adolescent health was therefore essential. A multisectoral approach involving the health, education, employment and other sectors was needed in order to address both health and non-health needs of young people and create an environment conducive to their

development. Existing policies should be refined; new policies developed, including policies on the advertisement and sale of tobacco and alcohol; and institutional capacity for implementation and analysis should be increased.

Countries in the Region had adopted policy instruments and programmes to facilitate the development of national policies and strategies on sexual and reproductive health, HIV, mental health and promotion of healthy lifestyles. A regional framework for action designed to improve the health sector response to adolescent health needs had helped member countries to address nutrition, mental health, substance use and intentional and unintentional violence. He supported the draft resolution and endorsed the future directions outlined in the report. Other possible actions might include the strategic use of technology in order to reach young people and address their health needs, and the development and implementation of standards for young people's health and social services.

Mrs YAHAYA (Nigeria) said that adolescents and youth made up more than half the population of Nigeria and were confronted with major health challenges. Early onset of sexual activity and early marriage, which were prevalent, led to unwanted pregnancies, unsafe abortions and sexually transmitted infections, including HIV, and increased rates of maternal mortality and morbidity. More than half the unsafe abortions in Nigeria each year were performed on young women, who accounted for 40% of total maternal mortality. Lack of accurate information and limited access to adolescent-friendly health services contributed to the poor reproductive health of Nigerian young people.

Her Government had revised its adolescent health policy in 2008, and in 2009 had assessed the national response to young people's sexual and reproductive health needs. As a result, the clinical service protocol for youth-friendly health services had been revised and a training manual on adolescent health and development produced. Steps were being taken to expand the availability of youth-friendly health services, train health providers in providing youth-friendly services, refurbish and reorganize facilities to make them more attractive to young people, modify service hours and payment arrangements in order to facilitate young people's access to health services and increase funding for youth health and development programmes. She supported the draft resolution.

Dr MANSOOR (Iraq) suggested that the word "adolescents" should be added to the title of the report and resolution. Actions for the prevention, early detection and treatment of young people's health problems should be integrated into primary health care services and be an integral part of essential health services packages, which should include reproductive health services. Partnerships among sectors and stakeholders, including civil society, should be forged in order to compile data on health risks among adolescents and youth; raise awareness and educate young people about health risks, including HIV infection and noncommunicable diseases, and how to prevent them; transmit health messages to young people through school health programmes and through youth centres, Internet cafés and other places frequented by young people; provide psychological support to young people; harness the energies of young people and encourage them to develop their talents while discouraging bad habits; and train them to provide peer education.

Ms LAWLEY (Canada) supported the draft resolution and the health promotion and risk prevention approaches outlined in the report, which were in line with Canada's approach to youth health. Her Government was committed to enhancing the wellness of young people and reducing their health risks. It recognized that youth was a transitional period when life-long behaviours were established, setting the stage for future health outcomes, and that it was therefore a crucial period for promoting healthy living, including good nutrition and maintenance of a healthy weight, physical activity and good mental health. Her Government was engaged in a range of information, education and programme interventions to address sexual health issues through a rights-based approach and prevention and treatment services.

Mr SUPRIYANTORO (Indonesia) welcomed the draft resolution, which addressed a critical issue with wide implications for development. In Indonesia young people represented almost one third

of the population and were a valuable asset for the country's future. However, they faced significant health risks related to social economic, religious and cultural factors. Economic development, for example, had expanded the network of main roads, with rising mortality and disability due to road traffic injuries. The work to be undertaken on youth and health risks should be linked to that under the United Nations Secretary-General's Global Strategy for Women's and Children's Health in order to ensure that it contributed to progress towards Millennium Development Goals 4 and 5. Furthermore, the Secretariat should support Member States in providing health programmes and services for young people.

Mr McIFF (United States of America) said that the report could help to focus attention on the health of young people and encourage action at country level. It clearly identified the risk behaviours among young people that negatively affected their health and suggested appropriate interventions.

Welcoming the draft resolution, he said that the alternative text of the third preambular paragraph proposed by his delegation reflected the spirit of the original paragraph and cited the key instruments on which work with regard to youth and health risks was to be based, but did so in terms that were more accurate legally. He urged the Committee to support the amended version. He appreciated the amendment proposed by the delegate of Egypt on paragraph 2, but pointed out that the informal drafting group had agreed that the inclusion of the words "as appropriate" in that paragraph made a reference to national laws and regulations unnecessary. There remained hesitancy on the part of some delegations about some language in the draft resolution, particularly in relation to access to services and education, and with a view to reaching consensus he proposed that in the twelfth preambular paragraph, "for example, age-appropriate" be inserted before "access".

Dr LAHTINEN (Finland), welcoming the draft resolution, highlighted the importance of promoting sexual and reproductive health among young people. Despite investments made by countries and the international community, the proportion of young people who had adequate knowledge about how to protect themselves against HIV infection remained far below the 95% target set during the special session of the United Nations General Assembly on HIV/AIDS in 2001. Nevertheless, in some countries young people were leading the HIV prevention revolution by delaying sexual initiation, limiting the number of their sexual partners and consistently using condoms, thereby reducing unwanted and unsafe pregnancies among adolescents and contributing to progress on Millennium Development Goal 5. The draft resolution sent a clear message to Member States and to the Director-General on crucial action for youth health and he supported its adoption.

Mrs TZIMAS (Germany) stressed the importance of prevention and information in reducing health risks among young people. Previously agreed action plans and strategies, such as the Global strategy to reduce the harmful use of alcohol, the 2008–2013 Action plan for the global strategy for the prevention and control of noncommunicable diseases and the WHO Framework Convention on Tobacco Control, set out many effective prevention interventions, which had already yielded positive results in her country. For example, smoking rates among young people aged 12 to 17 years had fallen from 28% to 13% and the percentage of young people who had never smoked had increased from 41% to 68% between 2001 and 2011. The draft resolution encouraged due attention to health issues relevant to young people and she fully supported it.

Mr CHIRINCIUC (Republic of Moldova) said that his Government wished to sponsor the draft resolution.

Mr KOVALEVSKIY (Russian Federation) said that young people's health was one of the main components of his country's national development strategy. A national survey conducted among young people aged 14 to 17 years, however, had found that they were not especially concerned about health issues or leading a healthy lifestyle. Unhealthy habits in youth represented health risks and could lead to ill-health and disease in adulthood, and he therefore welcomed WHO's efforts to

improve the health of young people and to support government policy-making on the matter. He endorsed the draft resolution.

Dr REN Minghui (China) supported the recommendations and interventions outlined in the report. Behaviours during youth had a long-term impact on health in adulthood and the health of future generations. A multisectoral approach was required to tackle health risks in young people. WHO had a key role to play in promoting youth health and in providing advice and technical support regarding the most suitable interventions at country level, in particular for developing countries. He supported the draft resolution, but asked why the Secretariat considered it necessary to mobilize additional human and financial resources for its implementation.

Dr NORHAYATI RUSLI (Malaysia) highlighted the importance of young people for the health and future well-being of all countries. A multisectoral approach was being applied in Malaysia to tackle the main health risks among young people, which included tobacco, alcohol and illicit drug use, road traffic injuries and sexual activity. National campaigns against tobacco and alcohol use had reduced smoking and drinking among youth. A holistic, multisectoral, gender-sensitive approach was required to address the health issues affecting young people. Families, communities and young people themselves should be involved. She called on the Secretariat to continue to provide the necessary support to Member States in order to improve the health and well-being of young people.

Ms ARRINGTON AVIÑA (Mexico), echoing the comments made by previous speakers, said that a joint, multisectoral approach was necessary to tackle the social determinants and risk factors affecting youth health. Mexico had incorporated age- and gender-specific youth health strategies into its national health agenda, and had national programmes addressing the specific sexual and reproductive health and other health care needs of young people. Action had been taken to reduce road traffic injuries and deaths and to promote early detection of mental health disorders. In August 2010 Mexico had hosted the World Youth Conference, demonstrating the importance that it attached to youth health issues. She supported the draft resolution.

Mr LAHLOU (Morocco) said that social and economic determinants were key influences on youth development. The health sector should ensure the right of young people to live in a healthy physical and social environment. Measures implemented to tackle youth health risks should be coordinated across institutions and should ensure that young people were equipped with the knowledge to enable them to lead a healthy and productive life in the future. A multisectoral approach, involving government and the private sector, was essential for the reduction of health risks. Young people should be involved in youth health programmes and activities in order to ensure their success and sustainability. Young people's involvement in school health programmes was particularly important. He commended WHO's efforts to promote youth health and expressed support for the draft resolution.

Mr MELLAH (Algeria) firmly supported the draft resolution. His Government attached great importance to the health and well-being of young people, who made up a large proportion of the country's population. National youth health programmes had been implemented to tackle the health risks affecting young people, especially tobacco and illicit drug use and violence. The Government had also introduced several initiatives to promote higher education and professional training and reduce unemployment among young people.

Ms CREELMAN (Australia), affirming her support for the draft resolution, suggested that "AIDS" in the fourteenth preambular paragraph should be replaced by "HIV/AIDS".

Ms NGARI (Kenya) observed that the physical and emotional changes of adolescence made youth especially vulnerable to health risks such as substance abuse and sexually transmitted infections,

and that lack of access to relevant information meant that they were often not well equipped to cope with those changes. Kenya had implemented a range of youth-friendly policies and programmes to reduce health risks in young people, including a national school health policy and a national road safety action plan, and had enacted legislation to curb tobacco and alcohol use among youths. Youth-friendly centres had been established in all primary and secondary health facilities. Because the period of youth encompassed a wide age range, interventions must be targeted and age-appropriate. Multisectoral approaches were needed. She requested support to enable countries in the African Region to expand interventions aimed at ensuring that young people developed into healthy and productive adults, and voiced support for the draft resolution.

Dr ARANYA CHAOWALIT (Thailand) strongly supported the draft resolution. It would not be possible to reduce youth health risks without modifying the behaviour of adults, who served as models for young people. Moreover, adults had created a social environment that made young people vulnerable to health risks and adults ran the companies that aggressively marketed harmful products to youths. The implementation of global policies to regulate such marketing techniques was essential. Many global policies, recommendations and strategies, including the WHO Framework Convention on Tobacco Control and the Global strategy on diet, physical activity and health were already being implemented, but more effort was needed in order to ensure that those tools were being used effectively to address youth health risks. Young people should be empowered and their involvement in health and social development should be encouraged.

She welcomed the Director-General's commitment not to collaborate with the tobacco industry, but found it disappointing that she had not made a similar commitment in respect of manufacturers and marketers of unhealthy foods and beverages, especially alcohol. She requested information on the Secretariat's progress in implementing resolution WHA36.12, on alcohol consumption and alcohol-related problems, in particular with regard to selection of that topic as a theme for a future World Health Day. She and other delegations had repeatedly urged that alcohol-related problems be selected as the theme of World Health Day, but that had not yet happened.

Dr MOHAMMAD KHAMIS (United Arab Emirates) said that priority should be given to youth health issues and allocation of the necessary resources. Laws should be enacted to regulate risk factors and strengthen the protection of young people. More data on the health of young people were needed if effective, evidence-based youth health policies were to be developed. To that end, her Government had undertaken several school-based health surveys in order to identify the principal health risks to which young people were exposed and devise prevention strategies, targeting young adolescents in particular in order to halt unhealthy behaviours as early as possible. Recognizing the importance of youth for the future development of the country, her Government had implemented various policies and programmes aimed at improving the health of young people and discouraging unhealthy lifestyles. She underlined policy coordination and multisectoral, interministerial collaboration in order to identify and address youth health risks.

Dr AL-GHAFIRIYA (Oman) said that her Government attached great importance to youth health and had implemented programmes targeting young people, including programmes on school health, prevention of HIV infection, improvement of nutrition, and mental health. In spite of those measures, many health risks remained, such as road traffic injuries and other physical and mental health risks. Stressing the need to involve civil society in tackling youth health risks, she expressed support for the draft resolution.

Mr MAULUDU (Papua New Guinea) supported the draft resolution. His country was experiencing rapid changes in lifestyle related to urbanization, which was creating new health risks for young people. Efforts were currently under way to collect the data needed in order to determine the extent of problems such as unintentional injuries and violence and mental and neurological disorders in the youth population. Programmes on sexual and reproductive health problems among young people

had been implemented, and condoms had been made widely available, which had helped to reduce new cases of HIV infection. Additional measures sought to promote good nutrition and discourage alcohol and illicit drug use. He welcomed the technical support that WHO was providing to his country and others to address youth health risks and issues.

Mr WOJDA (Poland) said that, although his Government fully supported the efforts of the international community to reduce the health risks affecting young people, the provision of reproductive health-care services must be carried out in accordance with national legal frameworks.

Ms MATALAVEA (Samoa) welcomed the draft resolution, which would help to ensure that high priority was given to youth and health risks at the global, regional and national levels. Her Government attached great importance to the health of young people and recognized that actions aimed at reducing youth health risks would yield high returns in the future. If the country's main health problems were to be dealt with effectively, it was essential to address the specific health issues affecting youth, in particular the negative effects of globalization and urbanization on their health and behaviour. She fully supported the draft resolution and urged speedy consensus on the various proposed amendments.

