



WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD

116TH SESSION

GENEVA, 26-27 MAY 2005

DECISIONS

SUMMARY RECORDS

GENEVA
2005

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

ACHR	– Advisory Committee on Health Research	PAHO	– Pan American Health Organization
ASEAN	– Association of South-East Asian Nations	UNAIDS	– Joint United Nations Programme on HIV/AIDS
CEB	– United Nations System Chief Executives Board for Coordination (formerly ACC)	UNCTAD	– United Nations Conference on Trade and Development
CIOMS	– Council for International Organizations of Medical Sciences	UNDCP	– United Nations International Drug Control Programme
FAO	– Food and Agriculture Organization of the United Nations	UNDP	– United Nations Development Programme
IAEA	– International Atomic Energy Agency	UNEP	– United Nations Environment Programme
IARC	– International Agency for Research on Cancer	UNESCO	– United Nations Educational, Scientific and Cultural Organization
ICAO	– International Civil Aviation Organization	UNFPA	– United Nations Population Fund
IFAD	– International Fund for Agricultural Development	UNHCR	– Office of the United Nations High Commissioner for Refugees
ILO	– International Labour Organization (Office)	UNICEF	– United Nations Children’s Fund
IMF	– International Monetary Fund	UNIDO	– United Nations Industrial Development Organization
IMO	– International Maritime Organization	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
OIE	<i>Office International des Epizooties</i>	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 116th session of the Executive Board was held at WHO headquarters, Geneva, from 26 to 27 May 2005.

The Fifty-eighth World Health Assembly elected 10 Member States to be entitled to designate a person to serve on the Executive Board in place of those whose term of office had expired,¹ giving the following new composition of the Board:

Designating country	Unexpired term of office²	Designating country	Unexpired term of office²
Australia	2 years	Lesotho.....	2 years
Azerbaijan.....	3 years	Liberia.....	3 years
Bahrain	2 years	Libyan Arab Jamahiriya.....	2 years
Bhutan.....	3 years	Luxembourg.....	2 years
Bolivia	2 years	Madagascar	3 years
Brazil	2 years	Mexico	3 years
Canada.....	1 year	Namibia.....	3 years
Czech Republic.....	1 year	Nepal.....	1 year
Ecuador.....	1 year	Pakistan.....	1 year
France	1 year	Portugal.....	3 years
Guinea-Bissau.....	1 year	Romania	2 years
Iceland	1 year	Rwanda	3 years
Iraq.....	3 years	Sudan	1 year
Jamaica	2 years	Thailand	2 years
Japan.....	3 years	Tonga.....	2 years
Kenya.....	2 years	Viet Nam.....	1 year

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

¹ By decision WHA58(8). The retiring members were those designated by China, Gabon, Gambia, Ghana, Guinea, Kuwait, Maldives, Russian Federation, Spain, and the United States of America.

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

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2. Election of Chairman, Vice-Chairmen and Rapporteur
3. Outcome of the Fifty-eighth World Health Assembly
4. Technical and health matters
 - 4.1 Control of genetic diseases
 - 4.2 International trade and health
 - 4.3 Nutrition and HIV/AIDS
 - 4.4 Gender, women and health: incorporating a gender perspective into the mainstream of WHO's policies and programmes
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 - 5.2 WHO country offices and country focus
 - 5.3 Committees of the Executive Board: membership
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7. Matters for information
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 - 7.2 WHO Commission on Intellectual Property Rights, Innovation and Public Health: progress report
 - 7.3 Expert committees and study groups
8. Closure of the session

¹ As adopted by the Board at its first meeting.

LIST OF DOCUMENTS

EB116/1 Rev.1	Agenda ¹
EB116/1(annotated)	Provisional agenda (annotated)
EB116/2	Outcome of the Fifty-eighth World Health Assembly
EB116/3	Control of genetic diseases
EB116/4	International trade and health
EB116/5	Guiding principles for strategic resource allocations
EB116/6	WHO country offices and country focus
EB116/7 and EB116/7 Add.1	Committees of the Executive Board: membership
EB116/8	Future sessions of the Executive Board and the Health Assembly
EB116/9	Implementation of resolution WHA55.16 on global public health response to natural occurrence, accidental release or deliberate use of biological and chemical agents or radionuclear material that affect health
EB116/10	WHO Commission on Intellectual Property Rights, Innovation and Public Health: progress report
EB116/11	Expert committees and study groups
EB116/12	Nutrition and HIV/AIDS
EB116/13	Gender, women and health: incorporating a gender perspective into the mainstream of WHO's policies and programmes

¹ See page vii.

EB116/14

Guiding principles for strategic resource allocations. Report of the Programme, Budget and Administration Committee to the 116th session of the Executive Board

Information documents

EB116/INF.DOC./1

Statement by the representative of the WHO staff associations

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DECISIONS

EB116(1) Membership of the Executive Board's Standing Committee on Nongovernmental Organizations

The Executive Board appointed Dr A.B. Insanov (Azerbaijan) and Dr H.N. Acharya (Nepal) as members of its Standing Committee on Nongovernmental Organizations for the duration of their term of office on the Executive Board, in addition to Dr F. Huerta Montalvo (Ecuador), Dr A.B. Osman (Sudan) and Mrs Le Thi Thu Ha (Viet Nam), already members of the Committee. It was understood that if any member of the Committee were unable to attend, his or her successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Committee.

(Fourth meeting, 27 May 2005)

EB116(2) Membership of the Programme, Budget and Administration Committee of the Executive Board

The Executive Board appointed as members of the Programme, Budget and Administration Committee Dr Jigmi Singay (Bhutan), Dr A.M. Ali Mohammed (Iraq), Mr J. Junor (Jamaica), Professor J. Pereira Miguel (Portugal), Dr J.D. Ntawukuliryayo (Rwanda), Dr V. Tangi (Tonga) for a two-year period or until expiry of their membership on the Board, whichever occurs first, Mr I. Shugart (Canada) for a one-year period, in addition to Ms J. Halton (Australia), Dr N.A. Haffadh (Bahrain), Professor D. Houssin (France), Dr M. Phooko (Lesotho) and Professor Suchai Charoenratanakul (Thailand), already members of the Committee, and Mr M.N. Khan (Pakistan), Chairman of the Board, member ex officio, and Dr D. Hansen-Koenig (Luxembourg), Vice-Chairman of the Board, member ex officio. It was understood that if any member of the Committee were unable to attend, his or her successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Committee.

(Fourth meeting, 27 May 2005)

EB116(3) Appointment of representatives of the Executive Board at the Fifty-ninth World Health Assembly

The Executive Board, in accordance with paragraph 1 of resolution EB59.R7, appointed its Chairman, Mr M.N. Khan (Pakistan), ex officio, and its first three Vice-Chairmen, Dr H.N. Acharya (Nepal), Dr K. Shangula (Namibia) and Ms J. Halton (Australia), to represent the Board at the Fifty-ninth World Health Assembly. It was understood that if any of those members were not available for the Health Assembly, the other Vice-Chairman, Dr D. Hansen-Koenig (Luxembourg), and the Rapporteur, Mr M. Bailón (Mexico), could be asked to represent the Board.

(Fourth meeting, 27 May 2005)

EB116(4) Date, place and duration of the 117th session of the Executive Board

The Executive Board decided that its 117th session should be convened on Monday, 23 January 2006, at WHO headquarters, Geneva, and should close no later than Saturday, 28 January 2006.

(Fourth meeting, 27 May 2005)

EB116(5) Place, date and duration of the Fifty-ninth World Health Assembly

The Executive Board decided that the Fifty-ninth World Health Assembly should be held at the Palais des Nations, Geneva, opening on Monday, 22 May 2006, and that it should close no later than Saturday, 27 May 2006.

(Fourth meeting, 27 May 2005)

PART II
SUMMARY RECORDS

LIST OF MEMBERS AND OTHER PARTICIPANTS

MEMBERS, ALTERNATES AND ADVISERS

PAKISTAN

Mr M.N. KHAN, Federal Minister for Health, Islamabad (**Chairman**)

Alternates

Ms T. JANJUA, Minister, Deputy Permanent Representative, Geneva

Dr A. AHMED, Deputy Director-General, Ministry of Health, Islamabad

Mr A.A. KHOKHAR, First Secretary, Permanent Mission, Geneva

Mr R.S. SHEIKH, First Secretary, Permanent Mission, Geneva

AUSTRALIA

Ms J. HALTON, Secretary, Department of Health and Ageing, Canberra (**Vice-Chairman**)

Alternates

Ms C. HALBERT, Assistant Secretary, Policy and International Branch, Department of Health and Ageing, Canberra

Ms L. PODESTA, Assistant Secretary, Biosecurity and Disease Control Branch, Department of Health and Ageing, Canberra

Ms C. PATTERSON, Minister Counsellor (Health), Permanent Mission, Geneva

Mr B. ECKHARDT, Director, International Policy and Communications Section, Department of Health and Ageing, Canberra

Mr M. SAWERS, First Secretary, Permanent Mission, Geneva

Advisers

Ms A. GORELY, Counsellor, Permanent Mission, Geneva

Mr G. ADLIDE, Counsellor (AusAID), Permanent Mission, Geneva

Mr M. PALU, Director, Coherence and Strategic Issues Group, AusAID

Ms L. OATES-MERCIER, Programme Officer (AusAID), Permanent Mission, Geneva

AZERBAIJAN

Dr A.B. INSANOV, Minister of Health, Baku

Alternates

Mr E. AMIRBAYOV, Ambassador, Permanent Representative, Geneva

Dr A. UMNAYASHKIN, Head, International Relations Department, Ministry of Health, Baku

Mr E. MAMMADOV, Third Secretary, Permanent Mission, Geneva

BAHRAIN

Dr A.W.M. ABDUL WAHAB, Assistant Under-Secretary for Primary Care and Public Health, Ministry of Health, Manama (**alternate to Dr N.A. Haffadh**)

BHUTAN

Dr Jigmi SINGAY, Minister of Health, Thimphu

Alternates

Dr D. WANGCHUK, Director, Department of Medical Services, Ministry of Health, Thimphu

Mr P. WANGCHUK, Deputy Secretary, Policy and Planning Division, Ministry of Health,
Thimphu

Adviser

Mr C. TENZIN, First Secretary, Permanent Mission, Geneva

BOLIVIA

Dr. F. ANTEZANA ARANÍBAR, Ministro de Salud y Deportes, La Paz

BRAZIL

Dr J. GOMES TEMPORÃO, Director-General, National Cancer Institute of Brazil, Rio de Janeiro
(alternate to Dr P.M. Buss)

Alternate

Mr A.C. DO NASCIMENTO PEDRO, Minister Counsellor, Permanent Mission, Geneva

Advisers

Mr S. ALCÁZAR, Counsellor, Head, Department of International Affairs, Ministry of Health,
Brasília

Mr P.M. DE CASTRO SALDANHA, Second Secretary, Permanent Mission, Geneva

Mr D. LINS MENUCCI, Technical Expert, National Agency of Health Surveillance, Ministry
of Health, Brasília

CANADA

Ms C. GILDERS, Director-General, International Affairs Directorate, Health Canada, Ottawa
(alternate to Mr I. Shugart)

Alternates

Mr G. WIERINGA, Senior Program Officer, United Nations and Commonwealth Program,
Canadian International Development Agency, Ottawa

Mr D. STRAWCZYNSKI, Adviser, International Affairs Directorate, Health Canada, Ottawa

Mr D. MACPHEE, Counsellor, Permanent Mission, Geneva

Mr T. FETZ, Second Secretary, Permanent Mission, Geneva

CZECH REPUBLIC

Professor B. FIŠER, Head, Physiology Institute of the Masaryk University, Brno

Alternate

Mr M. BOUČEK, Deputy Permanent Representative, Geneva

ECUADOR

Dr. F. HUERTA MONTALVO, Secretario Ejecutivo, Convenio “Andrés Bello”

Alternates

Sr. H. ESCUDERO MARTÍNEZ, Embajador, Representante Permanente, Ginebra

Srta. L. BAQUERIZO GUZMÁN, Tercer Secretario, Misión Permanente, Ginebra

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Alternates

M. B. KESSEDJIAN, Ambassadeur, Représentant permanent, Genève,

Dr. J.-B. BRUNET, Direction générale de la Santé, Ministère des Solidarités, de la Santé et de la Famille, Paris

Mme F. AUER, Conseiller, Mission permanente, Genève

Mme I. VIREM, Direction générale de la Santé, Ministère des Solidarités, de la Santé et de la Famille, Paris

Mme A. LE GUEVEL, Deuxième Secrétaire, Mission permanente, Genève

M. J.-F. CONNAN, Mission permanente, Genève

Adviser

Mme N. MATHIEU, Mission permanente, Genève

M. J.-F. TROGRIC

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ICELAND

Mr D.Á. GUNNARSSON, Permanent Secretary, Ministry of Health and Social Security, Reykjavik

Alternates

Mr S.H. JÓHANNESSEN, Ambassador, Permanent Representative, Geneva

Mr I. EINARSSON, Head of Department, Ministry of Health and Social Security, Reykjavik

Mrs V. INGÓLFSDÓTTIR, Chief Nursing Officer, Directorate of Health, Reykjavik

Mrs A. KNÚTSDÓTTIR, Attaché, Permanent Mission, Geneva

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Alternates

Mr B. AL-SHABIB, Ambassador, Permanent Representative, Geneva

Mr N.S. ABID, General Director, Ministry of Health, Baghdad

Miss M.A. YASS, First Secretary, Permanent Mission, Geneva

Mr A.R. KHRNOB, Ministry of Health, Baghdad

Mr A.H. SALMAN, Ministry of Health, Baghdad

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Dr B. WINT, Chief Medical Officer, Ministry of Health, Kingston (**alternate to Mr J. Junor**)

Alternate

Ms S. BETTON, First Secretary, Permanent Mission, Geneva

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Dr H. SHINOZAKI, President, National Institute of Public Health, Tokyo

Alternates

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Dr Y. NISHIJIMA, Section Chief, International Affairs Division, Minister's Secretariat, Ministry of Health, Labour and Welfare, Tokyo

Ms T. TSUJISAKA, First Secretary, Permanent Mission, Geneva

KENYA

Dr J. NYIKAL, Director of Medical Services, Ministry of Health, Nairobi

Alternates

Ms A.C. MOHAMED, Ambassador, Permanent Representative, Geneva

Mr P.R.O. OWADE, Ambassador, Deputy Permanent Representative, Geneva

Mrs L. NYAMBU, First Secretary, Permanent Mission, Geneva

LESOTHO

Dr M. PHOOKO, Minister of Health and Social Welfare, Maseru

Alternates

Mr T.J. RAMOTSOARI, Principal Secretary, Ministry of Health and Social Welfare, Maseru

Dr N. LETSIE, Ministry of Health and Social Welfare, Maseru

Mrs K. MAFIKE, Ministry of Health and Social Welfare, Maseru

Miss T. TSEKOA, Minister Counsellor, Permanent Mission, Geneva

LIBERIA

Dr P.S. COLEMAN, Minister of Health and Social Welfare, Monrovia

LIBYAN ARAB JAMAHIRIYA

Dr S. AWENAT, General People's Committee of Health, Tripoli (**alternate to Dr F. Al-Keeb**)

Alternates

Mr A. BENOMRAN, Minister Plenipotentiary, Permanent Mission, Geneva

Dr M. NUAJE, Head of Health, Canton of Caltuna Batnan

LUXEMBOURG

Dr D. HANSEN-KOENIG, Directeur de la Santé, Direction de la Santé, Luxembourg

(Vice-Chairman)

Alternates

M. A. BERNS, Ambassadeur, Représentant permanent, Genève

Dr C. KAPP-JOEL, Chargé de Mission, Mission permanente, Genève

Mme D. GREGR, Chargé de Mission, Mission permanente, Genève

Mme E. FISCHER, Mission permanente, Genève

M. J. NILLIEHOOEK, Secrétariat général du Conseil de l'Union européenne, Genève

MADAGASCAR

Dr P. RAHANTANIRINA, Directeur de la Santé de la Famille, Ministère de la Santé et du Planning familial, Antananarivo **(alternate to Dr R.R. Jean Louis)**

Alternate

M. J.M. RASOLONJATOVO, Premier Conseiller, Mission permanente, Genève

MEXICO

Sr. M. BAILÓN, Director General de Relaciones Internacionales, Secretaría de Salud, México, DF

(Rapporteur)

Alternates

Sra. D.M. VALLE, Consejero, Misión Permanente, Ginebra

Sra. S. HERNÁNDEZ, Directora de Asuntos Multilaterales, Dirección General de Relaciones Internacionales, Secretaría de Salud, México, DF

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NAMIBIA

Dr K. SHANGULA, Permanent Secretary, Ministry of Health and Social Services, Windhoek

(Vice-Chairman)

NEPAL

Dr H.N. ACHARYA, Chief, Policy Planning and International Cooperation Division, Ministry of Health, Kathmandu **(Vice-Chairman)**

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Alternates

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Alternates

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Alternates

Dr E.A. ELSAYID, Director, Immunization Programme, Federal Ministry of Health, Khartoum

Dr S. MANDIL, Consultant, Federal Ministry of Health, Khartoum

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THAILAND

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Mrs AREEKUL PUANGSUWAN, Program and International Affairs Officer, Thai Health Promotion Foundation, Bangkok

Mrs WALAIORN PATCHARANARUMOL, Pharmacist, International Health Policy Program, Ministry of Public Health, Nonthaburi

TONGA

Dr V. TANGI, Minister of Health, Nuku'alofa

VIET NAM

Mrs LE THI THU HA, Deputy Director, Department of International Cooperation, Ministry of Health,
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Alternate

Mr PHAM HONG NGA, Counsellor, Permanent Mission, Geneva

MEMBER STATES NOT REPRESENTED ON THE EXECUTIVE BOARD¹**ALGERIA**

Mlle D. SOLTANI, Deuxième Secrétaire, Mission permanente, Genève

ANGOLA

Dr E. NETO SANGUEVE, First Secretary, Permanent Mission, Geneva

Dr S. NETO DE MIRANDA, Assistant for Health, Permanent Mission, Geneva

ARGENTINA

Srta. A. DE HOZ, Ministro, Misión Permanente, Ginebra

AUSTRIA

Mrs C. KOKKINAKIS, Deputy Permanent Representative, Geneva

Dr C. LASSMANN, Minister, Federal Ministry of Foreign Affairs, Vienna

Mrs E. STROHMAYER, Deputy Director, International Health Relations Department, Federal
Ministry of Health and Women, Vienna

Dr J.-P. KLEIN, Expert for Infectious Diseases and Immunization, Federal Ministry of Health and
Women, Vienna

Dr D. ZIMPER, International Health Relations Department, Federal Ministry of Health and Women,
Vienna

BANGLADESH

Dr T. ALI, Ambassador, Permanent Representative, Geneva

Mr MAHBUB-UZ-ZAMAN, Minister, Permanent Mission, Geneva

Mr N.U. AHMED, Third Secretary, Permanent Mission, Geneva

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

BELGIUM

Mme F. GUSTIN, Représentant permanent adjoint, Genève

BELIZE

Ms A. HUNT, Chargé d'affaires, Permanent Mission, Geneva

Mr M. TAMASKO, Permanent Mission, Geneva

Mr T. TICHY, Permanent Mission, Geneva

BENIN

M. Y. AMOUSSOU, Premier Conseiller, Mission permanente, Genève

BOSNIA AND HERZEGOVINA

Mrs J. KALMETA, Ambassador, Permanent Representative, Geneva

Ms D. KREMENOVIĆ-KUSMUK, First Secretary, Permanent Mission, Geneva

BOTSWANA

Mr C.T. NTWAAGAE, Ambassador, Permanent Representative, Geneva

Mr G. PITSO, First Secretary, Permanent Mission, Geneva

CAMBODIA

M. CHHEANG VUN, Ambassadeur, Représentant permanent, Genève

M. KEO PHEAK KDEY, Ministre Conseiller, Mission permanente, Genève

M. PHAN PEUV, Deuxième Secrétaire, Mission permanente, Genève

CHILE

Dr. P. GARCÍA, Ministro de Salud, Santiago de Chile

Sr. J. MARTABIT, Embajador, Representante Permanente, Ginebra

Sr. J.E. EGUIGUREN, Ministro Consejero, Misión Permanente, Ginebra

Dr. R. TAPIA, Jefe, Oficina de Cooperación y Asuntos Internacionales, Ministerio de Salud, Santiago de Chile

Dra. X. AGUILERA, Jefa, División de Planificación Sanitaria, Subsecretaría de Salud Pública, Ministerio de Salud, Santiago de Chile

Sr. B. DEL PICÓ, Segundo Secretario, Misión Permanente, Ginebra

Dra. P. FRENZ, Asesora, Ministerio de Salud, Santiago de Chile

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Dr QI Qingdong, Assistant Director-General, Department of International Cooperation, Ministry of Health, Beijing

Ms DENG Hongmei, Counsellor, Permanent Mission, Geneva

Ms HU Meiqi, Consultant, Division of International Organizations, Department of International Cooperation, Ministry of Health, Beijing

Mr YANG Xiaokun, Second Secretary, Permanent Mission, Geneva

Mr XU Jian, Programme Officer, Division of International Organizations, Department of International Cooperation, Ministry of Health, Beijing

Dr DING Baoguo, Programme Officer, Division of International Organizations, Department of International Cooperation, Ministry of Health, Beijing

Mr ZHANG Ze, Attaché, Permanent Mission, Geneva

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Sr. A. SOLANO, Ministro Consejero, Misión Permanente, Ginebra

DENMARK

Ms M. KRISTENSEN, Senior Adviser, National Board of Health, Copenhagen

Ms J. MICHELSEN, Counsellor, Permanent Mission, Geneva

Ms M. HESSEL, Secretary of Embassy, Permanent Mission, Geneva

Ms L. JOHANNSEN, Assistant Attaché, Permanent Mission, Geneva

DOMINICAN REPUBLIC

Dra. M. BELLO DE KEMPER, Consejero, Misión Permanente, Ginebra

EL SALVADOR

Sr. R. RECINOS TREJO, Ministro Consejero, Misión Permanente, Ginebra

ESTONIA

Ms H. LEHT, Second Secretary, Permanent Mission, Geneva

FINLAND

Ms S. SAMMALKIVI, Second Secretary, Permanent Mission, Geneva

Mr R. POMOELL, Ministerial Counsellor, Head of Medical Affairs, Ministry of Social Affairs and Health, Helsinki

GABON

Mme M. ANGONE ABENA, Conseiller, Mission permanente, Genève

GERMANY

Mr K. METSCHER, Deputy Permanent Representative, Geneva
Mr T. HOFMANN, Councillor, Ministry of Health and Social Security, Berlin
Mr I. VON VOSS, Counsellor, Permanent Mission, Geneva
Mr S. PREUSS, Attaché, Permanent Mission, Geneva

GHANA

Dr K. BAWUAH-EDUSEI, Ambassador, Permanent Representative, Geneva
Ms M.A. ALOMATU, First Secretary, Permanent Mission, Geneva

GUATEMALA

Dr. L. PIRA, Embajador, Representante Permanente, Ginebra
Sra. S. HOCHSTETTER, Consejero, Misión Permanente, Ginebra
Srta. S. URRUELA, Segundo Secretario, Misión Permanente, Ginebra

HUNGARY

Mr T. TÓTH, Ambassador, Permanent Representative, Geneva
Mr B. RÁTKAI, Third Secretary, Permanent Mission, Geneva

INDIA

Mr D. SAHA, Deputy Permanent Representative, Geneva
Mr A.K. CHATTERJEE, First Secretary, Permanent Mission, Geneva

IRELAND

Mr B. PHELAN, Principal Officer, International Unit, Department of Health and Children, Dublin
Ms G. COYLE, Higher Executive Officer, International Unit, Department of Health and Children,
Dublin

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Mr I. LEVANON, Ambassador, Permanent Representative, Geneva
Dr Y. SEVER, Director, Department of International Relations, Ministry of Health, Jerusalem
Mrs N. FURMAN, Counsellor, Permanent Mission, Geneva
Mrs E. ZARKA, Adviser, Permanent Mission, Geneva

JORDAN

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Dr S. AL MAWAJDEH, Director-General, Food and Drug Corporation of Jordan
Mr H. AL HUSSEINI, First Secretary, Permanent Mission, Geneva

KAZAKHSTAN

Mr A. AKHMETOV, Counsellor Minister, Permanent Mission, Geneva
Mr M. ZHAGIPAROV, Third Secretary, Permanent Mission, Geneva

LATVIA

Ms G. VITOLA, Third Secretary, Permanent Mission, Geneva

MOROCCO

Mme S. BOUASSA, Ministre plénipotentiaire, Mission permanente, Genève

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Mrs AYE AYE MU, Counsellor, Permanent Mission, Geneva
Mr THA AUNG NYUN, Counsellor, Permanent Mission, Geneva
Mr KYAW THU NYEIN, Second Secretary, Permanent Mission, Geneva
Mrs KHIN OO HLAING, Second Secretary, Permanent Mission, Geneva

NETHERLANDS

Mr H. VAN DER HOEVEN, Senior Policy Adviser, Ministry of Foreign Affairs, The Hague

NEW ZEALAND

Dr D. MATHESON, Deputy Director-General of Public Health, Ministry of Health, Wellington

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Mr AHN Hyo-hwan, Counsellor, Permanent Mission, Geneva

Mr LEE Suk-kyu, Director, International Cooperation Division, Ministry of Health and Welfare, Seoul

Mr CHO Choong-hyun, Deputy Director, International Cooperation Division, Ministry of Health and Welfare, Seoul

RUSSIAN FEDERATION

Mr A.E. GRANOVSKIY, Director, Department of International Organizations, Ministry of Foreign Affairs, Moscow

Mr V.M. ZIMJANIN, Principal Counsellor, Department of International Organizations, Ministry of Foreign Affairs, Moscow

Dr A. PAVLOV, Counsellor, Permanent Mission, Geneva

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M. A. BASSE, Premier Secrétaire, Mission permanente, Genève

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SLOVAKIA

Ms N. ŠEPTÁKOVÁ, First Secretary, Permanent Mission, Geneva

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Mr A. HILMERSON, Desk Officer, Ministry of Health and Social Affairs, Stockholm

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Dr C. PRESERN, Counsellor, Permanent Mission, Geneva
Ms H. NELLTHORP, First Secretary, Permanent Mission, Geneva
Ms L. REID, Programme Officer, Department for International Development, East Kilbride
Ms S. BALDWIN, Acting Head of Specialized Agencies, Department for International Development, East Kilbride
Mr B. GREEN, Team Leader (WHO), United Nations and Commonwealth Department, Department for International Development, East Kilbride
Ms H. THOMAS, Attaché, Permanent Mission, Geneva

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Ms A. BLACKWOOD, Director for Health Programs, Office of Technical Specialized Agencies, Bureau of International Organization Affairs, Department of State, Washington, DC
Ms D. GIBB, Senior Technical Adviser, Bureau for Global Health, United States Agency for International Development, Washington, DC
Mr D. HOHMAN, Health Attaché, Permanent Mission, Geneva
Ms K. KRUGLIKOVA, International Resource Management Officer, Permanent Mission, Geneva
Mr J. SANTAMAURO, Trade Attaché, Office of the United States Trade Representative, Permanent Mission, Geneva
Ms M.L. VALDEZ, Deputy Director for Policy, Office of Global Health Affairs, Office of the Secretary, Department of Health and Human Services, Washington, DC

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Food and Agriculture Organization of the United Nations

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Mr P. PAREDES-PORTELLA, Liaison Officer, FAO Liaison Office with the United Nations in Geneva

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International Telecommunications Union

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World Meteorological Organization

Mr NING Ying, Seconded Expert, World Climate Programme Department

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Mrs K. LEE RATA, Senior Counsellor, External Relations and Cooperation with Certain Countries in Europe and Asia

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African Union

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International Organization for Migration

Dr D. GRONDIN, Director, Migration Health
Department

Organization of the Islamic Conference

Mr M.A. JERRARI, Minister Counsellor,
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**Council on Health Research for
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Ms S. DE HAAN
Mr A. KENNEDY

Cystic Fibrosis Worldwide

Mrs C. NOKE
Mrs G. STEENKAMER

Global Forum for Health Research

Professor S. MATLIN
Dr A. GHAFFAR
Ms M.A. BURKE

**Inter-African Committee on Traditional
Practices affecting the Health of Women
and Children**

Mrs B. RAS-WORK

International Alliance of Women

Mrs H. SACKSTEIN
Mrs M. PAL

**International Association for Maternal and
Neonatal Health**

Dr R. KULIER

**International Catholic Committee of Nurses
and Medico-social Assistants**

Mrs I. WILSON

**International Clearinghouse for Birth
Defects Monitoring Systems**

Dr P. MASTROIACOVO

International College of Surgeons

Professor P. HAHNLOSER

International Council of Nurses

Dr T. GHEBREHIWET
Ms B. WIENKAMP-WEBER

International Council of Women

Mrs A. TAN
Mrs C. SHENK MONFRINI

International Federation of Business and Professional Women

Ms M. GERBER
Ms G. GONZENBACH

International Federation of Medical Students Associations

Mr A. RUDKJØBING
Mrs J. MYNDIUKOVA

International Federation of Oto-rhinolaryngological Societies

Professor J.J. GROTE

International Federation of Pharmaceutical Manufacturers Associations

Dr E. NOEHRENBERG
Ms A.-L. BOFFI

International Hospital Federation

Professor P.-G. SVENSSON
Miss S. ANAZONWU

International Stroke Society

Dr S. AYBEK

Thalassemia International Federation

Mrs C. NOKE

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Dr R. BACCHUS

World Federation for Medical Education

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Professor L. CHRISTENSEN

World Federation for Mental Health

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Dr S. FLACHE

World Federation of Hemophilia

Dr P. GIANGRANDE

World Heart Foundation

Ms C. ADLER

World Self-Medication Industry

Dr D. WEBBER
Dr H. CRANZ
Ms. S. DURAND-STAMATIADIS

World Vision International

Dr M. AMAYUN

COMMITTEES AND WORKING GROUPS¹

1. Programme, Budget and Administration Committee

Mr D.Á. Gunnarsson (Iceland), Chairman of the Board, member ex officio, Dr A.A. Yoosuf (Maldives), Vice-Chairman of the Board, member ex officio, Ms J. Halton (Australia), Dr N.A. Haffadh (Bahrain), Mr I. Shugart (Canada), Dr Yin Li (China), Professor B. Fišer (Czech Republic), Professor D. Houssin (France), Dr M. Camara (Guinea), Dr M. Phooko (Lesotho), Dr H.N. Acharya (Nepal), Mr M.N. Khan (Pakistan), Professor Suchai Charoenratanakul (Thailand), Dr W.R. Steiger (United States of America).