Professor ARSLAN (Bangladesh) said that his country had made considerable progress towards the achievement of Millennium Development Goals 4 and 5, but further targeted action on youth health issues was necessary. The principal risks included early marriage and pregnancy, HIV and other sexually transmitted infections, undernutrition, anaemia, obesity, tobacco and alcohol use, suicide and unintentional injuries and violence. It was crucial to address those risks, given the long-term impact that behaviours in youth had on health in adulthood.

Many countries in the South-East Asia Region, including Bangladesh, were focusing on the provision of youth-friendly health care. In 2005, his Government had adopted national standards for the delivery of quality health services to young people. It had also committed to ensure that one third of primary health care centres were providing youth-friendly services by 2015. However, advocacy work was necessary to encourage young people to avail themselves of those services. He supported the draft resolution.

Ms CADGE (United Kingdom of Great Britain and Northern Ireland) said that her Government's approach to young people's health was in line with the approach advocated in the resolution, including targeting the most vulnerable groups, addressing risk behaviour, collecting and sharing evidence and coordinating activities across sectors. She supported the draft resolution.

Mr KESKINKILIÇ (Turkey) welcomed the report, although it had not given sufficient attention to the risks posed by the use of the Internet, and supported the draft resolution. Noting that the draft resolution requested the Director-General to collaborate with other bodies in the United Nations system, he urged her to work with ITU to promote Internet safety.

Ms BENJEDDI (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, welcomed the draft resolution and its recognition of the role that young people could play in solving health problems and promoting healthy lifestyles. Social and economic factors, such as limited access to education and health care and unequal distribution of resources, had a negative impact on the health of young people, and it was to be hoped that those issues would be addressed at the forthcoming World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, 19-21 October 2011). Adolescent girls were a particularly vulnerable group, as they were at risk of unwanted pregnancy, violence, HIV infection, poor nutritional status and lack of access to education. Their health should be a priority. The health of young people could be improved by ensuring access to higher education and information through the use of social media and communication technologies, and her organization encouraged governments to make use of such

resources in their national strategies on youth health. Peer education was also of great value in promoting health and reducing risks among young people. She expressed the hope that Member States would take advantage of the knowledge and resources that medical students could provide.

Mr Shin-Lan KOONG (Chinese Taipei) said that efforts to address health risks among young people should take account of culture-specific issues, such as the problem of betel quid consumption, which was common in Chinese Taipei and elsewhere. Surveillance was essential in order to identify and prioritize youth health risks, and Chinese Taipei regularly carried out youth behaviour surveys for that purpose. Preventing road traffic injuries was a priority in Chinese Taipei, which had introduced legislation requiring helmet and seat belt use.

Noncommunicable diseases in adulthood were related to behaviour adopted during adolescence, especially smoking, drinking and lack of physical activity. It was important for governments to invest in preventing risks and promoting healthy attitudes and to put in place regulations to ensure that youths under the age of 18 years could not gain access to tobacco, alcohol or other harmful substances. School-based programmes were effective, and Chinese Taipei had been focusing on health promotion in schools. It would welcome the opportunity to share its experiences with others.

Dr MASON (Child and Adolescent Health and Development) thanked the Government of Tunisia for proposing the inclusion of youth and health risks on the governing bodies' agendas. Young people were an important group from a public health standpoint, and insufficient attention had been paid to their health needs. The resolution would strengthen attention to those needs and therefore contribute to the attainment of Millennium Development Goals 4, 5 and 6, and would also serve as a reminder of the importance of young people's health to decision-makers in other forums, such as the forthcoming high-level meetings on noncommunicable disease and HIV/AIDS.

As had been emphasized by many delegates, it was important to empower young people to take responsibility for their own health and to involve them in decision-making about health programmes. Youth-friendly health services, which had also been mentioned, were vital to ensure better access to health care for young people. Road traffic injuries were a leading cause of death among young people, and it was essential, particularly at the start of the Decade of Action for Road Safety, to ensure that young people played an integral part in the actions to be undertaken.

Responding to the question raised by the delegate of China about resources, she explained that the cost of implementing the draft resolution could be largely covered using existing and expected resources; however, additional staff would be required at regional level to ensure provision of adequate support to Member States, and additional financial resources would therefore be needed.

Dr POZNYAK (Management of Substance Abuse), responding to the comments by the delegate of Thailand, said that the Secretariat's interaction with the alcohol industry was guided by resolutions and the mandates it received from the governing bodies and never took the form of collaboration or partnership. The Secretariat, together with Member States, had done extensive work in recent years to draw attention to the health problems associated with alcohol consumption, culminating in 2010 in the adoption of the Global strategy to reduce the harmful use of alcohol, which was currently being implemented. Among other activities, the Global Information System on Alcohol and Health had been strengthened considerably, and the *Global status report on alcohol and health*¹ had been published in February 2011. The Secretariat was currently developing technical tools to support Member States' efforts to combat the harmful use of alcohol.

Dr DAYRIT (Secretary) read out the proposed amendments to the draft resolution. The delegate of the United States of America had proposed an alternative text for the third preambular paragraph, to read: "Recalling the right of everyone, including adolescents and youth, to the enjoyment of the

¹ *Global status report on alcohol and health 2011*. Geneva, World Health Organization, 2011.

highest attainable standard of physical and mental health, also recalling the International Covenant on Economic, Social and Cultural Rights, the United Nations Convention on the Rights of the Child, the United Nations Convention on the Elimination of All forms of Discrimination against Women and other international and regional human rights instruments, and emphasizing the need to promote the equality of young women and men and respect for diversity.” The same delegate had proposed that in the twelfth preambular paragraph “provide young people with access” should be amended to read “provide young people with age-appropriate access” and that “ensuring that adolescents have information” should be amended to read “ensuring that adolescents have age-appropriate information”. In the fourteenth preambular paragraph, the delegate of Australia had proposed that “AIDS” should be changed to “HIV/AIDS”. In paragraph 2, the delegate of Egypt had proposed that “in accordance with their national laws and regulations” should be inserted after “Member States”, but that proposal had not been supported by the delegate of the United States of America.

The CHAIRMAN asked whether the Committee wished to approve the draft resolution as amended.

Dr LAHTINEN (Finland) supported the proposed amendments to the third, fourth and twelfth preambular paragraphs. He recalled that the informal drafting group had inserted the phrase “as appropriate” in paragraph 2 in response to concerns raised by several delegates. He had consulted with the concerned parties and, in a spirit of compromise, proposed that the Committee accept the proposal by the delegate of Egypt and delete the phrase “as appropriate”.

Dr EL SAYED (Egypt) agreed with the solution proposed by the delegate of Finland.

Ms ARRINGTON AVIÑA (Mexico) supported the proposed amendment to the third preambular paragraph. She suggested that in the twelfth preambular paragraph the word “ensuring” should be rendered “*garantizar*” in the Spanish-language version of the text.

Ms LAWLEY (Canada), supported by Dr LAHTINEN (Finland) and Mr McIFF (United States of America), pointed out that the phrase “as appropriate” in paragraph 2 referred to “accelerating action”. That being the case, it should not be deleted.

The CHAIRMAN took it that the Committee was ready to approve the draft resolution as amended.

The draft resolution, as amended, was approved.¹

Mr Dukpa took the chair.

Progress reports: Item 13.17 of the Agenda (Document A64/26)

A. Poliomyelitis: mechanism for management of potential risks to eradication (resolution WHA61.1)

Dr PRASITCHAI MANGJIT (Thailand) said that the reported progress demonstrated the great effort and commitment by Member States to eradicating poliomyelitis. Certain concerns remained. The delay in the detection of outbreaks and re-establishment of polioviruses in certain countries indicated weak surveillance systems and the need to sustain a sufficiently high vaccination rate. Although the continuing gaps in vaccination coverage stemmed from operational problems, increasing

¹ Transmitted to the Health Assembly in the Committee’s fourth report and adopted as resolution WHA64.28.

community involvement, public acceptance of vaccination services and supplementary immunization activities could improve coverage. Given the persistent funding shortfalls, he called on the Secretariat to urge potential donors and Member States to make good those gaps, in order to achieve the global goal of a poliomyelitis-free world.

There had been no new case of poliomyelitis in Thailand since 1998 and his Government remained fully committed to the campaign to eradicate the disease.

Mr NABEEL (Pakistan) expressed appreciation of the Secretariat's collaboration with the Pakistani national authorities on the eradication of poliomyelitis. Since the launch of the Polio Eradication Initiative in his country in 1994, significant progress had been made, reducing the number of confirmed cases to 89 cases in 2009. Despite an increase in the number of cases in 2010, only 39 cases of poliomyelitis had been confirmed in the current year so far.

His Government had launched various initiatives to combat poliomyelitis, the latest being the National Emergency Action Plan 2011 for Polio Eradication, which included specific strategies to improve government oversight, address security issues, and reach migrant populations, with political commitment at the highest political level. National and provincial task forces had been created, and timelines set.

Although the fight against poliomyelitis continued to be an uphill struggle, compounded by security problems and serious flooding, no new case had been reported in the previous six months in the province of Punjab, home to 50% of the country's population, and no poliovirus type 3 had been detected during that time. The Government recognized the gravity of the situation. Planned measures included assisting those lowest administrative levels that had been identified as being at high risk, targeting migrant populations, improving the quality of vaccination campaigns by monitoring the more than 97 000 vaccination teams involved, and appealing for the continued support of international partners.

Dr KOBELA (Cameroon), speaking on behalf of the Member States of the African Region, recalled that by 2008 all but four Member States had interrupted the indigenous transmission of wild poliovirus. In 2010, 598 cases of poliomyelitis had been confirmed in 12 countries in the Region, 11% fewer than in 2009. However, a new outbreak had been confirmed in Congo in September 2010, with 382 reported cases. Moreover, there were concerns regarding the quality of monitoring at district level, for example the long chains of wild poliovirus transmission in Uganda had been linked to transmission in Kenya in February 2009. Furthermore, by mid-May 2011, 106 cases of wild poliovirus had been recorded in central Africa, including 52 in Chad, 48 in the Democratic Republic of the Congo, 4 in Angola, 1 in the Congo and 1 in Gabon.

One of the main objectives of the Strategic Plan of the Global Polio Eradication Initiative 2010–2012 was to stop all poliovirus transmission in at least two of the four countries with endemic poliomyelitis by the end of 2011. Angola, Chad and Nigeria had introduced emergency measures. In 2010, Nigeria had recorded only 21 cases of wild poliovirus, a drop of 95% in comparison with 2009. The other countries in the Region had remained vigilant in order to avoid re-transmission. Cameroon had introduced measures to strengthen political commitment to eradicating poliomyelitis, engaging local leaders and neighbouring States at risk of importing the virus, in order to ensure full acceptance of and participation in poliovirus vaccination campaigns. The results were encouraging. Three-dose vaccination coverage with oral poliomyelitis vaccine nationally had risen from 79.0% in 2009 to 83.2% in 2010. No wild poliovirus had been detected in 2010.

Challenges remained; the lack of financial resources, shortage of appropriate vaccines, and insufficient technical assistance could impede progress towards the goals of the Strategic Plan 2010–2012. It was also vital to maintain a high level of political engagement and improve the quality of prevention and eradication campaigns.

She thanked all the technical and financial partners for their support and expressed confidence that, if the relevant conditions were met, the countries in the Region would succeed in interrupting the transmission of poliovirus by 2012.

Dr DJIGUEMDE (Burkina Faso) thanked all the partners helping his country to interrupt the spread of wild polioviruses; it had been able to conduct several vaccination campaigns, step up routine vaccination and carry out surveillance at all levels. In 2010, no wild poliovirus had been detected. However, in view of his country's location and regional population movements, it would need further support to achieve eradication.

Professor ARSLAN (Bangladesh) said that it was evident that, despite successful efforts towards global eradication of poliomyelitis, attainment of the second milestone of the Strategic Plan 2010–2012 was at risk because of persistent transmission of poliovirus in some countries and that the third might not be reached owing to operational difficulties. Moreover, the international spread of wild polioviruses posed a substantial risk to achieving the goal of eradication. According to a recent study, completing eradication would result in total savings worldwide of US\$ 42 000 million over the period 1988–2035 but it was important to stress the improvement to quality of life and the number of people benefiting. He expressed concerns that 38% of the US\$ 1860 million budget of the Global Polio Eradication Initiative for 2011–2012 remained unfunded; it was to be hoped that the shortfall would be made up.

Most countries in the South-East Asia Region were poliomyelitis-free. Thanks to political commitment, strong vigilance and prompt action to interrupt transmission, there had been no case in Bangladesh since November 2006. All the global and regional strategies recommended by WHO to interrupt wild poliovirus circulation were being implemented and supplementary immunization activities were being continued; child vaccination coverage exceeded 99%; and acute flaccid paralysis surveillance was being maintained at international standards. The country's immunization programme consistently achieved high coverage rates. Preventing re-infection remained a challenge for all countries in the Region. Bangladesh would need assistance with maintaining a high level of immunity, ascertaining for how long it should conduct periodic risk assessment to determine the risk of re-infection and deciding whether to conduct immunization campaigns.

Dr SUGIURA (Japan), expressing appreciation of the report, welcomed the significant drop in the number of cases reported in India and Nigeria over the previous year and the declining incidence of wild poliovirus worldwide. He expressed concern, however, at the increased number of countries with re-established poliovirus transmission and the broader geographical spread. The importation of wild polioviruses and the emergence of countries with re-established poliovirus transmission were matters of global public health interest, which was why Japan set great store by the Global Polio Eradication Initiative.

Although eradication of smallpox had raised hopes for the eradication of poliomyelitis, political momentum had to be maintained and further financing had to be found. A broader range of international stakeholders needed to make eradication a priority. Successful eradication programmes were grounded in strong political commitment and partnership. WHO must use its influence to convince politicians and religious leaders in countries with endemic poliovirus transmission of the importance of controlling the disease. The correct balance needed to be struck between routine vaccination and supplementary immunization. In particular, in the four remaining countries with endemic transmission and countries with re-established transmission, routine immunization programmes would have to be strengthened.

Dr MANSOOR (Iraq) said that combating poliomyelitis was important as it was closely linked to other primary health matters. Surveillance of acute flaccid paralysis should be regarded as a public safety issue. Eradication could be achieved only through adequate surveillance, high vaccination coverage rates and systematic immunization of children under the age of five years. Cooperation with neighbouring countries on all eradication-related activities, enhanced capacity building, and sharing of expertise between countries and regions were crucial. In Iraq, administration of a third dose of vaccine to children had improved results, despite practical difficulties caused by the security situation in the country. Recently, the detection rate of cases of acute flaccid paralysis had risen to 3 per 100 000

population (i.e. above the recommended rate of 2 per 100 000 population) under the age of 15 years. There had been no case of poliomyelitis in Iraq since January 2000.

Mrs YAHAYA (Nigeria) noted the report and confirmed that cases of poliomyelitis in her country had declined by 95% from 2009 to 2010. The reduction in transmission had been due to progress in improving programme quality, community commitment and child vaccination coverage. Despite the steep decline in transmission, all three serotypes of poliovirus persisted in Nigeria, owing to gaps in immunization, including the failure to vaccinate children in several high-risk areas, and poor surveillance. In 2011, Nigeria had so far confirmed eight cases of wild poliovirus (types 1 and 3). In April 2011, the Independent Monitoring Board of the Global Polio Eradication Initiative, which had been advised that Nigeria was at moderate risk of not interrupting transmission by the end of 2011, had commended Nigeria's progress towards eradication since 2009, but highlighted major gaps in vaccination and surveillance quality and the decline in political commitment during the election period. It acknowledged the Government's plans for action. The progress made could be attributed to greater political commitment since 2009, in particular among traditional leaders in the high-risk northern states. Lessons learnt from that partnership would be applied to secure sustained engagement among key religious leaders in the highest-risk states.

Nationwide rounds of vaccination had taken place, with funding from the Federal Government towards operational costs. The improvement of routine immunization had resulted in a national rate of coverage with three doses of oral poliomyelitis vaccine of 73.9%, significantly higher than the 37% coverage reported in 2006. A comprehensive emergency action plan for the high-risk areas had been drawn up and its implementation would be closely monitored by national coordination committees. A major challenge to implementing the Global Polio Eradication Initiative in Nigeria was inadequate funding: of the estimated US\$ 275 million required for 2011–2012, there was a US\$ 128 million shortfall. Furthermore, the decline in confirmed cases had led to complacency among political leaders and health workers. The emergency action plan was intended to reverse that attitude because even more progress would be needed to interrupt transmission by the end of 2011. She thanked WHO and all other partners for their support.

Dr NORHAYATI RUSLI (Malaysia) expressed her country's appreciation of WHO's work on eradicating poliomyelitis and congratulated the European Region for its swift control of the 2010 outbreak. As wild poliovirus type 2 had been eradicated, and given the need for countries to stockpile vaccines in order to respond to the importation of wild polioviruses, bivalent oral poliomyelitis vaccine should be mass produced, and WHO should examine mechanisms to ensure that those vaccines were affordable and accessible. She appreciated the commitments of countries with endemic poliovirus transmission to reduce or minimize the threat of spread, but she urged them to make a commitment to achieving eradication in the near future.

Ms CADGE (United Kingdom of Great Britain and Northern Ireland), welcoming the progress made towards eradication of poliomyelitis, said that the decline in cases in India and Nigeria offered grounds for cautious optimism. Nevertheless, the outbreaks in the Democratic Republic of the Congo and Tajikistan and the situation in Pakistan were sober reminders of the fragile situation in Africa and Asia. The current year would reveal whether the progress made in 2010 was part of a cycle or the beginning of a sustained trend towards full eradication. That goal would be achieved with commitment to significantly stronger routine immunization and sustained worldwide political engagement, especially in the countries with endemic poliovirus transmission and those with re-established transmission. The funding shortfall was serious, but her Government had recently announced a doubling of its financial contribution to the Global Polio Eradication Initiative over the next two years, with a built-in challenge element designed to encourage other donors to contribute. All countries had an interest in helping to make up the existing budget shortfall in order to make eradication a reality.

Mr BLAIS (Canada) warned that the eradication of poliomyelitis could not be achieved without further funding. He urged all countries and other donors to increase their contributions towards the eradication of poliomyelitis, the goal set for the end of 2012. Political commitment to taking action at the national and international levels was vital.

Ms ZHANG Xiaobo (China) welcomed the remarkable progress made in 2010, in particular the significant decline in the number of wild poliovirus isolations reported in India and Nigeria. Nevertheless, WHO must be more proactive in meeting the challenges posed by countries with new outbreaks due to an imported poliovirus and those with re-established poliovirus transmission; the outbreak in Tajikistan was particularly alarming.

The international community must make eradication a priority and set aside more financial and other resources in order to meet the targets set in the Global Polio Eradication Initiative. WHO should provide more support to countries at risk of importing polioviruses. In her country, for example, transmission of the disease had been interrupted in 2000 but there was a risk of importation from neighbouring countries where the viruses had been endemic. She appealed to the Secretariat for help, in particular for country-specific immunization programmes.

Mr KOVALEVSKIY (Russian Federation) stressed the importance of eradication of poliomyelitis and the risk of importation of wild polioviruses in particular. He drew attention to inaccuracies in paragraph 5 of the progress report: there had been no outbreak of the disease in 2010 and no case of poliomyelitis in the Russian Federation in 2011; imported cases had been detected and isolated in good time. He asked for the text to be corrected.

Dr AL HAJERI (Bahrain) recalled that her country had made significant progress against communicable diseases, including poliomyelitis, from which it had been free since 1994. Its monitoring and surveillance programme had helped to prevent any case due to wild poliovirus. The national vaccination campaign conducted since 1981, with WHO's help, had been an important tool for combating the disease. In 2010, 99.6% of the population had received three doses of poliomyelitis vaccine; the first oral dose had been replaced by an injection. Local, regional and international cooperation to eradicate the disease was essential. She was confident that Bahrain would remain poliomyelitis-free.

Dr KOUILLA (Gabon), congratulating the Secretariat on its coordination of the international fight to eradicate poliomyelitis, said that, although Gabon did not qualify for support for vaccination, it was committed to eradicating poliomyelitis by means of strict management in every health district. In 2010 there had been an outbreak of the disease in the neighbouring Congo, which had led the Government to plan and finance a three-stage preventive vaccination campaign. He requested support for the country's health system at the national and local levels, without which it would be unable to achieve eradication.

Ms DE MORA (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, welcomed the progress made in 2010 towards eradicating poliomyelitis, thanks to the priority accorded by governments and the global community. The fact that more than 80% of cases in 2010 had been in non-disease-endemic countries highlighted the vulnerability of the rest of the world. The outbreak in Tajikistan had been especially alarming but the country's Red Crescent Society had supported the emergency response. Similarly, the Congolese Red Cross had responded to the outbreak in Congo. Timely outbreak response operations had greatly improved, but routine immunization systems had to be strengthened in order to prevent outbreaks. Her Federation agreed with the Independent Monitoring Board that greater attention should be paid to the elements of social mobilization and communications in the Strategic Plan 2010–2012. In 2010 more than 20 000 volunteers from her Federation had assisted with vaccination rounds in Africa, Asia and

Europe. The Federation would continue to support the Strategic Plan 2010–2012 in order to eradicate poliomyelitis.

Mr NICOSIA (Rotary International), speaking at the invitation of the CHAIRMAN, reiterated Rotary International's commitment to eradication of poliomyelitis. Rotary International had donated more than US\$ 1000 million to support eradication in 122 countries over 20 years, in which time incidence had declined by 99%. It would continue to do all it could to achieve full eradication. In April 2011, the Independent Monitoring Board had identified the US\$ 665 million shortfall in funding for global eradication as the major threat to achieving that goal. Rotary International was therefore fast-tracking a donation of US\$ 80 million. He appealed to other donors to match that commitment and to all countries and partners to ensure that their poliomyelitis campaigns were well executed with surveillance of the highest quality. Money alone would not eradicate the disease; the remarkable progress made in India and Nigeria had been made thanks to full commitment at every political level. He urged Angola, Chad, the Democratic Republic of the Congo and Pakistan to intensify their district-specific efforts to achieve eradication of poliomyelitis.

Dr AYLWARD (Assistant Director-General) agreed that the Global Polio Eradication Initiative was at a pivotal point. Striking progress had been made towards eradication, with only 12 cases of wild poliovirus type 3 reported to date in 2011. According to the Independent Monitoring Board, eradication would be achieved in the near future, although possibly not by the end of 2012. Nevertheless, broad application of the best practices that had led to the remarkable success in India and Nigeria could result in complete eradication by the deadline of the current Strategic Plan.

Financing was indeed the major challenge. Despite generous contributions, there remained a budget shortfall of US\$ 665 million, and some activities had already had to be cut. The Director-General had been personally involved in the outreach to existing partners, in particular the world's richest countries, and to a broader group of new stakeholders. That effort had been complemented by generous contributions by Rotary International and the Bill & Melinda Gates Foundation and key partners, such as the Government of the United Kingdom of Great Britain and Northern Ireland. Important new donors, such as the Crown Prince of Abu Dhabi, had made contributions. He thanked the delegate of Bangladesh for highlighting the new economic analysis indicating that the incremental net benefits of completing poliomyelitis eradication aggregated over the period 1988–2035 would be up to US\$ 50 000 million.

The Strategic Plan 2010–2012 included pre-emptive campaigns to stop the international spread of the disease and rapid responses to new outbreaks. The Independent Monitoring Board had decided to monitor quarterly performance and risks. Those risks had been highlighted by the outbreaks in 2010 in Congo and Tajikistan. The main current threats to eradication were to be found in Pakistan and the countries with re-established poliovirus transmission. He agreed that the latter needed to be paid increased attention. The Director-General and WHO's partners would provide the countries where poliovirus transmission had been re-established with the same level of support as that given to countries with endemic poliovirus transmission in order to achieve the 2012 goal.

All partners recognized the need to strengthen routine immunization in order to secure a poliomyelitis-free world. India and Nigeria had recently reported that over the previous five years they had succeeded in carrying out aggressive eradication measures at the same time as stepping up their immunization programmes in the highest-risk areas. WHO had already begun cooperation with the GAVI Alliance to strengthen routine immunization. Significant progress had been made in 2010 on preparing for the post-eradication era, with the publication of studies outlining new strategies to reduce the cost of vaccination in low-income settings with inactivated poliovirus vaccine in the post-eradication era. Negotiations with UNICEF on a stockpile of monovalent vaccines were nearing completion, and new antiviral agents were in the pipeline.

He assured the delegate of the Russian Federation that any errors in the progress report would be corrected as appropriate.

The Director-General and key partners had agreed that they would meet on a quarterly basis to review the assessment of the Independent Monitoring Board in order to support all Member States with eradication through application of the best practices. Increasing emphasis would be laid on post-eradication issues, including cessation of the use of trivalent vaccines and introduction of bivalent vaccine in advance of stopping the use of oral vaccines and routine immunization programmes after eradication. WHO and its partners were fully committed to acting in accordance with the recommendations of the Independent Monitoring Board in order to meet the end-2012 deadline for eradication.

The meeting rose at 12:35.