Second meeting, 14 May 2005: Dr A.A. Yoosuf (Maldives, Chairman), Ms J. Halton (Australia, Vice-Chairman), Dr A.W.M. Abdul Wahab (Bahrain, alternate to Dr N.A. Haffadh), Mr D. MacPhee (Canada, alternate to Mr I. Shugart), Dr Yin Li (China), Professor B. Fišer (Czech Republic), Dr J.-B. Brunet (France, alternate to Professor D. Houssin), Dr M. Camara (Guinea), Mr D.Á. Gunnarsson (Iceland, member ex officio), Dr M. Phooko (Lesotho), Dr H.N. Acharya (Nepal), Dr Suwit Wibulpolprasert (Thailand, alternate to Professor Suchai Charoenratanakul), Ms A. Blackwood (United States of America, alternate to Dr W.R. Steiger)

2. Standing Committee on Nongovernmental Organizations

Dr A.B. Insanov (Azerbaijan), Dr F. Huerta Montalvo (Ecuador), Dr H.N. Acharya (Nepal), Dr A.B. Osman (Sudan), Mrs Le Thi Thu Ha (Viet Nam)

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

SUMMARY RECORDS

FIRST MEETING

Thursday, 26 May 2005, at 09:40

Chairman: Mr D.Á. GUNNARSSON (Iceland)

later: Mr M.N. KHAN (Pakistan)

1. **OPENING OF THE SESSION AND ADOPTION OF THE AGENDA:** Item 1 of the Provisional Agenda (Document EB116/1)

The CHAIRMAN declared open the 116th session of the Executive Board and invited members to consider the provisional agenda.

The agenda was adopted.¹

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

The CHAIRMAN called for nominations for the office of Chairman.

Dr ABDULLA (Sudan) nominated Mr Khan (Pakistan). The nomination was seconded by Dr ALI MOHAMMED (Iraq) and Dr ABDUL WAHAB (Bahrain).

Mr M.N. Khan was elected Chairman.

The DIRECTOR-GENERAL thanked Mr Gunnarsson, the outgoing Chairman, for his excellent leadership of the Executive Board over the past year and the strong commitment he had shown to furthering the objectives of the Organization as a whole.

The Director-General presented Mr Gunnarsson with a gavel.

Mr GUNNARSSON (Iceland) thanked the Board for its support and encouragement over the past year and said that it had been both an honour and an enriching experience to serve as its Chairman. It had also been a privilege to work with the Director-General and his team as they took on the challenge of moving forward the work of the Organization.

Mr Khan took the Chair.

The CHAIRMAN paid tribute to Mr Gunnarsson for his hard work and dedication over the past year and thanked the Board for the confidence it had shown in him by electing him as its Chairman at

¹ See page vii.

a time when the Organization was facing enormous global challenges. He invited nominations for the four posts of Vice-Chairman.

Dr NYIKAL (Kenya) nominated Dr Shangula (Namibia).

Professor FIŠER (Czech Republic) nominated Dr Hansen-Koenig (Luxembourg).

Dr SUPACHAI KUNARATANAPRUK (Thailand) nominated Dr Acharya (Nepal).

Mrs LE THI THU HA (Viet Nam) nominated Ms Halton (Australia).

Dr SÁ NOGUEIRA (Guinea-Bissau), Mrs IORDACHE (alternate to Professor Cinteza, Romania), Dr SHINOZAKI (Japan) and Dr SINGAY (Bhutan) seconded the four nominations.

Dr K. Shangula (Namibia), Dr D. Hansen-Koenig (Luxembourg), Dr H.N. Acharya (Nepal) and Ms J. Halton (Australia) were elected Vice-Chairmen.

The CHAIRMAN explained that, under Rule 15 of the Rules of Procedure of the Executive Board, if the Chairman were unable to act between sessions, one of the Vice-Chairmen should act in his place, and that the order in which the Vice-Chairmen should be requested to serve must be determined by lot at the session at which the election took place.

It was determined by lot that the Vice-Chairmen should serve in the following order: Dr Acharya (Nepal), Dr Shangula (Namibia), Ms Halton (Australia) and Dr Hansen-Koenig (Luxembourg).

The CHAIRMAN invited nominations for the office of Rapporteur.

Ms GILDERS (Canada) nominated Mr BAILÓN (Mexico); Dr ANTEZANA ARANÍBAR (Bolivia) and Dr HUERTA MONTALVO (Ecuador) seconded the nomination.

Mr Bailón was elected Rapporteur.

3. OUTCOME OF THE FIFTY-EIGHTH WORLD HEALTH ASSEMBLY: Item 3 of the Agenda (Document EB116/2)

The CHAIRMAN reminded members that the Board had been represented at the Fifty-eighth World Health Assembly by Mr Gunnarsson (Iceland), Dr Osman (Sudan), Dr Yin Li (China) and Dr Yoosuf (Maldives). He invited Mr Gunnarsson to present a report.

Mr GUNNARSSON (Iceland), introducing document EB116/2, said that the Health Assembly had worked in an exceptionally cooperative manner, which was reflected in the fruitful outcome. In addition to adopting the International Health Regulations (2005), which represented a major achievement, the Health Assembly had adopted 33 other resolutions and 11 decisions. Although the programme of work had been heavy, the decision to refer certain items to working groups or less formal consultations had resulted in consensus being achieved.

Dr ANTEZANA ARANÍBAR (Bolivia) agreed that the Health Assembly had been extremely productive. In particular, he stressed the significance of the adoption of the International Health Regulations (2005) after seven years of dedicated input by many people. Without wishing to detract

from the importance of the other issues that had been the subject of resolutions, he said that those Regulations would be a vital tool for responding effectively to new and emerging threats to global health and would reaffirm WHO's public health leadership role.

Dr NYIKAL (Kenya) drew attention to the resolution on health financing, which was of particular importance to the African Region and developing countries in general. The issue had been discussed at the two previous sessions of the Board, which had recommended a draft resolution to the Fifty-eighth World Health Assembly. He was pleased to note that health financing was becoming an important issue, and, as stated in resolution WHA58.33, the Board would engage in further discussions on outstanding issues.

The auxiliary meetings arranged in conjunction with the Health Assembly had been far too numerous, especially for small delegations, and diverted delegates' attention from the work of the Health Assembly.

Mrs LE THI THU HA (Viet Nam) agreed that adoption of the International Health Regulations (2005) represented an important landmark for public health. Developing countries looked forward to WHO's support for capacity building for implementation of the Regulations within a fixed time. Another important step was adoption of resolution WHA58.5 on strengthening pandemic-influenza preparedness and response, which would enable countries affected by avian influenza to take the necessary action. The Secretariat would have to play a leading role and provide technical support to Member States in that regard.

Dr ABDULLA (Sudan) said that the Health Assembly had been one of the most fruitful in his experience. He commended the report and resolution WHA58.28 on eHealth but considered that countries should be more closely consulted in the preparation of such matters.

Dr ACHARYA (Nepal) said that the resolutions on the revision of the International Health Regulations and infant and young-child nutrition were particularly important.

Ms GILDERS (Canada) commented that the Health Assembly had considered a wide range of challenging global health issues, some for the first time, such as laboratory biosafety and the financing of health systems. The main priority for her country had been the adoption of the International Health Regulations (2005), but she also welcomed the adoption of the appropriation resolution for the financial period 2006-2007. The Health Assembly had shown that great progress could be achieved, even in a short time.

Dr SHANGULA (Namibia) shared the general sentiment that the Health Assembly had been successful. He wished to place on record, however, his concern that in recent years the Health Assembly had always begun on a sour note owing to the proposal for inclusion of a supplementary agenda item on one subject that always produced the same outcome. It was a time-wasting ritual detrimental to the spirit of the Health Assembly, which was attended by more than 190 delegations. He requested the Executive Board or the Director-General to find a way to ensure that the Health Assembly would no longer be subjected to discussion of that subject.

Dr HANSEN-KOENIG (Luxembourg), acknowledging the adoption of 34 important resolutions, said that Member States were turning to the Secretariat for support in implementing them according to their priorities. She recognized the historic importance of the adoption of the International Health Regulations (2005). She had attended all the negotiating sessions and recognized the huge effort made by both Member States and the Secretariat to achieve consensus. Another important resolution was that concerning pandemic-influenza preparedness and response. All countries would need the Secretariat's help to take effective and timely action.

Dr WINT (Jamaica) said that the richness of the Health Assembly's agenda underscored the importance of health to human development and security. He too welcomed the adoption of the International Health Regulations (2005). With international mobility critical to the economies of countries like Jamaica, threats such as severe acute respiratory syndrome and pandemic influenza had to be prepared for. He stressed the challenge represented by the migration of health personnel in regard to achievement of the Millennium Development Goals. Developing countries had to retain their health personnel and protect their primary health-care infrastructure; he looked forward to meaningful solutions in that area. He welcomed the progress in implementing resolution WHA56.24 on violence and health as violence was a major problem in his country, and the advances made in health promotion and the encouragement of healthy life styles.

Dr RAHANTANIRINA (Madagascar) said that implementation of the resolutions adopted by the Health Assembly would contribute to development and the achievement of health objectives. In countries such as hers, it was above all financial, structural and managerial obstacles that hindered the full realization of national health programmes. Implementation of the resolutions on the draft global immunization strategy, universal coverage of maternal, newborn and child health interventions and infant and young-child nutrition would contribute to achievement of the Millennium Development Goals.

Dr PHOOKO (Lesotho) emphasized the importance of the Millennium Development Goals, which would continue to occupy developing countries for some time to come. Many developing countries were finding it difficult to meet the targets, in particular because of a lack of human resources.

Mr BAILÓN (Mexico) said that the Fifty-eighth World Health Assembly would be remembered for the adoption of some major resolutions, such as those on the revision of the International Health Regulations, sustainable health financing, health research, and disability.

Dr TANGI (Tonga) agreed that the Health Assembly had been successful. He reiterated an observation he had made during the Health Assembly regarding the Programme budget 2006-2007: few organizations, ministries or countries had enjoyed such a large budget increase as the 17% accorded by the Health Assembly. The Secretariat must have been relieved that the budget was adopted so quickly. The governing bodies at their next sessions should look closely at performance and the use of the massive increase in funding.

Dr ABDUL WAHAB (Bahrain) said that adoption of the resolution on the revision of the International Health Regulations represented a great achievement. Two resolutions, that on public health problems caused by harmful use of alcohol and that on health conditions in the occupied Palestinian territory, were of particular importance to his country. The resolutions and decisions of the Health Assembly would be reflected in improvements in global health.

Dr AWENAT (Libyan Arab Jamahiriya) said that the Health Assembly had been successful. All its resolutions and decisions were consistent with the enormous challenges facing international public health.

Dr COLEMAN (Liberia) noted that, although many resolutions had been adopted by the Health Assembly, implementation at country level was often delayed. He appealed to the Director-General to speed up that process. He commended WHO's presence in conflicts and crises around the world. In his country, WHO had been present throughout the recent period of conflict, assisting the population and coordinating many activities, including the work of nongovernmental organizations. It had shown itself to be quick in intervening in crises, such as that following the tsunami in south Asia in December 2004, the situation in Darfur in Sudan and the outbreak of Marburg disease in Angola; some years

previously, WHO had been criticized for being the last to arrive, but since then it had become one of the first. He underlined the importance of the issue, raised by the member for Jamaica, of the emigration of health workers from developing countries, which posed a serious threat to the health systems of such countries. He appealed to the Director-General and the Executive Board to take action to reverse the trend.

Mr GUNNARSSON (Iceland) expressed concern that resolutions previously adopted by the Executive Board after extensive discussion had been amended substantially at the Health Assembly, sometimes by Member States represented on the Board that had agreed to the original wording only months earlier. The Secretariat and the Board should examine ways of avoiding such a situation.

Ms HALTON (Australia) said that much had been said about the success of the Health Assembly. The issues of particular concern to her had been well dealt with and the significant number of resolutions adopted was evidence of goodwill and hard work. She shared the concern regarding the difficulty facing small delegations of trying to attend the many meetings.

The work done by the Secretariat on budgetary matters had had a significant impact, leading to the adoption of a substantial increase in the budget. WHO thus had a responsibility to continue the excellent work and she looked forward to collaborating with the Secretariat in that context. She also endorsed the views of the member for Iceland regarding the need to ensure that the Board's decisions were followed through.

Dr GOMES TEMPORÃO (Brazil) welcomed the adoption by the Health Assembly of resolution WHA58.22 on cancer prevention and control, which provided excellent guidance on tackling a universal public health challenge.