SEVENTH MEETING

Monday, 23 May 2011, at 14:35

Chairman: Dr M.T. VALENZUELA (Chile)

later: Dr A.-Z. GOLEM (Croatia)

TECHNICAL AND HEALTH MATTERS: Item 13 of the agenda (continued)

Progress reports: Item 13.17 of the agenda (Document A64/26) (continued)

B. Onchocerciasis control through ivermectin distribution (resolution WHA47.32)

Miss NANOOT MATHURAPOTE (Thailand) welcomed the provision by the manufacturer of ivermectin that was free of charge in areas endemic for onchocerciasis. It was to be hoped that such rare commitments by the pharmaceutical industry to help the poor would become more common. She noted that the African Programme for Onchocerciasis Control had effective strategies for interrupting transmission of the disease, such as community-directed treatment with ivermectin, rapid epidemiological mapping, strengthening primary health care and coordination among governments, nongovernmental organizations, sponsoring agencies, donors and the ivermectin manufacturer. It seemed feasible that the disease would be brought under control in Africa, even though the programme would end in 2015. In the other areas in which the disease was found, Latin America and Yemen, control activities had been integrated into national action plans, thereby interrupting transmission. Control or even elimination or eradication of onchocerciasis could be attained in the near future.

Dr WATT (United Kingdom of Great Britain and Northern Ireland) welcomed the impressive progress in onchocerciasis control. Her Government supported the work of the African Programme for Onchocerciasis Control, which reached the poorest in rural areas where health systems were weak or non-existent. There was good evidence of increasing national commitment to the Programme by African countries. Concurrent implementation of other programmes was a real strength; it should be emphasized, however, that the community-based approach was complementary to primary level services and not a substitute.

The main task of the Programme in 2011 was to determine its role after it ended in 2015, including the cost and feasibility of achieving elimination of onchocerciasis by 2020. The strategies should include examination of sustainability, as countries absorbed a greater share of the budget, and the degree to which the process complemented the broader agenda of neglected tropical diseases and primary health care.

Mr METCALFE (International Agency for the Prevention of Blindness), speaking at the invitation of the CHAIRMAN, said that his organization was proud to be one of the founding partners, together with WHO, of the VISION 2020 initiative, "The Right to Sight". He congratulated all stakeholders – national governments, development partners, local communities and not least the commercial partners – on the progress made in combating onchocerciasis. He appealed to donor governments to consider carefully the possibility of extending the African Programme for Onchocerciasis Control for another five years, to 2020, in order to reap all the benefits of past efforts and to ensure that the world was rid of a ghastly disease.

C. Climate change and health (resolutions WHA61.19 and EB124.R5)

Mr ZHAO Yuechao (China) commended the Secretariat on supporting Member States' health ministries in implementing workplans for climate change and health. The issue should be brought within the overall framework of global climate change policy and action, to guide governments in formulating effective, scientifically based response strategies. Adaptation and mitigation constituted a long-term process, one that was particularly important for developing countries, and he suggested that the Secretariat should step up its support to those countries in that respect.

Dr MANSOOR (Iraq), noting the global importance of climate change and health, said that common programmes should be designed for implementation by countries and followed up in accordance with international standards. The studies should be global and multisectoral as climate change affected all areas of health.

Dr JARUAYPORN SRISASALUX (Thailand) said that climate change and its impacts on human health were increasingly acknowledged as a matter of concern by the Thai people. Thailand had launched a project, "Global warming reduction led by health-care facilities", to promote sustainable sanitation activities and reduce production of greenhouse gases by health facilities. The health sector would thus serve as a model of best practices for other communities.

Climate change, a global issue, should be given high priority in WHO's work from the point of view of health security, in which WHO had a good track record. The United Nations Secretary-General had sent a strong message to all United Nations agencies to reduce their carbon emissions. The staff in 52 United Nations agencies created about 1.7 million tonnes of CO₂ equivalent, mainly from international travel. WHO should take concrete action in that area, ensuring that staff travelled less, more often in economy class, and made greater use of communications technology, such as teleconferencing and e-mail. Furthermore, she asked the Secretariat to advise Member States on surveillance and preparatory systems for dealing with future problems, in view of the growing frequency of disasters. A healthy environment was needed for a healthier world.

Dr ISSA MOUSSA (Niger), speaking on behalf of the Member States of the African Region, observed that climate change was affecting many countries in the Region, for instance in the form of desertification, which in turn was increasing the prevalence of malnutrition in several countries of West Africa.

Recalling the Libreville Declaration on Health and Environment in Africa (2008), in which African health ministers had undertaken to implement 11 priority actions, the African Group reaffirmed its support for the decisions taken at the Second Inter-Ministerial Conference on Health and Environment in Africa (Luanda, 23–26 November 2010). In the joint declaration made in Libreville, the ministers had committed their governments to pay special attention to managing the harmful effects of climate change on health, by taking sound, factual decisions based on accurate climate information and implementing a series of preventive actions to reduce the vulnerability of their populations and diminish the additional burden of climate-related diseases. The ministers of each country had undertaken to evaluate, before the end of 2012, the vulnerability of their populations to climate change and to establish a package of health interventions that would increase resistance to climate change by 2014. Those commitments had been strengthened by the recommendations made at the African Union Conference of Ministers of Health (Windhoek, 17–21 April 2011).

A major problem was the low level of participation of the health sector in current negotiations on climate change. Most countries had yet to set up mechanisms for close collaboration between the health and environment sectors, in which joint policies could be formulated to plan, implement, monitor and evaluate actions to address the harmful health consequences of climate change.

The African Group called on WHO, UNEP and other development partners to support accelerated implementation of the Libreville Declaration.

Dr WATT (United Kingdom of Great Britain and Northern Ireland) said that her country continued to applaud WHO's work on climate change and health, and especially its recent work on "health and the green economy". She congratulated the Secretariat on its work at the United Nations Climate Change Conference (Cancún, Mexico, 29 November–10 December 2010) and looked forward to supporting it in the preparations for the next Conference of the Parties in Durban, South Africa, later in 2011. She urged the Secretariat to continue and increase its support to countries in developing adaptation plans, especially those that were the poorest and most vulnerable.

Professor ARSLAN (Bangladesh), speaking on behalf of the Member States of the South-East Asia Region, observed that the Region contained one quarter of the world's population and 30% of the global disease burden. Recent cyclones, tsunamis, landslides, floods and other extreme weather conditions had shown that no country of the Region was immune to the effects of climate change but Bangladesh was the most vulnerable country in the world, owing to its low elevation and its huge population of those at risk. The country faced serious flooding as a consequence of shrinking glaciers in the Himalayas, increased monsoon rainfall and the rise in sea-level, which exacerbated storm surges resulting from cyclones. At the same time, increased salinity in coastal areas was leading to drinking-water shortages and reduced food production.

The Region welcomed WHO's increasingly dynamic role in bringing health to the top of the global climate change agenda and urged it to continue advocacy and awareness-raising, supporting the generation of scientific evidence, and strengthening health systems to protect populations from the adverse health impacts of climate change. In addition, the Regional Office had provided support in the form of working groups, a framework for national plans, and support for research on vulnerability to climate-sensitive diseases. It had also organized high-level meetings in Bangladesh, the second of which had adopted the Dhaka Declaration on Climate Change (2008) to voice the Region's concerns on issues of health.

Bangladesh had shown its commitment to programmes to mitigate the effects of climate change. It had in place a climate change strategy and action plan that included food security, social protection and health; a multi-donor trust fund, to which it had committed US\$ 100 million; a new five-year health plan with provisions to address the impact of climate change on health comprehensively; and strengthened intersectoral coordination on climate change and health.

Countries vulnerable to climate change should collaborate in building capacity in the health sector, conducting research, identifying priorities, taking adaptation measures and mobilizing resources. The Secretariat should maintain its central role in facilitating collaboration and resource mobilization.

Dr KOSHY (Malaysia) said that her Government was fully committed to tackling the issue of climate change and had achieved the highest level of political commitment, with a National Green Technology and Climate Change Council, chaired by the Prime Minister. The Ministry of Health was a member of the Council and was represented in three of the seven technical working groups that had been established. The Government had prepared a national policy on climate change to ensure climate-resilient development for national sustainability, which would affect health.

The health sector had worked closely with other sectors in conducting a vulnerability assessment and to plan adaptation strategies. Malaysia looked forward to further engagement with the Secretariat and other international bodies in order to enhance its capability to deal with climate change and health, on the basis of much-needed expertise from developed countries. Regional collaboration on climate change should also be strengthened.

Mr WAHABI (Morocco) welcomed the efforts of the Secretariat to make Member States aware of the health effects of climate change and to assist them in overcoming them. Climate change had become a reality, with changes in weather patterns and disturbance of the natural balance affecting the most basic needs of life.

His Government had placed environmental questions at the core of its sectoral development strategy, as the predicted climatic changes could jeopardize the country's development. The principles of sustainable development were therefore integrated in all Government programmes. By drafting a national strategy for adaptation of the health sector to the effects of climate change, Morocco had laid the groundwork for implementing the provisions of resolution WHA61.19. Several challenges remained, such as obtaining national data on the consequences of climate change on health, adapting environmental and health monitoring systems to measure climate-related health effects, and identifying emerging risks.

To help countries to overcome such challenges, Morocco urged WHO and other relevant United Nations bodies to study the consequences of climate change on health in developing countries; support countries financially and technically in conducting studies of health vulnerability to climate change; help countries to establish or strengthen environmental and health monitoring to measure climate-related health effects and identify emerging risks; promote the sharing of experiences, capacity-building and a mechanism to follow-up countries' compliance with the United Nations Framework Convention on Climate Change; support implementation of all conventions and agreements on climate change; and establish a regional network to monitor climate-sensitive diseases.

Mrs ARRINGTON AVIÑA (Mexico) said that her Government was committed to strengthening the capacity of its health system so as to reduce to a minimum the effects of climate change. It was also committed to taking mitigation and adaptation measures, in the health area and other sectors, as actions or omissions in one sector could have repercussions on the health of the population.

Mexico had organized a side event during the current Health Assembly to prepare for future United Nations Climate Change Conferences. She thanked the Member States that had participated for their valuable contributions and suggestions, and the WHO Secretariat staff for their support, both during the Conference in Cancún and subsequently.

Dr NEIRA (Public Health and Environment) thanked Member States for their comments and recommendations, which would be pursued. The topic of climate change and health was an increasingly greater priority for WHO: the Director-General on many occasions had characterized climate change as an emerging risk to health, which could jeopardize achievements made so far.

The Secretariat would continue to offer support to Member States in making national evaluations of vulnerability and in their efforts to strengthen their health systems in order better to face up to the challenges of climate change. WHO would be active in all discussions on climate change. The Secretariat would support Member States in including health in climate change negotiations and debates. Adaptation of the health sector to climate change and recognition of the benefits of mitigation for health were central to public health agendas.

In response to the suggestion that WHO should reduce its carbon footprint, she said that the Secretariat had already conducted an assessment and had proposed measures for reducing the carbon footprint of both headquarters and the regional offices. She would report to the Health Assembly on their success in due time.

She welcomed the requests from Member States to accelerate implementation of the Libreville Declaration and to support the efforts of African countries to follow-up on the Second Inter-Ministerial Conference on Health and Environment in Africa. She was also grateful for the support from the delegate of the United Kingdom and others to continue work on "health in the green economy" and to participate fully in international climate change negotiations. In particular, she thanked the delegate of Mexico for its leadership both in Cancún and at the present Health Assembly. Headquarters fully supported the efforts of the regional offices with regard to climate change and health.

D. Improvement of health through sound management of obsolete pesticides and other obsolete chemicals (resolution WHA63.26)

Mr WAHABI (Morocco) recalled that the international community in the early 1970s had declared sound management of obsolete pesticides and other obsolete chemicals to be one of the major aspects of sustainable development. In order to implement resolution WHA63.26, Morocco had adopted a national legislative framework on the use of chemicals and had implemented provisions of the Stockholm Convention. He thanked all countries that had assisted Morocco financially in those areas and in building capacity for rational handling of obsolete pesticides and chemicals as well as in finding acceptable substitutes for them. Nevertheless, difficulties had been encountered, and Morocco urged WHO to draw up practical guides on the handling of obsolete pesticides and other chemicals and to support countries in drafting appropriate legislation.

Mr KOVAČIČ (Slovenia) praised the work of the Secretariat in the field of obsolete chemicals, notably through the WHO Pesticides Evaluation Scheme, under which 13 Member States in several regions received support for life-cycle management of pesticides used for public health. Slovenia encouraged the Secretariat to expand that project to other countries and to continue to strengthen its presence in the Strategic Approach to International Chemicals Management mechanism, including the preparations for the third session of the International Conference on Chemicals Management that would take place in May 2012 in Geneva.

Many countries of eastern Europe and the Caucasus faced dire environmental and health problems caused by dangerous chemicals left over from the time of the former Union of Soviet Socialist Republics. Significant work had been done by the governments of Armenia, Poland, Ukraine and others, particularly Azerbaijan, which in September 2011 would host the 11th International HCH and Pesticides Forum, where issues of regional cooperation on sound management of obsolete pesticides would be further discussed. He drew attention also to the Danube Strategy of the European Union and its action plan for removing obsolete pesticides and other chemicals from the Danube region. Much remained to be done, however, and more financial support and donor attention were needed. WHO and other international bodies, such as the Strategic Approach to International Chemicals Management, had a role to play in achieving the ultimate goal of eliminating obsolete pesticides and other dangerous chemicals all over the world. He suggested that implementation of resolution WHA63.26 be reviewed again at a forthcoming governing body session.