Dr QI Qingdong (China)¹ agreed that the Fifty-eighth World Health Assembly, with its well-defined theme and compact schedule, had achieved valuable results. The adoption of the International Health Regulations (2005) was a milestone. In addition, the various technical briefings and events had provided rich content that would facilitate the understanding of new work. The 34 resolutions adopted covered a wide range of topics, but they had often been finalized at the last moment. The Secretariat should endeavour to identify the resolutions on which consultation was required so that appropriate arrangements could be made, in order to avoid pressure on delegations at later stages of the Health Assembly. Furthermore, the resolutions were far too long, cumbersome and difficult to understand; they should be understandable and concise, and should be implemented in line with their original intent.

He fully agreed with the member for Namibia that future Health Assemblies should focus on technical health problems, rather than debating, year after year, political issues that it could not solve.

The CHAIRMAN, summing up the debate, concurred that time should not be spent on matters that did not lie within the purview of the Health Assembly. In addition, decisions taken in the Board should not be altered subsequently but should progress towards implementation. In relation to the budget increase, great care must be taken to ensure that resources were not wasted. Finally, there was general agreement that the key lay in implementation.

The DIRECTOR-GENERAL said that there were two facets to the implementation of resolutions: the responsibility Member States were imposing on themselves, and the actions Member States were requesting of the Director-General and the Secretariat. The former was often forgotten but was, in fact, often more important than the latter.

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

The CHAIRMAN emphasized teamwork between Member States and the Secretariat. He recalled his belief that it was time to do things that were morally right, nothing being politically right that was morally wrong.

The Board noted the report.

4. TECHNICAL AND HEALTH MATTERS: Item 4 of the Agenda

Control of genetic diseases: Item 4.1 of the Agenda (Document EB116/3)

Dr ANTEZANA ARANÍBAR (Bolivia) stressed the importance of the potential public health benefits of knowledge and management of genetic diseases and congenital malformations, but noted several unresolved issues. First, universal primary health care was still unavailable to significant numbers of people, particularly among the poorer populations of developing countries (and the term “developing countries” covered a variety of countries at different stages of development, some having good access to primary health care, others not). Secondly, there was a need to identify educational, informational and financial mechanisms to ensure equitable access to genetic services. Thirdly, he queried the extent to which WHO was in a position to facilitate access. It was one thing to deal with the matter in the abstract, but another to take specific action to turn the potential benefits into reality. Lastly, there was the question of managing the ethical implications of the technologies and processes involved in the control of genetic diseases.

Professor FIŠER (Czech Republic), recalling the emphasis that the Fifty-eighth World Health Assembly had placed on the provision of full information, particularly for mothers, suggested that the Secretariat should prepare a report comparing various approaches to genetic diseases, evaluating their impact on genetic disease incidence and the quality of life of affected children. It was vital that such a report should be readily understandable.

Dr SHINOZAKI (Japan) commended WHO’s action on the control of genetic diseases and welcomed the progress in research, which had made a significant contribution to the prevention, diagnosis and treatment of genetic diseases. He also recognized the importance of confidentiality and ethical issues in relation to genetic information. Japan was promoting the application of genome research, proteomics and nanotechnology to clinical practice, and was willing to provide technical cooperation for an international research network.

Mrs LE THI THU HA (Viet Nam) said that the control of genetic diseases had not been properly considered in developing and low-income countries because of lack of infrastructure and human resources. In Viet Nam treatment for genetic diseases was available only in major cities. In recent years, thousands of children with cleft lip or palate had received treatment, thanks to the support of many partners, but demand remained huge. Some pilot genetic counselling centres for patients with haemophilia had been established, with encouraging results.

Member States should develop a comprehensive strategy for control of genetic diseases covering all aspects of prevention and treatment, training, research, and ethical, legal and social issues as part of the national health strategy. Delivery of genetic services should be integrated into all levels of health care. In order to improve understanding and awareness of genetics, developing countries should post frequently asked questions on the subject and their answers on their existing health web sites. Viet Nam also supported the expansion of international collaboration and was willing to work with WHO and other partners on the control of genetic diseases.

Dr ALI MOHAMMED (Iraq) suggested that the title of the report should have read “Control of genetic diseases and congenital malformations” or, given the focus on genetic diseases, the words “and congenital malformations” should have been omitted from the final sentence of paragraph 2. He further suggested that paragraph 8 should have concluded by stating that support for screening programmes was essential. WHO should adopt a clear position on the scientific and ethical aspects of genetic research and attention should be given to chemical and radioactive contamination of the environment and its relationship with genetic diseases and congenital malformations.

Dr RAHANTANIRINA (Madagascar) said that, although genetic diseases were rare in her country, genetic haemoglobinopathies, in particular sickle-cell anaemia, posed a public health problem in certain areas. National health priorities meant that those conditions were orphan diseases, receiving no special resources. She therefore welcomed inclusion of the item on the agenda as an opportunity to raise awareness of the importance of implementing policies and strategies to reduce the risk of genetic diseases, and of including, at the primary health-care level, such actions as public education in genetics and training to improve detection of genetic risks in the community. To that end, it was important to stress the use of simple and affordable technologies to facilitate integration into primary health-care services and to optimize use of existing resources. Genetic diseases had implications for achievement of the Millennium Development Goals, particularly as they were a major cause of death of pregnant women. The ethical issue associated with the control of genetic diseases was also extremely pertinent; the ethical dimension was one reason why little attention was paid to the subject in Madagascar.

Professor CİNTEZA (Romania) said that the prevention and control of genetic diseases should be integrated into a broader strategy for tackling noncommunicable diseases that included action to increase awareness and education among communities and health professionals. There was also a need for training programmes and technology investments to introduce genetic diagnostic tests at the primary health-care level. Such efforts should correspond to each country’s specific burden of genetic diseases, while taking into account the expertise of other countries. Romania hoped to learn from international experience.

Dr GOMES TEMPORÃO (Brazil) highlighted the importance of tackling sickle-cell anaemia, which killed many infants in Brazil. Action was urgently needed, and the Community of Portuguese-Speaking Countries had already taken a political decision in that direction, formalized in the Declaration of São Tomé in July 2004. Support from WHO in that regard would be greatly appreciated.

The sensitivities related to genetic diseases had been carefully addressed in the report, but the reference in paragraph 9 to “premarital genetic counselling, and encouragement of reproduction at optimal maternal ages” seemed to contradict not only paragraph 10, which mentioned the need for genetic counselling to be “sensitive to the cultural, religious and ethical views of the individual or couple”, but also several United Nations and WHO resolutions. The concept of “optimal maternal ages” was problematic, particularly since far more factors were involved than purely biological ones, and it would have been preferable to omit any reference to it.

Dr INSANOV (Azerbaijan), welcoming the report, observed that genomics research was revealing a growing number of genetic determinants of health, and genetic technologies were increasingly being used in the treatment not only of genetic diseases and congenital malformations but also of communicable and noncommunicable diseases. The report highlighted the significance of genetic factors for public health and emphasized that future technological developments in the field would give rise to serious ethical and social dilemmas. Those aspects should be examined at global level, with WHO playing a leading role. However, the key issue was the successful application of genetic technologies to clinical practice, for which the Secretariat would have to continue its support

to Member States in the development of genetic medicine services and the education of doctors and communities. He suggested that the Board should adopt a resolution on control of genetic diseases.

Dr ACHARYA (Nepal) contrasted the relatively new area of genomics, particularly for developing countries, with the age-old problem of congenital malformations and genetic disorders, which formerly, and in some cases still, were regarded as a curse on the person concerned. The acquisition of scientific knowledge leading to the development of measures to prevent and treat genetic diseases was relatively recent. As developing countries were still also burdened with a high prevalence of communicable diseases, genetic diseases came low on their list of priorities. Because communities in some developing countries, including Nepal, continued the tradition of consanguineous marriage, increasing awareness and knowledge of the causative factors of genetic diseases were of great importance. Public education in genetics, premarital genetic counselling and encouraging child-bearing at optimal maternal ages were measures that could be effective, even in developing countries, within primary health-care services. WHO should take the lead in formulating a strategy for promoting genetic services, with special emphasis on developing countries.

Dr SÁ NOGUEIRA (Guinea-Bissau) said that genetic diseases and congenital malformations were a major health problem with social and economic effects in all countries. Developing countries suffered from a lack of information and diagnostic facilities and WHO's efforts to define strategic directions in the field of genetic diseases and to incorporate genetic services into all levels of the health system, particularly in primary health care, were much appreciated. WHO should continue its technical support for the preparation and implementation of national programmes.

Dr BRUNET (alternate to Professor Houssin, France) welcomed the emphasis on the burden of genetic diseases in poor countries, genetic counselling and rare diseases. France had recently established a national agency for biomedicine to deal with medical, social, legal and ethical issues, especially in relation to genetic diagnosis. It was essential, given the rate of progress in cloning and emerging technologies such as proteomics, for such vital social issues to be discussed openly in order to keep citizens fully informed. It was also essential to ensure a high standard of genetic counselling, in order that potential mothers, in particular, received accurate information. To that end, genetic counsellors in France were Government-regulated.

The report might perhaps have devoted more attention to international cooperation in the ethical aspects of genetics. His country was particularly interested in the work of the Steering Committee on Bioethics of the Council of Europe; it would be in WHO's interests to work closely with that body. The latest additional protocol to the Convention on Human Rights and Biomedicine would serve as a model well beyond the boundaries of Europe.¹ His country also followed with interest the work of the United Nations and UNESCO, including the Universal Declaration on the Human Genome and Human Rights of 1997 and the International Declaration on Human Genetic Data of 2003. His country's National Consultative Bioethics Committee had recently expressed concern about the possible availability of tests for genetic disorders that could be purchased and used without the benefit of genetic counselling.

The free access to genomic and gene-sequencing databases was a promising new development. WHO should continue to support Member States in the preparation of appropriate responses to new developments and to disseminate country experiences in order to expedite progress in an important area.

Dr ABDULLA (Sudan) said that genetic disease control was particularly important to developing countries, where the prevalence of inherited genetic diseases was rising and the extent of

¹ Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, Oviedo, Spain, 4 April 1997.

the problem was undoubtedly underestimated owing to poor surveillance systems. WHO should increase efforts to strengthen genetic disease surveillance systems, and encourage national policy-makers to place the issue at the top of their agenda. WHO should also advocate the use of cost-effective measures to control genetic diseases, through integration of genetic disease strategies into the primary health-care system, promoting best practice and sharing experience among countries.

The high cost of many genetic disease-control interventions remained a barrier to access for developing countries. WHO should carry out research into affordable, cost-effective treatments, and encourage the countries that owned the technologies to make them available to the developing world. He welcomed the fact that the Secretariat had not entered the debate on the issue of the use of genetics in reproduction, given the cultural and religious sensitivities involved.

Professor PEREIRA MIGUEL (Portugal) said that the beneficial applications of genomics were evolving and that in the future it could make a significant contribution to public health. During the past 20 years, Portugal had been operating a programme for the control of haemoglobinopathies, set up with WHO guidance, and had made significant progress in research. Its current priority was better integration of those control measures in health centres. To that end, policy-makers and health managers needed to be made aware of the urgent need for further work in the field of medical genetics with a view to generating substantial health gains overall. Strategic goals were, inter alia, to improve the quality of genetic services, create conditions for the certification of genetic laboratories, in particular those targeting pre-birth diagnosis, and establish protocols for proven and cost-effective treatments.

He supported WHO's proposed approach for the control of genetic diseases with primary health care forming the basis for all genetic health actions, and the emphasis on wide-reaching programmes with simple and affordable technology. It was essential to develop genetic education and training for health professionals, genetic research and regulatory structures to protect privacy and confidentiality. The availability of affordable medicines was similarly essential. Basic genetic counselling that was educational, voluntary and non-prescriptive should be integrated into primary health care in all countries.

Dr HANSEN-KOENIG (Luxembourg) agreed with previous speakers about the importance of not widening the gap between rich and poor countries. In that context, the approach taken by the Secretariat, notably concerning the integration of genetic services (including education, prevention and counselling) into primary health care, was particularly useful. The link between prevention and treatment was also extremely important with a view to screening only for genetic diseases that were treatable. WHO guidance in the form of evidence-based information would be instrumental in highlighting the need for training and research on the subject, with emphasis on the ethical issues at stake.

Dr SUPACHAI KUNARATANAPRUK (Thailand) said that WHO should address the issue of primary and secondary prevention of genetic diseases, which had been made possible by advances in medical knowledge. Thalassaemia was the most common genetic disorder in Thailand but, despite extensive research, no effective intervention had yet been introduced. Other drawbacks were the lack of awareness about genetic diseases among the general public, and the lack of appropriate training for health professionals due to the mistaken belief that genetic services were expensive and complex and therefore not a priority for developing countries. Premarital counselling was an important entry point for primary prevention of common genetic disorders. His Government had introduced a comprehensive counselling programme for HIV/AIDS and genetic disorders and promoted family-tree analysis to predict and prevent certain genetic disorders.

In view of the serious ethical concerns about the diagnosis and treatment of genetic diseases, he called on WHO to continue to analyse the social, ethical and legal aspects of the issue and to provide guidance for Member States.

Dr SINGAY (Bhutan) endorsed the remarks made by the member for Bolivia and emphasized the weakness of the health systems in developing countries, their limited resources and capacities. Was the necessary technology so readily available that countries could afford to provide such genetic services at the primary health-care level? Had their cost-effectiveness and impact on the leading causes of mortality been explored? Did genetic information and counselling services have adequate backing? In short, was the provision of genetic services both realistic and sustainable?

Dr HUERTA MONTALVO (Ecuador) suggested that “control” was too strong a term to be used in the title of the document, as it might raise expectations that could not be met. The report made it clear that the distinction between medicine and public health was increasingly hazy, and that the training of doctors and public health workers needed to be reconsidered. It was also important to ensure that the gap between the services available in the rich countries, with the resources to undertake and apply genetic research, and those available in the poor countries, which were largely onlookers, did not widen further; WHO could play a useful coordinating role in that respect. The question of genetics and commerce was linked to that of international trade and health, which the Board would also be discussing, and thought should be given to the role of countries and WHO in that regard.

Ms GILDERS (Canada) said that, although it was important for WHO to consider the potential role of genetic knowledge in improving global health, the ethical, legal and social issues involved needed to be tackled with sensitivity. She concurred with the member for Brazil on the reference to “optimal maternal ages”, expressing concern both over the potentially negative repercussions of putting pressure on women to have children at a certain age, particularly in the absence of the necessary social and financial support systems, and with regard to whether such a concept was compatible with reproductive autonomy. She also shared the concerns of the member for Ecuador regarding the use of the word “control” in the context of genetic diseases.