Mrs KHOELI (Lesotho), speaking on behalf of the African Region, said that the problems of the large stockpiles of obsolete chemicals remained unsolved, in African and other developing countries, and mass exposures had occurred. In the African Region, with the support of the Regional Office, selected countries were implementing the WHO approach to the sound management of pesticides to reduce risks to human health. The Region, however, faced challenges, including unmet needs for capacity-building in sound management of pesticides and other chemicals and a lack of or inadequate involvement of the health sector in the forums that addressed pesticides and chemicals, contributing to failure to consider and finance health issues. The Region therefore underlined the importance of paragraph 2 of resolution WHA63.26, urging all stakeholders, especially pesticides manufacturers and waste management companies, to provide capacity-building, and asked them to desist from dumping pesticides and chemicals in the countries that were least equipped to manage the stockpiles appropriately. Sharing of technical expertise should be a priority. WHO's involvement in monitoring compliance with conventions and regulations at central, regional and country levels was pivotal.

Professor AHMED (Bangladesh) observed that more than 60% of the working population in countries of the South-East Asia Region were farmers, who had increasing occupational exposure to chemicals. The general public was also exposed to chemicals and pesticides owing to a lack of awareness of their harmful effects and insufficient labelling. Most countries of the Region had endorsed international policy instruments that supported components of resolution WHA63.26,

including the Basel Convention on the Control of Transboundary Movements of Hazardous Wastes and their Disposal, and the Stockholm Convention on Persistent Organic Pollutants.

Although Bangladesh had banned 25 pesticides and chemicals, some were still produced and used in neighbouring countries, and the status of their stockpiles of those and other obsolete pesticides was unknown. His country lacked the infrastructure and equipment, such as high-temperature incinerators, required for the safe disposal of obsolete chemicals and called for international assistance in that regard. International cooperation was needed to prevent the transboundary movement of hazardous chemicals through effective implementation of international instruments such as the Basel and Stockholm Conventions and the International Health Regulations (2005).

Mr ZHAO Yuechao (China) said that the sound management of obsolete pesticides and other obsolete chemicals was important for the protection of public health. He welcomed WHO's efforts in that area and the achievements set out in the progress report. He called upon the Secretariat to strengthen the capacity of Member States to deal with the stockpiling and to ensure sound management of obsolete pesticides.

Dr NEIRA (Public Health and Environment), having thanked Member States for their useful contributions, said that the second meeting of the Bureau of the International Conference on Chemicals Management due to be held in Ljubljana on 9 and 10 June 2011, would consider a strategy to enhance engagement of the health sector in the sound management of chemicals. It would provide a good opportunity for WHO to influence multisectoral actions to reduce the burden of diseases attributable to chemicals, estimated to be around 10%. WHO also continued to be involved in implementation of the Strategic Approach to International Chemicals Management through its programme of work on chemical safety, and provided staff time for the secretariat of the Approach, as donor support allowed. She welcomed Slovenia's call for increased financial support for the programme and for recognition of health in conventions relating to chemicals.

Mr BOS (Public Health and Environment) thanked Member States for their supportive comments. Part of the sound management of pesticides was preventing the accumulation of obsolete chemicals, and WHO strongly promoted that strategy. It would continue to work with FAO, UNEP and other United Nations bodies to support Member States in that regard. He pointed out that support to countries in the management of public health pesticides and vector-borne disease control had increased.

E. Improvement of health through safe and environmentally sound waste management (resolution WHA63.25)

Mr ITTIPORN WANDEE (Thailand) commended the accelerated implementation of the Libreville Declaration on Health and Environment in Africa and the Luanda Commitment of 26 November 2010. Concerning the use of mercury in health care, he welcomed the decision taken by the Ministry of Health of Argentina in 2010 to halt the import and sale of sphygmomanometers. Mercury-based medical devices were being phased out in all health-care facilities in Thailand. He called upon all Member States to strengthen national health-care and waste management policies, with continued support from WHO.

Ms EL-HALABI (Botswana), speaking on behalf of the Member States of the African Region, said that management of solid and liquid waste continued to present a challenge in countries of the Region. Inadequate legislation, regulatory frameworks and technical expertise; inequitably allocated and limited resources; and political and economic unrest in many countries impeded the implementation of various multilateral environmental agreements, such as the Libreville Declaration and the Luanda Commitment. Significant progress had, however, been made by the establishment of

the African Core Group on the Strategic Approach to International Chemicals Management, through which it was hoped that access to that body's Quick Start Programme Trust Fund would be enhanced.

Countries should reaffirm their commitment to prioritizing environmental issues that had a negative impact on health, such as poor sanitation and waste management. The African Region urged the Director-General to advocate full implementation of resolution WHA63.25. Noting that the African Region remained committed to enhancing implementation of various conventions on waste management, in partnership with WHO, the donor community and other interested parties, she called for assistance in the management of all hazardous wastes.

Professor ARSLAN (Bangladesh) said that poor management of health-care waste placed health-care workers, waste handlers and the community at risk of infection, toxic effects and injury. Bangladesh's production of hazardous medical waste was expected to increase from 8000 tonnes at present to 10 000 by 2015, and his Government had identified health-care waste management as one of the most important issues in the health sector programme for 2011–2016. Training in standard procedures for health-care waste management was given in hospitals, but compliance had to be improved. The continued dumping of non-segregated solid medical waste into roadside municipal dustbins and of liquid medical waste into drains and water bodies led to environmental contamination. The effectiveness and training needs of health-care workers had been evaluated with technical support from WHO. Health-care waste management should be linked to the protection of health-care workers, and environmentally sound management of hazardous waste would help to promote sustainable development.

Mr ZHAO Yuechao (China) stressed the importance of working with other parties to promote and support the safe management of chemicals and waste in the aftermath of natural disasters.

Dr MANSOOR (Iraq) said that science should be the basis of programmes of work for improving health through safe and environmentally sound waste management. Partnerships among stakeholders and experts should be strengthened in the framework of primary health care and steps taken to raise awareness in the population. Action to improve safe and environmentally sound waste management was essential for the achievement of Millennium Development Goal 7 (Ensure environmental sustainability).

Dr NEIRA (Public Health and Environment) thanked Member States for their comments and said that work on ensuring sustainability, waste management and environmental health would remain at the core of WHO's activities. She commended the important work undertaken by African countries through the Libreville Declaration on Health and Environment in Africa and the Luanda Commitment, which, it was to be hoped, would extend to waste management. She had noted the comments about the need to ensure safe waste management in emergencies and on the importance of establishing partnerships and linking work to achievement of the Millennium Development Goals. With regard to the phasing-out of mercury in health-care facilities, she drew attention to a WHO draft discussion paper issued on 2009 entitled "Healthy hospitals, healthy planet, healthy people: addressing climate change in health-care settings", which provided further information on the WHO initiative on safe and green health-care facilities.

F. Working towards universal coverage of maternal, newborn and child health interventions (resolution WHA58.31)

Ms VAN GULIK (Netherlands), speaking also on behalf of Canada, Denmark, Finland, France, Norway and Sweden on progress reports F, G and H, said that gender equality and the empowerment of women were crucial to achieving health goals and international development objectives. She expressed concern at the slow progress in ensuring gender equality in the Organization's work at all levels; more attention should be paid to addressing the place of women in leadership roles and the

Secretariat's accountability in that respect. In the context of WHO reform, she called for a strong accountability mechanism for gender equality and appropriate reporting.

Least progress in achieving the health-related Millennium Development Goals was being made in improving maternal health (Goal 5). Universal coverage of mothers, neonates and children with interventions and implementation of the United Nations Secretary-General's Global strategy for women's and children's health were essential. As the 2015 deadline for the Goals approached, it became even more urgent to scale up efforts and focus on interventions with the greatest impact. The recommendations of the United Nations Commission on Information and Accountability for Women's and Children's Health must be put into practice.

Sexual health and rights were central to maternal health and must be extended to all, regardless of sexual orientation and gender identity. Sexual and other gender-based violence had a pervasive impact on health, with high costs for both society and the individuals concerned. Those challenges must be addressed as a priority, including by political and religious leaders. Female genital mutilation and cutting was a form of violence against women and girls, a violation of their human rights, a worldwide challenge and a threat to achievement of the health-related Millennium Development Goals. The practice must be tackled comprehensively by all parts of society and at all levels of government. More reliable, evidence-based data were needed in order to form a clearer picture of effective methods to prevent female genital mutilation, and she welcomed the UNFPA/UNICEF Joint Programme and Trust Fund to accelerate abandonment of the practice, which was facilitating the process of change in some countries.

She encouraged WHO to cooperate with bodies such as United Nations Women, the Partnership for Maternal, Newborn and Child Health and UNFPA to ensure that women's rights and health were at the core of its activities, avoiding duplication of effort. It was important to maintain the highest political commitment at national and international levels to ensure that the current momentum was not lost.

Professor ARSLAN (Bangladesh) said that Bangladesh was one of 17 countries with a high burden of mortality of children under five years that had made good progress, having more than halved the rate since 1990. It had also made good progress with respect to Goal 5 (Improve maternal health), having reduced maternal mortality by 66% between 1990 and 2010, and was well on track to achieve the target of a 75% reduction by 2015. That progress was due to social mobilization and increased awareness. Demand for child immunization had increased, as had women's empowerment, through encouragement of female education and employment, promotion of family planning services and safe abortion. Bangladesh was planning to expand its community clinic services across the country, from some 11 000 at present to 18 000 in two to three years.

Reproductive health-care services were provided throughout the health-care network, in both facilities and households. The shortage of health personnel, in particular obstetricians, anaesthetists and skilled birth attendants, was a major obstacle to scaling up intensive programmes. The Ministry of Health was implementing an innovative maternal health voucher scheme to improve access to and use of high-quality maternal health services. Vouchers were distributed to some 274 000 poor pregnant women annually in 10% of the national territory, providing for antenatal check-ups, including medical tests and travel. The cost was US\$ 25 per pregnancy, and an additional cash incentive worth US\$ 27 was provided for childbirth by a skilled attendant. A case-control study in 2010 had concluded that the scheme had had an unprecedented impact on access to and use of maternal health services. Additional financial resources were required in order to expand the scheme throughout the country.

Challenges in the maternal and child health programme remained. Gaps had been identified in the continuum of care, particularly in the postnatal period, when the risk for mortality of both the mother and newborn infant was high. Efforts to promote institutional delivery, skilled birth attendance and close monitoring of newborn infants in the first few days of life could help Bangladesh to decrease significantly the maternal and child mortality rates.

Bangladesh had recently introduced a programme for monitoring vital events with innovative use of information technology, with support from the WHO Health Metrics Network. All stakeholders

were involved in tracking maternal and child events with respect to achievement of the indicators for Goals 4 and 5. His Government was also strengthening its health information system through appropriate technology. Other countries could benefit from Bangladesh's valuable experience.

Mr KAYITAYIRE (Rwanda), speaking on behalf of the Member States of the African Region, noted with concern that much remained to be done if Millennium Development Goals 4 and 5 were to be achieved in the Region. Maternal mortality would have to be reduced by a mean of 5.5% annually in order to achieve Goal 5 (Improve maternal health), but the annual reduction had been only 1.7% between 1990 and 2008. Although child mortality was currently falling at an average rate of 1.4% a year, African countries would have to achieve an average annual rate of 8% before 2015 in order to achieve Goal 4. Slow progress was being made in increasing coverage with essential interventions in the African Region: only 47.5% of births were assisted by skilled birth attendants, and a mere 12% of women requiring emergency obstetric assistance received the care they needed.

The "road map" for accelerating attainment of the Millennium Development Goals for maternal and newborn health in Africa adopted by African health ministers in 2004 had nevertheless advanced universal coverage with maternal, newborn and child health interventions in the Region. Outlining some of the steps taken, he said that in 2004 Member States had adopted a 10-year framework to reposition family planning in reproductive health services, in view of its essential role in reducing maternal and newborn mortality and morbidity. A campaign for accelerated reduction of maternal mortality in Africa, approved by health ministers in 2009, had been launched at national level by 29 Member States, and, in 2010, more than 220 managers of child health programmes from 18 countries had received training in planning and managing programmes, mobilizing resources, communication and exchange of competences. The conference on "Population, development and family planning in Francophone West Africa" (Ouagadougou, 8–10 February 2011) had demonstrated the commitment of States and partners to accelerate implementation of the road map.

Further challenges that the Region faced in the area of maternal, newborn and child health included the limited access of women and children to high-quality care and the absence of legislation to protect them. Sexually transmitted infections, including HIV, remained a problem, as did malaria, tuberculosis, poor nutrition, the increasing sexual exploitation of children, increasing vulnerability of adolescents due to early sexual activity and widespread traditional practices such as female genital mutilation. Moreover, there were shortages of financial and human resources, equipment and medicines for the provision of high-quality mother-and-child health-care programmes.

He welcomed the establishment of the United Nations Commission on Information and Accountability for Women's and Children's Health and its findings on the commitment of States and partners with respect to the planning, financing and monitoring of actions to promote women's and children's health.

With regard to implementation of resolution WHA58.31, he suggested that the budget allocations for relevant activities be increased to help Member States of the Region to meet the challenges that were hindering achievement of Millennium Development Goals 4, 5 and 6.

Dr NIPUNPORN VORAMONGKOL (Thailand) said that, in order to achieve sustainable universal coverage of maternal, newborn and child health, Member States must take into account important social determinants affecting reproductive health and behaviour. Steps to strengthen the existing family planning system and to provide reproductive health education for young people were essential in order to prevent unwanted and/or teenage pregnancies. She called upon the Director-General to provide support for evaluations of the cost-effectiveness of screening for common birth defects with a view to reducing the high burden of those that were preventable, thus increasing the resources available for maternal and child health. Maternal health was closely linked to risk factors for noncommunicable diseases, including smoking, alcohol use and obesity. Integration of sustainable health financing, universal coverage and the prevention and control of noncommunicable diseases should therefore be established at all levels.

Dr KOSHY (Malaysia) said that maternal, newborn and child health interventions were given prime importance in the national health policy of her country. Essential health interventions had been integrated into the health system to improve the health of women during pregnancy, childbirth and beyond. As a result of various interventions provided by static and mobile clinics and outreach programmes, coverage of maternal, newborn and child health had reached close to 100%. The services provided included infant and child vaccination, increased numbers of skilled birth attendants, access to emergency obstetric care, care of low-birth-weight infants and the provision of clean water and proper sanitation in both urban and rural areas. Maternal mortality had declined from 44 per 100 000 live births in 1991 to 28 in 2009, and deaths of children under five years of age had fallen from 16.8 per 1000 in 1990 to 8.7 in 2009. Malaysia had also established a reliable registration system to reduce the misclassification of deaths and generate more accurate information on maternal, infant and under-five-year-old deaths.

The current challenge was to improve child health further, in particular that of young children. Greater attention would be given to reducing maternal, newborn and child morbidity and mortality over the next four years in order to achieve Millennium Development Goals 4, 5 and 6. Actions would include: providing pre-pregnancy care and effective family planning for mothers at high risk, strengthening the delivery of postnatal care, improving sexual and reproductive health for adolescents and addressing unmet family planning needs. Good cooperation between the Government, nongovernmental organizations and the private sector would continue to play an important role in the provision of continuous, high-quality care.

Mrs YAHAYA (Nigeria) observed that between 2003 and 2008 in her country the maternal mortality rate had fallen from 800 per 100 000 live births to 545, the mortality rate among children under five years of age had decreased from 201 per 1000 live births to 157, and the infant mortality rate had fallen from 100 per 1000 live births to 75. In order to achieve universal coverage with maternal, newborn and child health interventions and to attain Millennium Development Goals 4 and 5, her Government had adopted an integrated maternal, newborn and child health strategy. Progress had already been made in areas including safe motherhood, family planning, adolescent reproductive health, sexually transmitted infections including HIV, and cancers of the reproductive tract. Her Government was also taking steps to strengthen institutional capacity and infrastructure, including refurbishing existing primary health centres and building new ones, procuring equipment for emergency obstetric and newborn care and strengthening the capacity of frontline health workers in areas such as life-saving skills. A capacity-building project for emergency obstetric and neonatal care had been conducted for doctors in eight States with the support of WHO, and a midwives' service scheme had been established to increase skilled birth attendance. Steps had also been taken to secure the provision of magnesium sulfate for use in the management of pre-eclampsia and eclampsia. Contraceptives had been procured with the assistance of UNFPA and development agencies, and the Federal Government had approved the free-of-charge distribution of contraceptives in public health sector facilities across the country.

In order to strengthen the health system further, many policy documents, including guidelines and protocols for the integrated management of childhood illnesses and a counselling guide for promotion of key household and community practices, had been revised to accommodate emerging issues. The vesico-vaginal fistula programme was a priority. The first National Family Planning Conference (Abuja, 22–24 November 2010) had been held in order to highlight the importance of family planning in maternal and child health; one output had been a financial commitment for the procurement of contraceptive commodities by the Office of the Special Assistant to the President on Millennium Development Goals.

Despite the achievements made, challenges remained, including: the low coverage with high impact interventions; poor access to health services; weak human resources development; poor referral linkages, in particular for obstetrics and neonatal emergencies; and inadequate financial support. She expressed confidence, however, that Nigeria would be able to attain all the health-related Millennium

Development Goals, given its readiness to tackle the challenges identified, strong political support and continued commitment and support from WHO and other development partners.

Ms SHI Qi (China) remarked that, although some progress had been made, coverage with effective interventions for mother, newborn and child health remained uneven. All Member States must therefore strive to promote universal coverage, which was essential for achieving Millennium Development Goals 4 and 5. Noting that the quality of service remained a concern, she said that the Secretariat should support Member States in reforming their health systems and offer guidance and support to improve service delivery and ensure high-quality health services for women and children. The United Nations Secretary-General's Global Strategy for Women's and Children's Health had provided a platform for sustained improvement, and it was to be hoped that WHO would continue to work towards universal coverage with maternal, newborn and child health interventions.

Dr WATT (United Kingdom of Great Britain and Northern Ireland) recalled that the achievement of universal coverage with maternal, newborn and child health interventions was linked to other issues addressed by the Health Assembly, including the health-related Millennium Development Goals, neonatal mortality and health system strengthening. The scaling up of vital interventions to save the lives of women and children, including increasing access to skilled birth attendants and family planning, and strengthening the quality of care were priorities for her Government. She supported the Secretary-General's global strategy for women's and children's health. Her Government looked forward to working with the Secretariat and partners to ensure that all relevant commitments were met.

Dr MANSOOR (Iraq) said that, in order to ensure universal coverage, national and regional strategies should take account of the indicators for Millennium Development Goals 4 and 5. Other measures for achieving universal coverage included sharing experiences and information on best practices, building capacity in the area of maternal, newborn and child health, forming partnerships with international organizations and civil society and raising public awareness. Such activities should be integrated into primary health care in order to improve the health of families. Emphasis should be placed on postnatal care in order to reduce maternal mortality, as well as on breastfeeding and reproductive health, given the importance of maternal, newborn and child health for sustainable development.

Mr GUENNAR (Algeria) observed that progress towards achieving Millennium Development Goals 4 and 5 had been slow, especially in low-income countries. For Goal 4, vaccination programmes to control diarrhoeal and acute respiratory infections among others had contributed to lowering child mortality, but newborn mortality, which accounted for 80% of child deaths, would be reduced only by adopting new strategies, requiring increased financial resources. In order to accelerate progress towards maternal and child health, his Government had adopted a three-year programme to standardize the organization and functioning of neonatal and perinatal services. The aim was to reduce by 2012 perinatal mortality by 30% and maternal mortality by 50%, through: screening and effective management of high-risk pregnancies in 246 referral centres; standardized obstetric monitoring procedures to reduce by 30% maternal deaths due to haemorrhaging (which was the main cause of maternal mortality in Algeria); and standardized delivery rooms as part of the same health infrastructure. A total of 26 mother and infant complexes had been established.

He called on the Secretariat to provide technical assistance and resources to reduce maternal, newborn and child mortality, and drew attention to the shortage of information systems for evaluating progress made in different sectors in attaining the Millennium Development Goals. To that end, his Government had set up a bureau tasked with developing a multisectoral statistical information system for the follow-up and evaluation of progress towards achieving the Goals.

Dr MASON (Child and Adolescent Health and Development) said that she recognized the need to support implementation of the recommendations of the Commission on Information and Accountability for Women's and Children's Health, and WHO was taking the necessary steps. WHO hosted the Partnership for Maternal, Newborn and Child Health and also worked closely with UNICEF, UNFPA, the World Bank, UNAIDS and UN Women. Member States' support of a continuum-of-care approach in accelerating achievement of Millennium Development Goals 4, 5 and 6 was gratifying.

G. Female genital mutilation (resolution WHA61.16)

Mr MONTEIRO (Cape Verde), speaking on behalf of the Member States of the African Region, said that progress had been made in implementing resolution WHA61.16. Twelve African countries had introduced national legislation and established national committees for the elimination of female genital mutilation in collaboration with United Nations organizations and local and national nongovernmental organizations. In several other countries of the Region, information and education on the practice had been provided, and interventions were being introduced at community level. Nevertheless, the practice persisted in numerous countries, where it was deeply rooted in culture, religion and the community; young girls and women continued to suffer serious haemorrhages and urinary problems and, in later life, often experienced complications when giving birth, sometimes with the death of the infant. It had been estimated that 100–140 million young girls and women in the world lived with the consequences of genital mutilation. The practice was common in Africa and some countries of the Middle East; furthermore, as a result of mass migration, it affected growing numbers of girls and women in Europe, North America, Australia and New Zealand. In Africa, it was estimated that more than 90 million women and girls over 10 years of age had been mutilated, and that some three million girls were at risk every year. Female genital mutilation was regarded internationally as a violation of the rights of girls and women, including the right to exercise control over their own bodies and their physical and mental health. The practice had to be eliminated if girls and women were to enjoy good health and the benefits of socioeconomic development. He therefore reiterated support for implementation of the resolution and called on all Member States and their development partners to commit to the long-term investment needed to eliminate female genital mutilation and to build the capacity of health professionals and health services to provide adequate care for girls and women who had been mutilated.

Dr KOSHY (Malaysia) urged Member States to accelerate actions in order to eliminate female genital mutilation, a practice that not only violated women's and girls' human rights, but was also a form of sexual abuse and gender discrimination.

It had been reported at the Fifty-second session of the United Nations Economic and Social Council's Commission on the Status of Women that female genital mutilation was permitted in Malaysia. She explained that only female circumcision, classified by WHO as type IV female genital mutilation, was performed in her country, as a religious obligation. A study conducted in 1999 had shown no evidence of injury to the clitoris or labia and no physical sign of excised tissue among women who had undergone female circumcision as infants. No complications had been reported, and it was not considered to be a medical issue.

Dr MANSOOR (Iraq) advocated strengthening cooperation with the international organizations concerned in order to tackle the problem of female genital mutilation in accordance with the minimum requirements under Millennium Development Goal 3 (Achieve gender equality and empower women). Female genital mutilation was a violation of human rights, and that should be made clear to, and understood by, the general public worldwide by use of the full range of communication techniques available.

Dr MBIZVO (Reproductive Health and Research) welcomed the call for additional resources for the elimination of female genital mutilation. Recent studies had demonstrated the adverse consequences of the practice for women in later life, in addition to the pain, suffering and violation of human rights of young girls.

H. Strategy for integrating gender analysis and actions into the work of WHO (resolution WHA60.25)

Dr SUPAT HASUWANNAKIT (Thailand) said that the progress report presented a satisfactory picture of staff knowledge and awareness of gender concepts, especially under strategic direction 1; however, progress was yet to be made under strategic direction 2. The 5% increase in the number of women in the professional category since 2007 would not suffice to achieve significant progress by 2013. According to the report on the staffing profile (document A64/36), 60% of WHO staff members in the professional and higher categories on long-term appointments were men, which indicated that gender equality in terms of employment would be reached by 2020. At higher grades, however, men clearly outnumbered women, and between grades P4 and D2 the number of women diminished, clearly indicating that men were the decision-makers at WHO. Hence, the Secretariat should accelerate its efforts to attain gender equity, particularly at higher grades. He appreciated the honesty of the Secretariat in reporting that little progress had been made under strategic direction 3 and urged it to increase its efforts. For strategic direction 4, he asked the Secretariat to explain which indicators were used to track gender integration.

Ms AREGAWI (Ethiopia), speaking on behalf of the Member States of the African Region, noted that, although the baseline assessment of gender integration in WHO in 2008 had used a comprehensive analysis, little progress had been made in implementing the 2009 strategy for integrating gender analysis into the work of WHO. The progress report in 2010, *Gender mainstreaming in WHO: where are we now?*, did not mention strategic direction 1, indicating that work was needed to build capacity and create an institutional environment that allowed staff members to apply gender analysis skills to their work. Under strategic direction 2, the report did not mention planning, programme or country cooperation strategies. Although there had been a 1.8% overall increase in the number of women in professional categories between 2007 and 2009, the numbers in country offices had declined. Performance at the top management level had not been tracked. Little progress had been made under strategic direction 3, and none at all under strategic direction 4. Top management should pay due attention to strategic direction 4 in order to establish accountability and should take the lead in implementing the new initiative.

The indicator used for measuring strategic direction 4 was the proportion of speeches made by the Director-General and regional directors that included at least one reference to gender. It would be more appropriate to track accountability on the basis of implementation of the strategy. Furthermore, most recommendations from the baseline assessment had not been addressed in the progress report. More effort was needed to address the strategic indicators. WHO reform should take into account gender analysis and planning, in order to ensure full implementation of the gender strategy and the inclusion of mainstreaming and analysis in health policies, strategies, care delivery and services.