A holistic approach to genetic diseases must be taken in order to pursue public health goals with due regard for bioethical norms and human rights; the work of UNESCO would be valuable in that area. She supported in particular WHO’s role in ensuring that the benefits of new genomic knowledge were widely shared. However, its work should be as focused as possible, and considered in the context of the Organization’s many priorities.

Mr BAILÓN (Mexico) endorsed the distinction in paragraph 2 of the report between genetic diseases and congenital malformations, and the suggestion by the member for Iraq that “congenital malformations” should be included in the title, so as to place more emphasis on that aspect of the subject and, consequently, on cost-effective preventive measures, such as the use of folic acid supplements by women of childbearing age to reduce the incidence of congenital malformations.

Dr ABDUL WAHAB (Bahrain) said that the problem of genetic diseases placed a major burden of responsibility on WHO, not least in view of the lack of adequate diagnostic information and experience. Moreover, solutions were usually out of reach to developing countries where such diseases were most prevalent. Bahrain, for instance, had a high incidence of thalassaemia and other haemoglobinopathies, mainly as a result of consanguineous marriage, and was implementing a strategy to improve public awareness of the problem through education, information and the introduction of compulsory pre-marital testing. He urged WHO to ensure that the subject received the attention it merited by swiftly affording it high priority, allocating the necessary budgets and putting in place a global strategy, taking into account religious, cultural and social sensitivities. The enormous body of genomic knowledge available in the developed countries should be used to benefit the human race, improve health and create stability. Any abuse of that knowledge for commercial or immoral purposes would be entirely at odds with religious and social beliefs, with disastrous consequences.

Dr WINT (Jamaica) said that the attempt to integrate such a highly scientific and specialized matter into the public health arena was a challenge for small countries, including Jamaica, where 10%

of neonates carried the sickle-cell gene, with consequent high morbidity and premature mortality. Jamaica's efforts in that area had so far been limited to university research centres. A sustainable primary health-care model approach would therefore be of keen interest. The provision of "a strong platform for the application of genetic technology to a broader range of public health challenges", referred to in the report, would be particularly timely in view of the global developments in genomics and the hopes and aspirations of sufferers. In Jamaica, the formation of support groups by and for those with genetic diseases had proved useful and effective in terms of both advocacy and self-help.

Mr GUNNARSSON (Iceland) said that knowledge of genetic diseases and diagnostic techniques in particular had increased enormously over the past two decades. The prevalence of such diseases raised complex ethical, legal, social and human-rights issues that were still unresolved. In his country, for example, the wide debate generated by the establishment of a genetic research company some 10 years previously continued. The most important challenge was to provide expert health-care services to as many people as possible, while protecting confidentiality and individual freedom of choice, in addition to minimizing the misunderstanding and stigmatization often surrounding genetic diseases. The main objective of controlling genetic diseases was to maximize the options available to people at risk, rather than to reduce the incidence of such diseases. WHO had an important role to play in further developing the public-health approach to genetic diseases. In that connection, he agreed with the member for France that the Council of Europe's Convention on Human Rights and Biomedicine could serve as a useful reference.

The meeting rose at 12:40.

SECOND MEETING

Thursday, 26 May 2005, at 14:05

Chairman: Mr M.N. KHAN (Pakistan)

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

Control of genetic diseases: Item 4.1 of the Agenda (Document EB116/3) (continued)

Dr NYIKAL (Kenya) said that the subject was important for his country, where the lack of screening and diagnostic facilities limited the advice and counselling available to patients, their families and the public in general. That was true even for diseases like sickle-cell disease, for which screening, diagnosis and care were affordable. If the appropriate protocols, guidelines and referral systems were put in place, it would be possible to incorporate the management of genetic disorders into primary health care. By focusing on the issue, WHO would encourage countries to do the same and to allocate more resources to genetic disorders. The earlier that was done the better, before the gap between developed and developing countries widened further as increasingly sophisticated methods of screening and diagnosis were developed. WHO should adopt a strategy encompassing the establishment of protocols and guidelines for screening and diagnosis, emphasizing genetic disorders for which treatment was simple and affordable; the promotion of training of health workers in screening, diagnosis, care and counselling; public information and education; and the creation of referral and diagnostic centres within primary health-care systems.

Mr POMOELL (Finland)¹ expressed surprise that rare diseases were mentioned only once in the report, as up to 80% of the 6000 or so rare diseases in the world were, to a greater or lesser extent, genetic in nature, and in some parts of the world they accounted for between 10% and 15% of mortality.

Mrs NOKE (Cystic Fibrosis Worldwide), speaking at the invitation of the CHAIRMAN, said that her non-profit organization had been formed after the merger in 2003 of two associations and had more than 56 member countries and associate members. Before the merger, a manual for implementing cystic fibrosis services in developing countries and guidelines for the diagnosis and management of the disease had been produced with WHO. From those working documents, her organization had developed a programme that offered support to patient organizations, educated medical professionals in the treatment and diagnosis of the disease and opened access to necessary medication, specialized-care facilities and the international cystic fibrosis community. It was working with partners in Georgia and India to increase the managerial, financial and advocacy skills of local cystic fibrosis associations, develop contacts with networks of nongovernmental organizations that targeted inherited chronic disease, and expand the links between those local nongovernmental organizations and the public and private sectors. From project evaluations a capacity-building manual for inherited chronic disease management in underprivileged countries would be produced, for potential dissemination by WHO. Evaluation of the management of cystic fibrosis would help in the development of a capacity-building model to enable other nongovernmental organizations to implement similar programmes.

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

The lack of appropriate treatment and care in developing countries meant that the median estimated life expectancy of children suffering from cystic fibrosis was much less than in developed countries. Full chronic disease management placed demands on family, health-care systems, governments, communities and international resources. Evaluations of successful programmes in developing countries could help grassroots organizations, established foundations and worldwide affiliations to operate more effectively in targeting chronic disease and helping sufferers. Continued partnership with WHO and other international nongovernmental organizations would ensure that current progress was translated into a roadmap for future programmes, increasing both the quality of life and the life expectancy of patients around the globe.

Dr MASTROIACOVO (International Clearinghouse for Birth Defects Monitoring Systems), speaking at the invitation of the CHAIRMAN, said that more than 40 birth-defects surveillance programmes were members of the Clearinghouse. It sought, through surveillance and research, to prevent birth defects and promote optimal care for affected children and their families. Since 1978 it had organized scientific meetings, published two editions of the World Atlas of Birth Defects, and was coordinating the International Database on Craniofacial Anomalies with more than 50 collaborating registries.

The global prevention of birth defects and care for affected people progressed by steps. Because most birth defects were structural malformations, with a prevalence of one in 33 births, and as they involved high cost and high infant mortality, the first step had two priorities: to develop efficient surveillance of congenital malformations, and to promote primary prevention. The latter required integrated public health interventions, such as folic acid fortification, promotion of the awareness of the dangers of smoking during pregnancy, rubella vaccination and safe use of medicines in pregnancy, and family-centred interventions such as preconception counselling, maternal and child health services and clinical genetic services. Scientific evidence had confirmed that promoting the fortification of staple foods with folic acid was the cheapest, simplest and most successful intervention, providing major benefits globally. The Clearinghouse was ready to collaborate with individuals and organizations to promote primary prevention and the efficient surveillance of birth defects.

Dr GIANGRANDE (World Federation of Hemophilia), speaking at the invitation of the CHAIRMAN, said that the Federation estimated that there were some 400 000 people with haemophilia worldwide (with an incidence of one in 5000 live male births), of whom only about 25% received adequate treatment. With proper treatment, haemophiliacs could live normal lives; without treatment most children with severe haemophilia would die before adulthood. Not treating haemophilia was costly in terms of human suffering, treatment of complications and loss of income for people unable to work.

For more than 40 years, the Federation had been improving haemophilia care worldwide and its experience had shown that sustainable improvement was only possible when that care was an integral part of a national health-care system whose stakeholders worked together. It had created a highly successful model for sustainable care for people with bleeding disorders in developing countries; in 2003, it had launched its Global Alliance for Progress in haemophilia, an intensive 10-year health-care development initiative with WHO as a partner in about 30 countries. It catalysed the creation of a core group of local supporters from the medical and patient communities that approached the health ministry with an initial plan in order to secure a commitment to establish a haemophilia care programme within the national health care system. The Federation provided data to show the economic advantages of a national haemophilia care programme. Diagnosis was the first step in improving care and a key element of the initiative. With WHO, the Federation ran an international external quality assessment scheme to monitor and improve laboratory diagnosis in 65 haemophilia treatment centres worldwide. Education and training for health-care professionals and patients were other key elements of the programme. Since 2003, projects had been launched in nine countries.

The collaborative work with WHO had had a tremendous impact on public health systems for those with haemophilia in the family and on improving the general health infrastructure. He urged

WHO to expand its activities on genetics and genetic diseases by adapting the Federation's successful model for application with other genetic diseases.

Mrs NOKE (Thalassaemia International Federation), speaking at the invitation of the CHAIRMAN, said that the Federation had begun compiling epidemiological information on thalassaemia, establishing national thalassaemia associations in numerous member countries and intensifying preventive activities and provision of better clinical management. The lack of effective prevention strategies in many countries meant that affected babies continued to be born, and created a constant rise in the demand for adequate and safe blood, and appropriate iron chelation and treatment regimens for other complications. That placed an extra burden on already strained national resources, especially in developing countries, and resulted in low-quality medical care, low survival rates and poor quality of life.

The Federation had worked in more than 60 countries to date, and had formed or strengthened partnerships with the medical community, national health services and national thalassaemia associations. It had supported research in fields relating to thalassaemia control, compiled epidemiological data, and built successful education programmes. In order to raise awareness among the public, patients, medical personnel and national health services, it published, translated and distributed educational material and other publications on the prevention and management of thalassaemia free of charge. It had contributed towards the establishment and promotion of national thalassaemia associations in 52 countries. In funding research, it had contributed to the improvement of therapeutic protocols and thalassaemia control. It had also encouraged the application of effective prevention programmes in 60 countries. Without WHO's help and support, none of those activities and achievements would have been possible, and she urged continued collaboration.

Hundreds of thousands of thalassaemic babies were born annually and thousands died because treatment was ineffective or lacking, and the quality of life of others suffered from sub-optimal treatment. Available data were still not accurate, and it was vital to compile more accurate epidemiological data. Experience had proved that the successful prevention and clinical management of thalassaemia provided an excellent model for other genetic diseases. Thalassaemia deserved more focused attention.

The CHAIRMAN, speaking in his capacity as the member for Pakistan, said that the occurrence of genetic diseases and congenital malformations was a matter of great concern; in resource-limited settings, the additional burden weighed heavily on the health system. Some of the most common genetic diseases could be managed successfully, but they required substantial resources, which were not available in many developing countries. Although genomic research was viewed with great enthusiasm, it would be a long time before its benefits were fully realized, but genetic engineering was the way forward. He urged the Secretariat to consider the moral, ethical, medical, legal, social, cultural and religious aspects of the control of genetic diseases. National and global strategies for prevention and control of, and for research into, human genetic diseases were essential.

Dr LE GALÈS-CAMUS (Assistant Director-General) said that she had noted the comments of members of the Board. The report had recognized both the importance for health of the potential applications of the results of genomic research and the complexity of the ethical, legal, social and economic issues they raised. The Secretariat was taking an integrated approach, seeking first to improve knowledge of the prevalence of genetic diseases and their impact on the lives of sufferers, their families, communities and countries, and was working to promote information and education and to provide advice on genetic diseases in the context of primary health care. It was recognized that putting such activities in place might entail difficulties for lower-income countries. Early screening was in line with such an approach, bringing undoubted benefits to sufferers and their families, and should only be carried out at their request. WHO also focused on access to treatment, where available and recognized to be effective and desirable, and assistance to sufferers and their families. In all cases, any action must be based on strict respect for the values and legal frameworks of the countries

concerned and after careful analysis of health systems, to avoid draining resources inappropriately or diverting them from other health policy priorities.

WHO's participation in international work was exemplified in the area of bioethics by its contribution to the Council of Europe's Steering Committee on Bioethics and its provision of secretariat services to the Global Summit of National Bioethics Commissions.

The Board took note of the report.

International trade and health: Item 4.2 of the Agenda (Document EB116/4)

The CHAIRMAN noted that the item had been deferred from the 115th session of the Board.

Dr SUPACHAI KUNARATANAPRUK (Thailand), welcoming the report, said that, although Thailand was a predominantly agricultural country, its share of international trade and services had grown significantly over the past 10 years, whereas income from agriculture had decreased. International trade had brought wealth and, as a result, Thailand would be able to make good its regular budget deficit. During the same period, the national health budget had risen from 5% to 10% of total government spending. He commended WHO's work as described in paragraph 10 of the report, and the setting up in February 2004 of the Commission on Intellectual Property Rights, Innovation and Public Health, in accordance with resolution WHA56.27.

Despite close collaboration at global level between WHO and partners in the trade sector, there was need at country level for better dialogue with ministries, notably those responsible for health, commerce and foreign affairs. It was also necessary to build capacity for analysis so that policy formulation could be based on sound evidence, in order to maximize the positive effects of trade liberalization and minimize its negative impact.

He wished to propose a draft resolution on the subject, and requested that the agenda item should remain open to allow time for the preparation of the text.

Dr ANTEZANA ARANÍBAR (Bolivia), noting the complexity of the issue of international trade and health, said that the decisions taken by different international organizations could sometimes be contradictory. That was certainly the case of WTO and WHO: WTO endeavoured to improve international trade, often without regard for the consequences for health, whereas WHO tried to protect the world from such consequences. The report highlighted issues concerning policies in the two areas; indeed, the very title "international trade and health" gave rise to deep concern, since the two elements could not be considered on an equal basis. The report referred to capacity building, but it was clear that that was feasible only in countries where the health sector was able to engage in dialogue with the leaders of the world economy to persuade them that health was essential to economic prosperity and development. The issue was linked to that of intellectual property rights and innovation; there was need to reconcile the right to innovation with the challenge of giving countries that were not fortunate enough to have much potential for dialogue access to health technology and products for improving health.

Risks remained, but there was some hope. The proposed workshops, meetings and other initiatives might help those who most needed them, yet without coordination between countries, cooperation between organizations would not prove effective. Member States should therefore shoulder that responsibility.

He thanked WHO for the cooperation it had offered the countries of the Andean Community and MERCOSUR with regard to antiretroviral medicines.

Dr SHANGULA (Namibia) said that, although the Health Assembly had discussed international trade and health on several occasions, the issue had assumed greater urgency with the advent of the HIV/AIDS epidemic and the benefits of antiretroviral medicines. Since those life-saving products were unfortunately subjected to the same regulations as other commodities, the flexibilities offered by

the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) were welcome. However, the developing countries were concerned about WTO's inability to find a permanent solution to the problem of enabling countries with little or no drug-manufacturing capacity to have access to affordable medicines. He urged closer collaboration between trade and health ministries, and between WHO and WTO. Medicines should not be subjected to the regulations applicable to other commodities.

Ms GILDERS (Canada) commended WHO's valuable work in fostering a better understanding and greater knowledge of the complex interrelationship of international trade and health. Health ministers needed to be able to provide trade and finance ministers with evidence of the potential impact of trade and trade negotiations on health. WHO should therefore continue its work, so that health policy considerations could be better taken into account at international trade negotiations. Canada would join the sponsors of the draft resolution proposed by the member for Thailand.

Mrs LE THI THU HA (Viet Nam) welcomed discussion of the issue, which was relevant to her country as it negotiated accession to WTO. Despite the interministerial collaboration and technical cooperation from which Viet Nam had benefited in recent years, few attempts had been made to tackle health and trade issues or to approach them from a public health perspective. Training and capacity building would be needed if the ministries concerned were to address trade and health-related issues in a more concerted manner, gain a better understanding of WTO agreements, and put in place mechanisms to track and monitor the health implications of those agreements.

Viet Nam's Ministry of Health and WHO had devised a project to improve the ability of officials to recognize the public health implications of multilateral trade agreements. Its implementation should make it possible to resolve national trade and health policy concerns during accession negotiations with WTO, and to generate evidence in selected areas such as the General Agreement on Trade in Services, access to drugs and the TRIPS agreement, food safety, and the Agreement on the Application of Sanitary and Phytosanitary Measures. She would support the draft resolution to be submitted by the member for Thailand.

Professor CINTEZA (Romania) said that his country was currently experiencing serious health and safety problems arising from the movement of persons, medicines and foodstuffs. So as not to present a danger to health, foodstuffs had to be properly stored and conserved, and it was thus essential to be sure of the harmlessness of food additives and preservatives. In view of the expansion of the regional and international trade in foodstuffs, careful monitoring of additives and preservatives was essential. His country also had problems in guaranteeing health and safety nationally, and therefore greatly appreciated the report.

Professor PEREIRA MIGUEL (Portugal) recalled that negotiations on trade issues within the framework of WTO had often been highly controversial. The debate on the impact of the General Agreement on Trade in Services on, for instance, health and social policy objectives had led critics to accuse it of undermining the right of Member States to pursue their social policies. The slow progress in implementing the Doha Declaration on the TRIPS Agreement and Public Health clearly exemplified the difficulty of such negotiations.

The report rightly advocated greater interaction between policy-makers and practitioners in the trade and health sectors in order to make domestic and international policy more coherent. Through broad consultations, health ministries needed to be more aware of trade issues and to understand the interface between implementation of national health policies and compliance with international trade agreements. That process would be an enormous challenge for the least developed countries, whose institutions lacked specialized skills and which therefore had to depend on international cooperation or expensive external advisory services. Although it might be desirable to strengthen capacities through the establishment in health ministries of specialized units with overall responsibility for international trade negotiations, in many developing countries not even trade ministries had such units. It might

therefore be worth trying to achieve institutional expertise across sectors, but with a focus on health and trade, since there was much common ground on trade-related issues in the various sectors.

He supported the approach set out in paragraph 12 of the report. Donor coordination would be needed to avoid overlap and to make the best use of the technical competence of bilateral donors and international organizations. He welcomed the proposed partnership between FAO, WTO, the World Bank, UNCTAD and OECD.

Dr SHINOZAKI (Japan) said that the question of the compatibility of public health and trade in internationally regulated goods like food and pharmaceuticals called for an evidence-based approach. Protection of intellectual property rights could in fact promote public health, since it encouraged research into new medicines. Collaboration between WHO and WTO should be encouraged in order to achieve synergy. Support for developing countries in the areas under discussion should continue.

Dr GOMES TEMPORÃO (Brazil) said that in an era of globalization it was impossible to separate the issues of international trade and health, to which he therefore supported an integrated, comprehensive approach. Concerted action was the best way to foster development, eliminate poverty and promote global public health.

In negotiations at WIPO, WTO and UNCTAD, his Government had adopted a positive stance, incorporating the public health perspective without creating unnecessary obstacles to trade. Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health had been a significant step towards securing wider access to medicines for HIV/AIDS, tuberculosis and malaria. Although in some circumstances trade liberalization could be harmful to health, it could also ensure better allocation of resources and increase income in developing countries. Alleged health concerns ought not to be used to justify subsidies, technical barriers to trade and arbitrary or discriminatory sanitary measures.

He requested further information on the detailed legal analyses on the agreements referred to in paragraph 12 of the report, especially with regard to the process of consultation, the experts who would be invited to contribute and the timeframe.

Brazil supported training and capacity-building activities at country level aimed at clarifying the links between trade and health and alerting the relevant authorities to those links, since it was vital to assess the impact of trade agreements on health in order to achieve coherence at regional and international level. The flexibilities allowed by the TRIPS Agreement and the Doha Declaration must be fully reflected in regional and bilateral trade negotiations. It was not a question of precedence of trade or health; they were issues that ran in parallel and had an impact on each other. For that reason, a transparent, comprehensive and integrated approach was essential in the international context. He would therefore support the resolution to be submitted by Thailand.

Dr SINGAY (Bhutan) said that his country was currently negotiating WTO membership. Health ministries should be involved in the negotiation of trade matters and should provide finance and trade ministries with evidence-based information. Unfortunately, countries often suffered from a lack of expertise and capacity. For that reason, he welcomed the report and would support the draft resolution to be submitted by Thailand.

Mr GUNNARSSON (Iceland) said that greater interaction and dialogue were needed between policy-makers and practitioners in the trade and health sectors. In his small island country, all health-sector equipment and medicines had to be imported, putting the health authorities at the mercy of the big multinational firms, which set prices without consulting national governments.

While expertise on trade was undoubtedly needed in the health sector, health ministries and WHO should not encroach on the work of other bodies such as WTO. It would, however, be advisable to define more clearly what was meant by "international trade", and for the Secretariat to pursue its work on international trade and health.

Dr TANGI (Tonga) also drew attention to the vulnerability of small island nations in trade relations and the fragility of their position in negotiations with WTO and other large entities. Such countries, which were obliged to import many health goods and spend a growing proportion of their budgets on them, were at the receiving end of many trade-related decisions over which they had little influence.

Professor FIŠER (Czech Republic) endorsed the statement made by the member for Portugal. Mentioning the reference in paragraph 17 of the report to partnerships with other international organizations, he observed that his country's health ministry had had a bad experience with the World Bank when, without even consulting national health authorities, Bank experts had put forward several proposals to the finance ministry for reforming the Czech health-care system, entailing lower cost but less coverage. He called on WHO, in its partnerships with other international organizations, to speak with a much stronger voice to promote health and health issues.

Professor HOUSSIN (France) commended WHO's technical support to countries adapting national legislation to take full advantage of the flexible arrangements provided for in the TRIPS Agreement. France was interested in the analytical work being done by the Secretariat to assess the impact of that agreement on access to medicines, particularly in India since 1 January 2005, as it was concerned to ensure that the flexibilities of the Doha agreements were used to respond to public health needs, particularly the management of HIV/AIDS.

Dr NYIKAL (Kenya) emphasized that WHO should help to strengthen the linkages between health and trade ministries and highlight the health issues that had to be borne in mind in trade negotiations. Health ministers were often only involved in such negotiations when a particular health-related matter arose, as had happened recently in negotiations to harmonize trade tariffs among the countries of eastern Africa. The need for WHO's support to strengthen interministerial cooperation on trade matters could be reflected in the proposed draft resolution.

Dr WINT (Jamaica), expressing support for WHO's work in international trade and health, said that the issue was indeed not trade *or* health but, rather, ensuring that trade had good consequences for health. He would support the proposed draft resolution, but wished to see more stress on collaboration between the health and agriculture sectors regarding food safety and the public health implications of trade in agricultural products. In relation to the evidence base, he noted that trade ministers generally looked at short-term cost implications, but health officials needed to highlight the costs of the long-term health implications of trade, which sometimes outweighed its short-term benefits.

Dr ALI MOHAMMED (Iraq) said that the report should have dealt more frankly with the sensitive issues involving health and trade – taxes on medicines for example. He expressed support for the draft resolution proposed by the member for Thailand.

Mr HOHMAN (United States of America)¹ agreed on the importance of international trade and health but criticized the report as superficial and lacking in critical analysis. He had concerns about the advice the Secretariat gave to Member States on the potential implications of trade rules from a public health perspective and the information it provided on best practices in trade negotiations. Such activities did not represent the best use of WHO's resources, particularly as he doubted the depth of expertise that the Secretariat could provide to Member States in that area. Furthermore, the Secretariat often showed bias against industry, free trade and intellectual property rights. Regarding the proposed draft resolution, he appreciated the prior consultations and would pass some suggestions to the member for Thailand.

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

Dr MATHESON (New Zealand)¹ sought clarification of the nature of the relationship between WHO and the World Bank, WIPO, WTO and other international organizations, suggesting that it would be fruitful for the Secretariat to work with those organizations to assist them in articulating their public health objectives more clearly and in devising indicators of progress towards the attainment of global public health goals as a result of their actions. WHO might then engage those organizations in regular, high-level discussions about their contributions to global health. He asked whether there was a joint work programme, in which objectives were shared or overlapped, particularly with agencies such as the World Bank that had a major involvement in public health, in order to maximize impact of international efforts for health. He also suggested consideration of the concept of global public health goods, broadly defined, requiring a cooperative rather than a competitive response to major health and trade issues as had happened in the response to the outbreak of sudden acute respiratory syndrome.

Dr QI Qingdong (China)¹ observed that many developing countries were still having technical difficulties in using the flexibilities of international trade rules to protect public health interests. He expressed appreciation of WHO's work in providing technical support to Member States on the complex issue of trade and health, especially through training for health professionals in developing countries to familiarize them with the WTO rules. China was particularly concerned about the way in which trade rules relating to patents and intellectual property rights raised the cost of technology transfer for the manufacture of new medicines beyond the means of developing countries. China welcomed the draft resolution proposed by Thailand and wished to become a sponsor.

Mr PHELAN (Ireland)¹ commented that the short report seemed to have been intended simply as an overview of the main issues in a complex area. In the light of the discussions during the Fifty-eighth World Health Assembly, the report should have given more attention to the international movement of health professionals, particularly in relation to the liberalization of trade in services and the rights of establishment of professionals from one country in another. Most countries had regulated medical professionals' rights to practise for consumer protection and public health reasons, but there was increasing pressure in international trade negotiations to relax such restrictions. The question of granting automatic rights to health professionals to work in other countries needed careful examination. WHO might consider trying to foster international consensus on the health issues involved, including protection of the health services of developing countries as developed countries might seek to relax their requirements on practice by foreign health professionals in order to solve their own human resources problems. The report also failed to examine the public health and patient safety issues associated with eHealth and telemedicine, and matters of liability and insurance in connection with trade in health services.

Mrs KJAESERUD (European Commission) said that the Commission saw international trade as a necessary tool for helping to ensure access to health care and improve public health. She therefore welcomed WHO's initiative to examine the broader aspects of health and trade and looked forward to further collaboration in that respect.

The CHAIRMAN, speaking in his capacity as the member for Pakistan, said that WHO had succeeded admirably in getting trading partners around the table and achieving relaxation of trade rules for health. He cited the adoption of the Doha Declaration on the TRIPS Agreement and Public Health as a positive step in response to the serious concerns of developing countries. Similarly, the adoption of the WHO Framework Convention on Tobacco Control and the International Health Regulations (2005) were symbols of success holding promise for future negotiations on matters such as remittances and international migration of health personnel. He therefore welcomed WHO's attention to the possible health implications of WTO's four major multilateral trade agreements and

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

encouraged the Organization to continue its advocacy and to explore options for providing training to enable health personnel to understand the implications of those agreements.

Dr LEITNER (Assistant Director-General) agreed that WHO must continue to concentrate on the public health aspects of trade in its work with WTO. The Secretariat and Member States, collectively, had an interest in ensuring that, as the international trade regime continued to evolve, a balance was struck at country level that maximized the positive aspects of trade on public health while minimizing the negative ones. Not all the challenges faced by developing countries were similar; obviously, the situation of a small island country differed vastly from that of a large country. The Secretariat had therefore avoided giving detailed advice on how countries should conduct their trade negotiations, its priority being to ensure that health officials had the information needed to interact with their trade and finance counterparts in order to establish what was in the best interest of public health in their country. To that end, it had published books, papers, technical notes and other guidance to help health authorities to understand the complexity of the issues. Many of the matters mentioned by various speakers had been dealt with in those publications, most of which were available on the WHO web site. Within the Secretariat, a very small department was concerned with general matters relating to trade and health and coherence between international trade and health policy; specific technical aspects were dealt with by the respective technical clusters. Regional offices were expected to take the lead on issues concerning regional trade agreements. With regard to capacity building, the Secretariat had developed training packages, also available on WHO's web site, aimed in particular at countries in accession negotiations with WTO, although, again, the aim was simply to explain the implications of the various trade instruments, not to provide specific advice to countries. Since it was receiving a growing number of demands for assistance in the area of trade and health, WHO would continue its work in that regard, ever striving to be demand-driven. In submitting the report, therefore, the Secretariat was seeking feedback from Member States and to identify their concerns so as to strike a balance between, on the one hand, being responsive to specific needs at country and regional levels and, on the other, responding to the need for a global policy framework in which the Secretariat would continue to work in the area of trade and health.

The CHAIRMAN expressed appreciation of the Secretariat's work in a complex area. Members of the Board, however, wanted the Secretariat to provide more country-level support on trade issues. They recognized that, although economics and profit were important, what counted in health was a more humane approach, particularly in order to meet the needs of the poor and the downtrodden, so that instead of eradicating the ills of the third world, trade and globalization did not merely create a fourth world of the poorest of the poor.

He took it that the Board wished to keep the agenda item open so that the draft resolution proposed by Thailand could be considered the following day.