Dr MANSOOR (Iraq) said that the WHO gender strategy, which he commended, should be implemented effectively throughout the Organization in order to make the best use of the available human resources and to ensure equality in the workplace, taking into account the specificities of each country.

Dr BEARD (Gender, Women and Health) said that he had noted the comments on the slow progress being made in gender mainstreaming. Despite capacity-building initiatives, the pace of change had been frustratingly slow. Both the quantitative review and the suggestions of delegates on how the indicators could be refined would help to make the strategy more effective in the future. The

accountability measures suggested by the delegate of the Netherlands were particularly pertinent. In response to the question from the delegate of Thailand about progress within WHO, he said that about 43% of managers classified their programmes as gender responsive, but the indicator needed to be validated.

I. Progress in the rational use of medicines (resolution WHA60.16)

Mr KUDO (Japan) observed that inappropriate use of medicines could harm patients even though their quality, safety and effectiveness had been assured. Rational use of medicines was essential for ensuring proper medical care for patients. Comprehensive efforts were required to enhance the rational use of medicines, including ensuring the safety of medicines and monitoring sales, strengthening human resources and health-care systems and providing information to the public. WHO should continue to take the initiative in rational use of medicines.

Mr DRIECE (Netherlands) said that the rational use of medicines was an essential element of health and pharmaceutical policy. It was relevant to many health issues, such as the quality, organization and cost of care, as well as antimicrobial resistance. His Government attached great importance to the matter and, in 2010, had organized a European workshop on improving information for patients, with WHO. It was preparing for a ministerial summit on the rational use of medicines, to be held in Amsterdam in October 2012, to coincide with the Centennial Congress of the International Pharmaceutical Federation, with the aim of providing an opportunity to discuss the rational use of medicines at the political level.

Professor NIKIEMA (Burkina Faso), speaking on behalf of the Member States of the African Region, said that, since the adoption of resolution WHA60.16, considerable progress had been made, in particular in training health professionals to use best practice when prescribing and by promoting the rational use of medicines in health institutions in several countries including the Central African Republic, Chad, Ethiopia, Mali, Senegal and Zambia. A national communication strategy to improve rational use in communities had been adopted in the United Republic of Tanzania. The capacity of technical committees in seven countries had been reinforced for new projects on better medicines for children, and seven countries had revised their national lists of essential medicines and their treatment guides. In order to consolidate the progress made, the Regional Office for Africa had launched a study on resistance to antibacterial agents used in the treatment of diseases of public health importance in Burkina Faso, Ethiopia and Zambia. The results of a household survey in five African countries were being analysed to identify indicators of the use of antibiotics.

The report showed that, although there had been real progress, it was not enough. Most Member States in the African Region had neither adopted a plan of action nor allocated sufficient resources to promote the rational use of medicines. He therefore called on Member States to redouble their efforts.

Dr KAJEERATN PRUGAEGO (Thailand) recalled that in 2009 WHO had reported that medicines were used inappropriately in more than 50% of cases in developing countries, with consequent risks of poor patient outcomes and antimicrobial resistance. In 2006, her country's health ministry, with support from WHO and other partners, had initiated an "antibiotics smart use programme" in order to promote rational use of targeted antibiotics nationwide by 2012. Guidelines on the rational use of medicines had also been issued and widely circulated. Her Government had endorsed a national medicines policy and strategy in April 2011, and had an independent strategy on the appropriate use of medicines in the public and private sectors and at community level.

Dr NORHAYATI RUSLI (Malaysia) said that, since 2006, rational use of medicines had been a crucial component of the national medicines policy in her country. Various strategies were in force to promote rational prescribing and appropriate use of medicines by health-care providers and consumers. Those strategies were promoted by the Ministry of Health and other stakeholders, in order

to maximize health outcomes, reduce adverse events and keep health costs within affordable limits. In hospitals, dedicated committees were responsible for developing and coordinating in-house medicines and treatment policies and for adopting the national essential medicines list. Information centres answered questions on medicines and related matters either in person or by telephone, and the Government had set up a national pharmacy call centre that was open 24 hours a day, and a dedicated Internet portal.

Mr CONSTANT (Trinidad and Tobago) said that his country was reviewing its national policy in order to integrate the regulation of medicines and related health products, goods and services, including food, in the essential public health functions of the Ministry of Health. The medicines supply management system was being strengthened, and the pharmaceutical policy, which had been formulated in 1990, was being updated. The recent approval of the Caribbean pharmaceutical policy by health ministers of the member countries of the Caribbean Community would ensure universal access to medicines and appropriate, cost-effective use of medicines by health professionals and patients. A subregional strategy and workplan were envisaged, including regulations, norms and standards. His country represented the Caribbean Community in the steering committee of the Pan-American Network for Drug Regulatory Harmonization. His country's progress in the rational use of medicines had been facilitated by a partnership coordinated by the European Commission, WHO, and Africa, the Caribbean and the Pacific Islands (the EC/WHO/ACP Partnership on Pharmaceutical Policies), which had been terminated in September 2010. In order to consolidate the progress made, his Government requested that the project be renewed.

Mrs LUTTERODT (Ghana) said that her Government recognized that the rational use of medicines critically affected health financing and outcomes of health-care delivery. She commended the Secretariat's innovative approaches to promoting rational medicines use, especially the recruitment of highly qualified staff at country level as technical focal points, and she welcomed the issue of the list of essential medicines to treat maternal and child health problems, which would contribute to the achievement of Millennium Development Goals 4 and 5.

Rational use of medicines was a cross-cutting matter that was strategic to the delivery of health care in Ghana and to national insurance schemes, by reducing waste and increasing efficiency. Implementation of resolution WHA60.16 would, however, require partnerships in order to address the funding gap.

She reaffirmed her Government's commitment to WHO's Essential Medicines and Pharmaceutical Policies and the tools developed for their implementation, which had been used as the basis for the sixth edition of the Ghana Standard Treatment Guidelines and Essential Medicines List in 2010. Ghana was piloting the "better medicines for children" project, although access to paediatric medicines was poor. WHO should form appropriate partnerships to ensure that children were not offered reconstituted adult medications.

Monitoring the rational use of medicines required training and good practice on the part of health-care personnel, advocacy, behavioural change and clear policies, all of which would involve capacity-building and effective monitoring, ideally supported by WHO. She commended WHO's planned programme on antimicrobial resistance management, which it was to be hoped Member States would support through alliances and partnerships.

Mr BESANÇON (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN and on behalf of the World Health Professions Alliance, mentioned the planned ministerial summit in October 2012 on the responsible use of medicines. Feedback and factual information on prescribing and dispensing patterns indicated that, in community settings, collaboration among health-care professionals and delivery of coordinated multidisciplinary care could maximize resources and lead to better, more responsible use of medicines and thus improve health outcomes and reduce costs.

He drew attention to the lack of equitable access across the world to essential medicines for chronic diseases. That neglected area must be tackled if the Millennium Development Goals were to be achieved. Health-care professionals were well placed to advocate better pricing, availability and quality as well as rational use of essential medicines for noncommunicable diseases. The Alliance called on countries to work collaboratively with national health professional organizations to include rational use of medicines in their plans and to commit the resources needed to implement integrated system-based programmes that ensured equitable availability of medicines and health personnel.

Dr HOGERZEIL (Health Systems and Services) said that the rational use of medicines remained a major concern because of the unrealized potential for achieving better health outcomes and reducing costs. Although some countries were making progress, others were facing challenges in collecting and presenting evidence in order to convince policy-makers. The Secretariat welcomed the opportunity to collaborate with the Government of the Netherlands in organizing the ministerial summit on the rational use of medicines, which would draw high-level attention to the topic. In preparation for the summit, the Secretariat would compile a review of the potential financial benefits of programmes on the rational use of medicines.

Dr Golem took the Chair.

J. Implementation by WHO of the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors (resolution WHA59.12)

Dr ORAPAN THOSINGHA (Thailand) thanked the Global Task Team to combat HIV/AIDS for its recommendations to strengthen the capacity of networks of multilateral organizations and international donors. Countries should nevertheless monitor and evaluate the activities of international partners such as WHO, UNFPA and UNICEF and also domestic governmental and nongovernmental organizations in order to ensure a reliable, participatory approach. WHO should provide syntheses of the outcomes of monitoring and evaluation, including feedback from countries, and inform its partner agencies at high-level United Nations meetings.

Ms KATJIVENA (Namibia), speaking on behalf of the Member States of the African Region, said that prevention remained the cornerstone of the regional response to the HIV/AIDS epidemic. Therefore, coordination of programmes targeting vulnerable groups, such as young people and mobile populations, and focusing on fidelity, fewer sexual partners and condom use remained priorities. She welcomed the Secretariat's close collaboration with UNAIDS, Member States, the Global Fund to Fight AIDS, Tuberculosis and Malaria and other stakeholders to coordinate and harmonize technical support to countries and its contribution to the UNAIDS technical support strategy, which clarified the comparative advantages and roles of the UNAIDS secretariat, its cosponsors and other United Nations entities and technical support providers. She urged the Secretariat to increase its role in building regional and national capacity in order to strengthen the response of the health sector. Formulation of national HIV/AIDS strategic plans was enhancing coordination among donors and development partners.

Although WHO's technical assistance to the AIDS response had increased in the African Region, support was still needed in the areas of: health-sector planning, health-system strengthening, HIV strategic information, HIV prevention in the health sector and access to health services for populations that were most at risk and vulnerable. She expressed appreciation of the achievements described in the report, but remaining obstacles included: major funding shortfalls for joint plans; domination by agency mandates of joint programmes; differences in skills, capacity and allocation of staff between agencies; difficulties in tracking expenditure; and segmented, agency-based implementation. WHO should strengthen the coordination of stakeholders in order to address those challenges. She welcomed the initiatives for improving coordination of AIDS programmes that

enhanced sustainable health systems, financing and technical support for the regional response. The Region would redouble its efforts to combat HIV in order to reach the long-term goal of zero discrimination, zero AIDS-related deaths and zero new infections.

Dr MANSOOR (Iraq) said that the Global Task Team for Improving AIDS Coordination had supported Iraq's own coordination activities. The Iraqi working group was composed of representatives of Government ministries and members of civil society, including people who had been affected by AIDS; it was headed by the Minister of Health. Its broad base was intended to ensure active participation, so that appropriate decisions could be taken on combating AIDS. The working group also included members of professional associations in an effort to strengthen the ties between the public and private sectors. A coordinated effort was required to use fully the available resources, especially donor funding.

Dr NORHAYATI RUSLI (Malaysia) supported the recommendations of the Global Task Team and urged other Member States to do the same, in line with the "three ones" principle (one agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners, one national AIDS coordinating authority, with a broad-based multi-sector mandate, and one agreed country-level monitoring and evaluation system) and the "three zeros" goal. WHO should continue to play a key role in improving coordination between multilateral agencies, particularly through technical support. She welcomed the target set by UNAIDS to eliminate mother-to-child transmission of HIV and congenital syphilis by 2015. To that end, the communicable diseases surveillance system needed continuous strengthening, particularly for HIV and sexually transmitted infections.

Dr BALL (HIV/AIDS) said that, since the adoption of resolution WHA59.12, much had changed in the HIV environment and the structure of multilateral and donor responses. The Second Independent Evaluation of UNAIDS and the subsequent UNAIDS Strategy 2011–2015, which had taken account of the recommendations of the Global Task Team, had resulted in a new framework for monitoring and reporting on the HIV response, including coordination between multilateral and other bodies. The endorsement of the global health sector strategy on HIV/AIDS 2011–2015 by the present Health Assembly provided a new framework for WHO to report on its efforts as well as to facilitate coordination of multilateral and donor responses. Those two strategies would be complementary, allowing monitoring to continue. He had noted the comments of the delegates of Namibia and Thailand concerning the specific areas in which WHO should strengthen its work, including monitoring and evaluation, contributing to high-level meetings and technical support for health-sector planning, health-system strengthening, strategic information and prevention among populations that were vulnerable and most at risk.

The Committee noted the reports.

The meeting rose at 17:45.

EIGHTH MEETING

Tuesday, 24 May 2011, at 09:15

Chairman: Dr A.-Z. GOLEM (Croatia)

1. FOURTH REPORT OF COMMITTEE B (Document A64/62 (Draft))

Mr TUITAMA LEAO TUITAMA (Rapporteur) read out the draft fourth report of Committee B.

Dr KOVÁCS (Hungary) said that the European Union, on whose behalf he was speaking, had wished to cosponsor the resolution on youth and health risks. He asked for that statement of intent to be entered into the official records.

The report was adopted.¹

2. CLOSURE OF THE MEETING

After the customary exchange of courtesies, the CHAIRMAN declared the work of Committee B completed.

The meeting rose at 09:20.

¹ See page 341.

PART II
REPORTS OF COMMITTEES

The text of resolutions and decisions recommended in committee reports and subsequently adopted without change by the Health Assembly has been replaced by the serial number (in square brackets) under which they appear in document WHA64/2011/REC/1.