It was so agreed.

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

Nutrition and HIV/AIDS: Item 4.3 of the Agenda (Document EB116/12)

Dr RAHANTANIRINA (Madagascar), speaking on behalf of the Member States of the African Region, welcomed the consideration given to the outcome of the technical consultation on nutrition and HIV/AIDS in Africa (Durban, South Africa, 10-13 April 2005) and the concerns voiced about the exacerbating effect of inadequate nutrition on the already precarious situation of people living with HIV/AIDS. She outlined the severity of the HIV/AIDS epidemic in sub-Saharan Africa. In the countries concerned, WHO had been providing specific priority-based technical support, in addition to general support for international efforts to create a vaccine.

She highlighted three major problems, the first being food insecurity. In the vicious circle of malnutrition and HIV/AIDS, the pandemic had a serious effect on food security, which was essential to economic and social development, and to adequate nutrition and so the ability to work. As poverty became more widespread, so it became harder to meet basic food needs, especially as families had to divert productive effort to care for the sick.

The second problem was infant feeding. Although the exact mechanism of mother-to-child transmission of HIV through breastfeeding was not known, risk factors had been identified relating to maternal health, infection during pregnancy and lactation, and the duration of breastfeeding. Mixed feeding often increased the risk.

The third problem related to the nutritional complications of HIV infection and AIDS. Recent research carried out in collaboration with WHO and UNAIDS indicated that in its early stages, when symptoms might not be apparent, HIV infection altered the nutritional state. The risk of malnutrition increased considerably as the infection progressed, through increased energy consumption at rest, reduced food intake, poor absorption of nutrients by the digestive system and the direct pathological effects of HIV.

Although adequate nutrition could not cure HIV infection, it was essential to protect immune function. Various proposals had already been made, including those reflected in the statement issued at the Durban meeting and WHO's workplan. Nutritional care of people infected with HIV, however, and the prevention of malnutrition in infants born to HIV-infected mothers needed to be considered, as did the application of a breastfeeding-substitute policy. WHO had been providing excellent support in research to that end.

Dr GOMES TEMPORÃO (Brazil) commended the work of WHO's Technical Advisory Group on Nutrition and HIV/AIDS, and the convening of a technical consultation on nutrition on HIV/AIDS in Africa. He agreed with using the recommendations from that meeting as the basis for establishing priorities and a workplan to incorporate nutrition into the comprehensive response to HIV/AIDS. Since effective interventions existed, HIV infection of infants was not acceptable. Accordingly, in addition to the global consensus that antiretroviral treatment must reach all who need it, programmes were essential to guarantee breast-milk substitutes for children of HIV-infected women, at least up to six months of age. Since 2002 the national programme of sexually transmitted diseases and AIDS had been implementing a policy of distributing infant formula to children of women living with HIV. That policy, which was part of an action to reduce vertical transmission of HIV and had been showing excellent results in reducing infection of children through breastfeeding, had been presented at the thirty-second session of the United Nations System Standing Committee on Nutrition (Brasília, 14-18 March 2005).

His Government was ready to contribute its experience to the Secretariat for the elaboration of priorities and a plan of work on nutrition and HIV/AIDS.

Dr SHINOZAKI (Japan), recognizing the importance of the issue, welcomed the results and recommendations of the Durban meeting. Research had yet to be conducted, however, on the relationship between antiretroviral agents and nutrition. Japan wished to contribute to operational and clinical research and the formulation and implementation of an evidence-based strategy, besides carrying out an HIV/AIDS programme domestically and globally.

Dr NTAWUKULIRYAYO (Rwanda) said that nutrition was especially relevant for people living with HIV/AIDS and receiving therapy, as it modulated the efficacy of antiretroviral treatment. Rwanda asked WHO, in collaboration with other organizations, to continue its efforts to improve the nutritional status of HIV/AIDS patients. The steps already being taken by Rwanda in that regard consisted of a nutrition policy including strategies to tackle malnutrition and meet the nutritional needs of people living with HIV/AIDS and on antiretroviral treatment; to make optimum use of available funds in order to deal with health problems more generally; and to provide microcredits to people

living with HIV/AIDS to help them to set up small-scale income-earning projects and so promote self-care.

Professor CINTEZA (Romania) said that during the 1980s Romania had had one of the highest rates of paediatric HIV infection in the world; many of those children were adolescents, with special needs. Romania treated all HIV/AIDS patients; the treatment included a special allocation of food, particularly to those in hospital. There was much more that the proposed programme could do, however. Romania would be glad to make its experience available in support of the activities outlined in the report.

Dr ALI MOHAMMED (Iraq) noted that WHO and UNICEF recommended that HIV-infected mothers should avoid breastfeeding when replacements were available, affordable, sustainable and safe. Otherwise, local authorities should take responsibility in cooperation with WHO, UNICEF and other support organizations, for offering replacement feeding to reduce or remove the risk of transmission of HIV from an infected mother.

Professor PEREIRA MIGUEL (Portugal) said that the latest scientific evidence had shown that adequate nutrition could not cure HIV infection but was essential for reinforcement of the immune system, maintenance of health and ultimately quality of life. Portugal had consequently taken action on various fronts, such as providing scientific advice for training courses on nutrition and HIV/AIDS, organizing nutrition training for health professionals working with HIV-infected people, adapting WHO's questionnaire on quality of life, with an emphasis on nutrition, and producing a manual for HIV-infected patients with answers to the most frequent questions, including those on nutrition. He fully agreed with the recommendations for action issued at the WHO consultation on nutrition and HIV/AIDS in Africa.

Dr SUPACHAI KUNARATANAPRUK (Thailand) commended the joint efforts of WHO and other parties in convening the consultation on nutrition and HIV/AIDS in Africa. Recent studies by his Government's Ministry of Public Health had highlighted the prevalence of food insecurity in poor households. The country's programme to prevent vertical transmission from HIV-infected pregnant women included the provision of free breast-milk substitutes, subsidized by the Ministry. According to a recent survey, 94% of infected pregnant women had used breast-milk substitutes under the programme, one of the best achievements in developing countries. The Government had made great efforts to integrate a comprehensive nutritional service into health care for people living with HIV/AIDS, through counselling, antiretroviral treatment and community health services.

He strongly supported the recommendations from the consultation, requesting the Director-General to take further action, in collaboration with FAO, WFP, UNAIDS and civil society, to ensure that nutrition care was an integral part of comprehensive HIV/AIDS interventions nationally and internationally. The subject warranted an Executive Board resolution for transmission to the Health Assembly in 2006.

Dr AWENAT (Libyan Arab Jamahiriya) said that, although Libya had not faced a major HIV/AIDS problem, it did have experience of nutrition problems in babies infected as a result of action by care nurses, some 500 children being concerned. Efforts had been made at the outset to tackle the problem by improving nutrition. Over time some useful experience had been accumulated, which his country would willingly share.

Dr NYIKAL (Kenya) said that no disease showed more clearly than HIV/AIDS the effect of nutrition on its pathology, whether the patient was on treatment or not. All global initiatives to deal with HIV/AIDS had previously ignored that aspect or assumed good nutrition to be available. The point should therefore be incorporated in all relevant activities, such as those of the Global Fund to Fight AIDS, Tuberculosis and Malaria, if the expected results were to be achieved.

He supported the recommendation by the member for Thailand that the Board should consider a draft resolution at its 117th session.

Ms MAFUBELU (South Africa)¹ recalled that her country had hosted the first technical consultation on nutrition and HIV/AIDS, and supported the ensuing recommendations. Statements from government institutions, scientists and nongovernmental organizations had affirmed the importance of food security and the role of nutrition in promoting good health in general and as part of a comprehensive response to HIV/AIDS. Since knowledge gaps remained, however, South Africa encouraged continuing research in the various areas, including the evidence base for policy formulation on reducing the risk of mother-to-child transmission of HIV and appropriate dosage of supplements. Although not all the answers were to hand, she was confident that enough information and evidence existed for policy formulation and implementation, particularly to strengthen the comprehensive response to HIV/AIDS, and she encouraged discussion on the report by the various regional committees.

Mr MASUKU (FAO) said that FAO had made good progress in developing comprehensive multisectoral responses to the HIV/AIDS epidemic. It was working with sister United Nations organizations to mitigate the epidemic's impact; the work done on HIV/AIDS and nutrition was part of that effort. He drew the Board's attention to a manual on nutritional care and support for people living with HIV/AIDS² and its accompanying training course on nutritional care and support for people living with HIV/AIDS, which governments were urged to disseminate as widely as possible.

It was important to recognize that nutritional risk from HIV threatened not only those infected; food insecurity and malnutrition often affected entire households and communities where HIV/AIDS had taken its toll. Nutrition must therefore feature prominently in the responses to HIV/AIDS. While the health sector had a primary part to play in that regard, the food and agriculture sector had a role as well, and the two sectors must pool their respective strengths. Nutrition must become an integral and continuing part of virtually all HIV/AIDS responses.

Ms WALDVOGEL (WFP) welcomed the convening of the Durban consultation. WFP was the principal supplier of food and micronutrients to people with HIV, and was working with WHO to build a global consensus on how to respond to the problem of HIV and hunger. WHO had made great progress in consolidating the scientific evidence available on the nutritional needs of people living with HIV. Key issues that emerged from the technical consultation included the need, based on scientific evidence, for immediate action to integrate food and nutrition into HIV/AIDS care, treatment and prevention. To that end, governments and aid organizations should focus on ensuring that antiretroviral therapy was accompanied by adequate nutrition and that children affected by HIV were fed and educated. The consultation had confirmed that adequate dietary intake was essential for obtaining the full benefits of antiretroviral therapy. Most of the 30 million HIV-infected people in Africa did not have access to the necessary basic nutrients for a healthy life, let alone those they needed to meet their increased energy requirements in the face of tuberculosis and other opportunistic infections. As more people joined antiretroviral treatment programmes, WHO and WFP were developing guidelines to identify those in need of nutritional support and ensure that they received it. WFP was expanding its own projects to bolster WHO's "3 by 5" initiative, and was committed to working with WHO to share its operational experience in that area.

To meet the nutritional needs of children infected with HIV and made vulnerable by HIV/AIDS, WFP and other agencies had played a leading role through community-based care, maternal and child health and school feeding programmes for orphans and vulnerable children in food-insecure areas.

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

² WHO, FAO. *Living well with HIV/AIDS: a manual on nutritional care and support for people living with HIV/AIDS*. Rome, Food and Agriculture Organization of the United Nations, 2002.

Well-targeted food assistance could help to end the vicious cycle in which AIDS forced children to drop out of school to care for a sick parent or to exchange sex for food, putting them at risk of HIV infection and greater poverty. The issue of how best to feed infants and young children who were no longer breast-fed must also be addressed. WHO, UNICEF and WFP would collaborate with universities and other partners in studying existing commodities for that purpose.

Record levels of funding were available to fight HIV/AIDS and for development assistance in general, but extending HIV-related nutritional interventions would require the mobilization of new resources. UNAIDS had begun to integrate food and nutrition into its continuing work on estimating global resource needs, and WFP was taking the lead in analysing which interventions required funding, and at what cost. It agreed with WHO that successful advocacy for the allocation of additional resources to integrate nutrition into care, treatment and support would help to ensure that internationally-agreed goals were met and that the Durban recommendations were implemented.

The technical consultation had also stressed the need for stronger political commitment in national policies and programmes to meeting the nutritional needs of people with HIV. Although national governments had the chief responsibility, WFP and other agencies, together with many community groups, were keen to ensure that their efforts in prevention, treatment and care were not jeopardized because nutrition had been overlooked.

Dr CHOW (Assistant Director-General) said that WHO saw nutrition as a key aspect of its cooperation with partner agencies and was taking an integrated approach to HIV/AIDS and nutrition: developing policy, providing technical support, participating in research on micronutrition and HIV/AIDS, and following up on recent technical meetings.

With regard to the statement by the member for Japan, WHO would welcome a research agenda to evaluate nutrition needs and potential interventions for women and children and specific indicators for HIV-positive people, as well as the inclusion of other micronutrients in the evaluation of the nutraceutical properties of key macro- and micro-nutrients.

In response to the remark by the member for Iraq, he said that when replacement feeding was not acceptable, feasible, affordable, sustainable and safe, WHO recommended exclusive breastfeeding for the first few months until the conditions of safe replacement feeding were in place. Clearly, the age for cessation depended on the situation of individual mothers and infants.

WHO was forging a chain of concerted action linking resources, expertise and implementation. WHO, FAO and WFP, in conjunction with the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank and bilateral donors, could work to combine nutritional and medical care at the country and community levels.

The CHAIRMAN commented that Africa in particular needed a great deal of assistance, and a massive collaborative effort was required. The subject of HIV/AIDS would be included on the agenda of the 117th session of the Board in January 2006, when members could continue discussion of the issues.

The Board took note of the report.

Gender, women and health: incorporating a gender perspective into the mainstream of WHO's policies and programmes: Item 4.4 of the Agenda (Document EB116/13)

Dr PHOOKO (Lesotho), speaking on behalf of the Member States of the African Region, recalled that in 1997 the United Nations Economic and Social Council had made specific recommendations for mainstreaming the gender perspective in the work of the United Nations system. Since then, WHO had taken steps through its governing bodies towards the goal of gender equality, including adopting resolutions aimed at achieving parity between men and women within the Secretariat and in the composition of scientific and technical advisory bodies. Some progress had been made, and the report identified the challenges remaining for the health sector and WHO.

Dr ANTEZANA ARANÍBAR (Bolivia) welcomed the report, the first of its kind to be submitted to the Board. Although the issue was not new, it was relevant and required attention, among other things in order to correct the perception that gender referred only to women. The report highlighted the complementarity of men and women. Two aspects required further attention and work: the need to look at health problems in different age groups, and especially the health of women outside their reproductive span; and women's participation in the work of the Secretariat and Member States on health, especially public health and health services.

Ms HALTON (Australia) agreed with the member for Bolivia that gender was a matter for both men and women. Her Government was strongly committed to the Beijing Platform for Action, and believed that women had particular issues with respect to equality, including in the health system, but it acknowledged that gender could have a real influence on health risks, in terms of health outcomes and experiences in the health system for women and men alike. Gender issues should consciously be included in WHO's policy and programmes. Her Government was responsive to the health needs of both men and women and believed that their different health experiences must be taken into account.