COMMITTEE ON CREDENTIALS

Report¹

[A64/52 – 18 May 2011]

The Committee on Credentials met on 17 May 2011. Delegates of the following Member States were present: Costa Rica; Fiji; Gabon; Latvia; Malawi; Maldives; New Zealand; Serbia; Uzbekistan.

The Committee elected the following officers: Dr Kevin Woods (New Zealand) – Chairman; and Professor David Mphande (Malawi) – Vice Chairman.

The Committee examined the credentials delivered to the Director-General in accordance with Rule 22 of the Rules of Procedure of the World Health Assembly. It noted that the Secretariat had found these credentials to be in conformity with the Rules of Procedure.

The credentials of the delegates of the Member States shown at the end of this report were found to be in conformity with the Rules of Procedure as constituting formal credentials; the Committee therefore proposes that the World Health Assembly should recognize their validity.

The Committee examined notifications from the Member States listed at the end of this paragraph which, although indicating the names of the delegates concerned, could not be considered as constituting formal credentials in accordance with the provisions of the Rules of Procedure. The Committee therefore recommends to the World Health Assembly that the delegates of these Member States be provisionally seated with all rights in the Health Assembly pending the arrival of their formal credentials: Egypt, Georgia, Marshall Islands, Tajikistan, The former Yugoslav Republic of Macedonia.

The Committee noted that the Secretariat had received two sets of credentials for two different delegations, each asserting that it represents the Libyan Government at the Sixty-fourth World Health Assembly. Namely:

- (a) On 12 May 2011, the Secretariat received by electronic mail provisional credentials for three delegates signed by the Secretary of the General People's Committee for Health and Environment of the Libyan Arab Jamahiriya. It was accompanied by a similar document signed by the "General Katib" (title: "Minister") of the General People's Committee for External Communication and International Cooperation mentioning the three same persons.

¹ Approved by the Health Assembly at its seventh plenary meeting. Formal credentials of Saint Lucia and Georgia were examined by the President and accepted by the Health Assembly at its ninth plenary meeting.

(b) On 16 May 2011, the Secretariat received by facsimile provisional credentials for two delegates emanating from the Permanent Mission of the Socialist People's Libyan Arab Jamahiriya to the United Nations Office at Geneva and other international organizations in Switzerland. Prior to that, the Director-General had received on 9 March 2011 a letter from the same Mission forwarding to the Organization a Statement of the Interim Transitional National Council of Libya by which, inter alia, "*all Libyan delegations to the UN [...] and members of the Libyans embassies who joined the revolution are considered legitimate representatives of the Council.*" Subsequently, on 16 March 2011, the General People's Committee for External Communication and International Cooperation of the Libyan Arab Jamahiriya informed the Director-General of the United Nations Office in Geneva that "*the Libyan Permanent Mission's diplomats accredited to the UN in Geneva are no longer representing the Libyan Arab Jamahiriya.*"

Statements on the question of the credentials of the Libyan Arab Jamahiriya were made by several members of the Committee on Credentials.

The Committee decided to recommend to the World Health Assembly that it defer a decision on the question of the credentials of the Libyan Arab Jamahiriya, pending guidance from the United Nations General Assembly, on the understanding that nobody would occupy the seat of that country at the Sixty-fourth World Health Assembly.

States whose credentials it was considered should be recognized as valid (see fourth paragraph above)

Afghanistan; Albania; Algeria; Andorra; Angola; Argentina; Armenia; Australia; Austria; Azerbaijan; Bahamas; Bahrain; Bangladesh; Barbados; Belarus; Belgium; Benin; Bhutan; Bolivia (Plurinational State of); Bosnia and Herzegovina; Botswana; Brazil; Brunei Darussalam; Bulgaria; Burkina Faso; Burundi; Cambodia; Cameroon; Canada; Cape Verde; Central African Republic; Chad; Chile; China; Colombia; Comoros; Congo; Cook Islands; Costa Rica; Côte d'Ivoire; Croatia; Cuba; Cyprus; Czech Republic; Democratic People's Republic of Korea; Democratic Republic of the Congo; Denmark; Djibouti; Dominican Republic; Ecuador; El Salvador; Equatorial Guinea; Eritrea; Estonia; Ethiopia; Fiji; Finland; France; Gabon; Gambia; Germany; Ghana; Greece; Guatemala; Guinea; Guinea-Bissau; Guyana; Haiti; Honduras; Hungary; Iceland; India; Indonesia; Iran (Islamic Republic of); Iraq; Ireland; Israel; Italy; Jamaica; Japan; Jordan; Kazakhstan; Kenya; Kiribati; Kuwait; Kyrgyzstan; Lao People's Democratic Republic; Latvia; Lebanon; Lesotho; Liberia; Lithuania; Luxembourg; Madagascar; Malawi; Malaysia; Maldives; Mali; Malta; Mauritania; Mauritius; Mexico; Micronesia (Federated States of); Monaco; Mongolia; Montenegro; Morocco; Mozambique; Myanmar; Namibia; Nauru; Nepal; Netherlands; New Zealand; Nicaragua; Niger; Nigeria; Norway; Oman; Pakistan; Palau; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Portugal; Qatar; Republic of Korea; Republic of Moldova; Romania; Russian Federation; Rwanda; Saint Kitts and Nevis; Samoa; San Marino; Sao Tome and Principe; Saudi Arabia; Senegal; Serbia; Sierra Leone; Singapore; Slovakia; Slovenia; Solomon Islands; Somalia; South Africa; Spain; Sri Lanka; Sudan; Swaziland; Sweden; Switzerland; Syrian Arab Republic; Thailand; Timor-Leste; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Turkmenistan; Tuvalu; Uganda; Ukraine; United Arab Emirates; United Kingdom of Great Britain and Northern Ireland; United Republic of Tanzania; United States of America; Uruguay; Uzbekistan; Vanuatu; Venezuela (Bolivarian Republic of); Viet Nam; Yemen; Zambia; Zimbabwe.

GENERAL COMMITTEE**Report¹**

[A64/56 – 19 May 2011]

At its meeting on 18 May 2011, the General Committee, in accordance with Rule 100 of the Rules of Procedure of the World Health Assembly, drew up the following list of 10 Members, in the English alphabetical order, to be transmitted to the Health Assembly for the purpose of the election of 10 Members to be entitled to designate a person to serve on the Executive Board: Cameroon, Mexico, Myanmar, Nigeria, Papua New Guinea, Qatar, Senegal, Sierra Leone, Switzerland, and Uzbekistan.

In the General Committee's opinion these 10 Members would provide, if elected, a balanced distribution of the Board as a whole.

COMMITTEE A**First report¹**

[A64/53 – 18 May 2011]

Committee A held its third meeting on 17 May 2011 under the chairmanship of Dr W. Ammar (Lebanon).

It was decided to recommend to the Sixty-fourth World Health Assembly the adoption of one resolution relating to the following agenda item:

13. Technical and health matters
 - 13.2 Implementation of the International Health Regulations (2005) [WHA64.1].

Second report¹

[A64/54 – 19 May 2011]

Committee A held its fourth meeting on 18 May 2011 under the chairmanship of Dr W. Ammar (Lebanon).

It was decided to recommend to the Sixty-fourth World Health Assembly the adoption of two resolutions relating to the following agenda items:

11. The future of financing for WHO [WHA64.2]
12. Programme and budget matters
 - 12.3 Medium-term strategic plan 2008–2013 and Proposed programme budget 2012–2013 [WHA64.3].

¹ Approved by the Health Assembly at its ninth plenary meeting.

Third report¹

[A64/57 – 20 May 2011]

Committee A held its sixth meeting on 19 May 2011 under the chairmanship of Dr H. Madzorera (Zimbabwe).

It was decided to recommend to the Sixty-fourth World Health Assembly the adoption of one resolution relating to the following agenda item:

- 13. Technical and health matters
 - 13.1 Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits [WHA64.5].

Fourth report¹

[A64/59 – 21 May 2011]

Committee A held its eighth and ninth meetings on 20 May 2011 under the chairmanship of Dr W. Ammar (Lebanon).

It was decided to recommend to the Sixty-fourth World Health Assembly the adoption of five resolutions relating to the following agenda item:

- 13. Technical and health matters
 - 13.4 Health system strengthening [WHA64.6], [WHA64.7], [WHA64.8], [WHA64.9] and [WHA64.10].

Fifth report¹

[A64/61 – 23 May 2011]

Committee A held its tenth meeting on 21 May 2011 under the chairmanship of Dr W. Ammar (Lebanon).

It was decided to recommend to the Sixty-fourth World Health Assembly the adoption of two resolutions and one decision relating to the following agenda items:

- 13. Technical and health matters
 - 13.12 Prevention and control of noncommunicable diseases [WHA64.11]
 - 13.7 Substandard/spurious/falsely-labelled/falsified/counterfeit medical products [WHA64(10)]
 - 13.3 Health-related Millenium Development Goals [WHA64.12].

¹ Approved by the Health Assembly at its tenth plenary meeting.

Sixth report¹

[A64/63 – 24 May 2011]

Committee A held its eleventh and twelfth meetings on 23 May 2011 under the chairmanship of Dr W. Ammar (Lebanon).

It was decided to recommend to the Sixty-fourth World Health Assembly the adoption of four resolutions relating to the following agenda items:

13. Technical and health matters
 - 13.3 Health-related Millennium Development Goals [WHA64.13]
 - 13.6 Draft WHO HIV/AIDS strategy 2011–2015 [WHA64.14]
 - 13.9 Cholera: mechanism for control and prevention [WHA64.15]
 - 13.11 Eradication of dracunculiasis [WHA64.16].

Seventh report¹

[A64/64 – 24 May 2011]

Committee A held its thirteenth meeting on 24 May 2011 under the chairmanship of Dr W. Ammar, Lebanon.

It was decided to recommend to the Sixty-fourth World Health Assembly the adoption of one resolution and one decision relating to the following agenda items:

13. Technical and health matters
 - 13.10 Malaria [WHA64.17]
 - 13.8 Smallpox eradication: destruction of variola virus stocks [WHA64(11)].

COMMITTEE B

First report²

[A64/55 – 19 May 2011]

Committee B held its first meeting on 18 May 2011 under the chairmanship of Dr M.T. Valenzuela (Chile).

It was decided to recommend to the Sixty-fourth World Health Assembly the adoption of one resolution relating to the following agenda item:

15. Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan [WHA64.4].

¹ Approved by the Health Assembly at its tenth plenary meeting.

² Approved by the Health Assembly at its ninth plenary meeting.

Second report¹

[A64/58 – 20 May 2011]

Committee B held its second meeting on 19 May 2011 under the chairmanship of Dr M.T. Valenzuela (Chile).

It was decided to recommend to the Sixty-fourth World Health Assembly the adoption of six resolutions relating to the following agenda items:

17. Financial matters
 - 17.1 Unaudited interim financial report on the accounts of WHO for the year 2010 [WHA64.18]
 - 17.3 Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution [WHA64.19]
 - 17.4 Special arrangements for settlement of arrears [WHA64.20]
 - 17.5 Scale of assessments for 2012–2013 [WHA64.21]
 - 17.7 Amendments to the Financial Regulations and Financial Rules [WHA64.22]
 - 17.8 Appointment of the External Auditor [WHA64.23].

Third report¹

[A64/60 – 21 May 2011]

Committee B held its fourth and fifth meetings on 20 May 2011 under the chairmanship of Dr M.T. Valenzuela (Chile) and Dr A.Z. Golem (Croatia).

It was decided to recommend to the Sixty-fourth World Health Assembly the adoption of three resolutions and one decision relating to the following agenda items:

13. Technical and health matters
 - 13.15 Strategies for the safe management of drinking-water for human consumption [WHA64.24]
18. Staffing matters
 - 18.3 Amendments to the Staff Regulations and Staff Rules [WHA64.25]
 - 18.5 Appointment of representatives to the WHO Staff Pension Committee [WHA64(8)]
20. International Agency for Research on Cancer: amendments to Statute [WHA64.26].

¹ Approved by the Health Assembly at its tenth plenary meeting.

Fourth report¹

[A64/62 – 24 May 2011]

Committee B held its sixth and seventh meetings on 23 May 2011 under the chairmanship of Dr M.T. Valenzuela (Chile) and Mr Z. Dukpa (Bhutan).

It was decided to recommend to the Sixty-fourth World Health Assembly the adoption of two resolutions relating to the following agenda items:

13. Technical and health matters
 - 13.14 Child injury prevention [WHA64.27]
 - 13.16 Youth and health risks [WHA64.28]

¹ Approved by the Health Assembly at its tenth plenary meeting.

LIST OF PARTICIPANTS

**MEMBERSHIP OF THE HEALTH ASSEMBLY
COMPOSITION DE L'ASSEMBLÉE DE LA SANTÉ**

**LIST OF DELEGATES AND OTHER PARTICIPANTS
LISTE DES DÉLÉGUES ET AUTRES PARTICIPANTS**

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