Mrs WALAIPORN PATCHARANARUMOL (adviser to Dr Supachai Kunaratanapruk, Thailand) commended WHO's progress in the area, including the establishment of an area of work on gender, women and health in the Programme budget 2006-2007, the fact that three WHO regions had taken gender issues into account, and the inclusion of gender-specific health statistics in *The world health report*. She welcomed the work being done to draft a global strategy and action plan, in consultation with regions and countries. The Millennium Development Goals highlighted the notion of gender equality, for instance, equal access to education for boys and girls; gender-specific and other socioeconomic dimensions should be incorporated into the health-related targets through the efforts of WHO, in cooperation with the World Bank, UNDP and UNICEF, by publicizing gender-disaggregated data on infant and under-five mortality rates, access to prevention, treatment, care and antiretroviral therapy for men and women living with HIV/AIDS, and immunization coverage among boys and girls. At the country level, there was a need to raise public and political awareness in order to minimize gender inequality.

With regard to the promotion and advancement of medical professionals, a recent study showed that career advancement in Thailand was easier for male doctors, although there was no prejudice at the recruitment and promotion stages. The causes of such a gender bias required further study. Likewise, she noted with concern that only 20% of the external experts appointed by the Director-General were women. Why were the numbers so low?

Ms GILDERS (Canada) said that including a gender perspective in the development of policies and programmes contributed to understanding how biological and social differences between the sexes affected health. She acknowledged the challenges involved, including the need for mechanisms to ensure policy implementation and assess progress. Her Government had played a leading role internationally to achieve consensus on gender-equality issues and would be pleased to share its expertise on accountability mechanisms to demonstrate the successful use of gender-based analysis.

Mr GUNNARSSON (Iceland) welcomed the efforts to develop a comprehensive strategy and action plan in order fully to integrate a gender perspective into WHO's work. A more gender-sensitive Secretariat with a clear conceptual framework could provide better guidance and leadership to Member States in their efforts to correct gender inequities, thereby enhancing the effectiveness and coverage of health interventions, programmes and policies.

WHO must do more to take account of gender considerations in its planning, resource allocation, budgeting and programme implementation, and in key publications and initiatives such as *The world health report* and the General Programme of Work. The experience of Member States should also be taken into account.

A gender perspective was not simply a matter of women's health, maternal and child health and reproductive health. It required a broader focus on gender inequality and gender-based norms and behaviour and how they affected the health of both men and women throughout their lives. The role of men and boys was equally important and needed to be considered. Formulating a global WHO strategy and plan of action was an important step in the active promotion of gender equity in health worldwide.

Dr GOMES TEMPORÃO (Brazil) stressed the importance of incorporating a gender perspective, not only in WHO but all international forums. That position was consistent with the actions taken by his own Government, particularly in the health sector. In 2004 the Government had launched a national pact to reduce maternal and neonatal mortality and in March 2005 a national policy on sexual and reproductive rights, envisaging measures to guarantee men and women healthy and responsible fulfilment of their sexuality and reproduction, and including access to publicly-funded assisted human reproduction services. It was also seriously committed to tackling the complex problem of domestic and sexual violence against women, and had devised a national multidisciplinary policy, covering the areas of health, security, justice, education and social and psychological assistance. The Brazilian national plan for women, launched in December 2004, would have a tremendous impact on society as a whole. It was based on four strategic axes: autonomy, equality at work and citizenship; inclusive, non-sexist education; women's health, sexual and reproductive rights; and combating violence against women. The Government was committed to pursuing the goals of the Beijing Platform for Action; it supported all relevant action by the Secretariat, particularly the establishment of an area of work on women's health and the launching of a gender policy. Efforts should be intensified to achieve the target of parity in gender distribution among professional staff, in line with resolution WHA56.17. He welcomed the inclusion of a gender perspective in the preparation of both the Eleventh General Programme of Work and programme budgets.

He suggested several points for inclusion in future discussions on a gender perspective: domestic workload as a health determinant; discrimination as a factor of exclusion from social services, including health services; exercising sexual and reproductive rights safely in order to avoid maternal mortality; the enhancement of the social infrastructure in order to ensure an adequate working environment for women and reduce employment-related health problems; and encouraging men to share equitably with women in the exercise of sexual and reproductive rights.

A global strategy and action plan, including implementation and accountability mechanisms, were necessary if progress was to be made towards incorporating a gender perspective into the mainstream of WHO's work. His Government was prepared to contribute positively and constructively to that exercise.

Dr INOUE (alternate to Dr Shinozaki, Japan) supported WHO's work on gender equality. Globally, gender inequities had been reduced during the 1990s but those in health were exacerbated by armed conflict, HIV/AIDS, natural disasters and violence against women. Gender equality was necessary to achieve the Millennium Development Goals, and he urged WHO to continue working to minimize inequality in health.

Professor FIŠER (Czech Republic) cautioned that achieving gender equality would be difficult. Czech women had won the right to vote in 1918 but gender problems still persisted. He supported efforts to incorporate gender perspectives into the mainstream of WHO's policies and programmes.

Dr COLEMAN (Liberia), also speaking on behalf of the Member States of the African Region, proposed that the Board should request the Director-General to develop a strategy and plan of action for incorporating a gender perspective into the mainstream of WHO's policies and programmes, and to submit a document to the Board at its 117th session, for consideration and possible recommendation of a draft resolution for adoption by the Fifty-ninth World Health Assembly. He also proposed that the Director-General should work on elements of such a draft resolution.

Ms MAFUBELU (South Africa)¹ recalled that, as 10 years had passed since the Fourth World Conference on Women (Beijing, 1995), it was appropriate to take stock of progress made in advancing gender equality and implementing the strategic objectives of the Beijing Platform for Action. She noted the progress achieved in integrating a gender perspective into the mainstream of WHO's policies and programmes, and welcomed the establishment of an area of work on women's health, in response to the Platform for Action. It was to be hoped the apparent 10-year time interval before that step had been taken was not a measure of the relative priority given by WHO to that area of work. The adoption by the Fifty-ninth World Health Assembly of a resolution on a strategy and plan of action for gender mainstreaming would give political visibility to that area of work, and provide a strong mandate to the Director-General.

Mr MARTIN (Switzerland)¹ said that, in the strategy it was preparing, the Secretariat should emphasize that women were not just victims who should be protected for example from domestic violence, but also human beings with rights to be exercised and defended. Moreover WHO, even at the preparation stage of its policy, had a duty to work in partnership with other international organizations and programmes, such as UNFPA, UNAIDS and the United Nations Development Fund for Women, as well as with civil society.

Dr MATHESON (New Zealand)¹ emphasized the significance of the report. Gender issues were a major determinant of health, and incorporating a gender perspective into health systems would have a profound impact on public health.

The CHAIRMAN, speaking in his capacity as the member for Pakistan, said that gender affected the health of both men and women, but it was necessary to highlight the health consequences of discrimination against women. In nearly every culture women faced barriers of poverty, unequal relations with men and illiteracy, which prevented millions of women worldwide from having access to health care and an adequate standard of health. Yet a healthy woman meant a healthy family, which in turn meant a healthy nation and healthy future generations. The focus should be on obtaining evidence and increasing knowledge of the impact of gender inequalities on specific health problems, and on finding successful responses. Programmes that systematically dealt with gender concerns, including gender-based violence, should be developed at the global, regional and country levels. Advocacy tools and activities could also be designed to improve public understanding of gender issues. Member States could be supported in formulating and promoting gender-sensitive health policies and strategies. The empowerment of women, in political and economic terms, must be a priority. In his own country, 20% of seats in the national and provincial assemblies were reserved for women. Pakistan had already more women legislators than anywhere else in the world, and in addition there were 40 000 female councillors at the district level. His country also had a special programme for the education of women and girls. Many women were victims of violence, both at home and in conflict situations, with grave implications for public health. Women acting together could do much to bring about peace in the world.

Mrs PHUMAPHI (Assistant Director-General) thanked members for their support. She welcomed the opportunity to work with Member States on gender equity in health, which stood for fairness and justice in the distribution of health-related benefits and responsibilities between women and men and was not limited to gender equality, which was the absence of discrimination on the basis of a person's sex. In reply to the representative of South Africa, she observed that a department had been created five, not 10, years after the Fourth World Conference on Women in Beijing. The Secretariat's work had evolved from focusing exclusively on women's health to studying how gender inequity and gender-based norms and behaviours affected the health of both women and men

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

throughout life, and, currently, how to integrate gender into public health and the problem of gender-based violence. A 10-country study had produced the disturbing finding that, in some countries, 60% of women experienced some form of violence during their lives. Many other studies had been conducted, some with UNAIDS, on gender and HIV/AIDS; a particular concern was that in the 15-24 year age group 75% of those infected were women.

She recognized that the work on gender and health must not be confined to women; it must include the action needed to tackle the whole range of disparities. She welcomed the adoption of resolution WHA58.30 on accelerating the achievement of the health-related Millennium Development Goals, which included a commitment by Member States in the United Nations Millennium Declaration to ensure that health and development policies were underpinned by gender analysis and to strive for gender equality and women's empowerment. The Secretariat could support Member States in achieving that goal. The gender strategy being developed would ensure that health data were disaggregated by sex, and would focus attention on the allocation of resources to neglected public health issues; it would promote involvement of men and boys in gender issues, and would help Member States to integrate a gender perspective into their policies. With their assistance, the Secretariat could design frameworks and tools for that purpose, which could be used by countries. The systematic integration of gender dimensions into WHO's policies and Health Assembly resolutions would help to tackle some of the specific issues raised by members. The representation of women in expert committees was a particular concern of the Director-General and all Assistant Directors-General had to report to him on the steps they were taking. She assured members that there would be extensive consultation in preparing the gender strategy with Member States, partner agencies within the United Nations system, regional colleagues and experts, and all stakeholders in health. A draft would be submitted to the Board in January 2006, with a view to a final version, together with a draft resolution, being presented to the Health Assembly in May 2006.

The CHAIRMAN took it that the Board wished to request the Director-General to submit a draft strategy and plan of action for consideration by the Board at its 117th session.

It was so agreed.

The meeting rose at 17:45.

THIRD MEETING

Friday, 27 May 2005, at 09:10

Chairman: Mr M.N. KHAN (Pakistan)

1. MANAGEMENT AND FINANCIAL MATTERS: Item 5 of the Agenda

Guiding principles for strategic resource allocations: Item 5.1 of the Agenda (Documents EB116/5 and EB116/14)

The CHAIRMAN said that, in response to decision WHA57(10) and following discussions at its 115th session, the Board was invited to consider the new draft guiding principles for the strategic allocation of resources throughout the Organization (document EB116/5) and the report of the Programme, Budget and Administration Committee (document EB116/14), which had considered the matter at its second meeting.

Ms HALTON (Australia), speaking in her capacity as Vice-Chairman of the Programme, Budget and Administration Committee, commended the Secretariat's management of WHO's funds. The considerable increase in the programme budget in part reflected a growing confidence in its management capacity. Results-based management clearly required a new look at the matching of resources to results. Robust systems were needed to foster confidence that the desired results would be achieved, that the resources would be directed to where they were needed, and that equity would be duly taken into account. A sophisticated model of health needs should be developed to underpin work and ensure that the regions and countries were not overlooked; the validation mechanism should deliver those outcomes. WHO's decision to integrate health needs into the whole approach to strategic planning and results-based management was commendable. Although the implementation of results-based management still amounted to work in progress, there had been a quantifiable improvement in management capacity.

Dr PHOOKO (Lesotho), speaking on behalf of the Member States of the African Region, expressed appreciation of the improvements made in the revised draft of the guiding principles for strategic resource allocations. He nevertheless reiterated the call by the African group at the Board's 115th session for guiding principles that would take account of special circumstances, especially the needs of least developed countries, the state of health systems, the disease burden and the situation of countries in conflict. Equity and support to countries in greatest need were principles that deserved mention in the guiding principles. He therefore proposed that the text "[A]lllocations between regions are firmly rooted in the principles of equity and solidarity in support to countries in greatest need, particularly least developed countries." should be moved from paragraph 29 to paragraph 12 of document EB116/5.

He also pointed to apparent contradictions between the Director-General's commitment to country focus and the approach envisaged in the principles. The emphasis on "doing the right thing, in the right way, and in the right place" suggested that the right place might not necessarily be the country level. How could that emphasis be respected while decentralizing resources to the country level?

The reference in paragraph 31 to "relative health and socioeconomic status" in the absence of agreed indicators for that concept was questionable and should be replaced by the United Nations language "least developed countries, developing countries and countries in transition". A further

problem remained concerning predictability and flexibility in the use of voluntary contributions. Document EB116/5 mentioned that core functions would be assigned to the most reliable funding source. That would leave country programmes vulnerable compared to headquarters, itself made up entirely of the core component. The risk associated with voluntary contributions should be shared equally. The fundamental question was whether the proposed arrangements were compatible with the Director-General's decentralization agenda.

The role of Member States in the process was not clear. WHO should engage in thorough consultation with Member States through regional meetings, particularly the regional committees, before finalizing the guiding principles. With regard to form, he proposed that the principles should be adopted through a Health Assembly resolution, which would give them much-needed legitimacy.

Mr EINARSSON (alternate to Mr Gunnarsson, Iceland) stressed that resource allocations should be based on objective criteria that would be applied to funds from all sources, and that account should be taken of equity, efficiency and performance. He welcomed the introduction of a validation mechanism and needs-based index to ensure that resources were allocated to countries in greatest need on the basis of objective national indicators.

Dr TANGI (Tonga) said that document EB116/5 provided a good overview of the direction that WHO should take, and should have been presented years before. However, long-term financing and the mix between assessed and voluntary contributions were a cause for concern. If the existing trend continued, the current proportions of 30% and 70% would have become 13% and 87% in 10 years' time. What were the implications for WHO in determining its priorities, and what were the expectations of those making voluntary contributions? The Organization existed for its Member States and serious thought would have to be given to the matter in the coming years.

Dr RAHANTANIRINA (Madagascar) said that in particular Principles 4, 5, 6 and 7 reflected the dynamic nature of the process, highlighting flexibility and giving regions and countries room to manoeuvre in the adjustment and updating of medium-term expenditure and biennial operational plans. As a developing country, Madagascar was concerned that the performance-based approach might penalize countries whose health systems did not perform well, thus aggravating existing problems. However, the approach might catalyse improvement of the performance and effectiveness of its health system and managerial capacity. Madagascar supported the amendments proposed by the member for Lesotho.

Dr SINGAY (Bhutan) said that, from the perspective of the developing countries, document EB116/5 seemed somewhat academic. Would they ever have the capacity needed to implement programmes in the way presented? In Bhutan, WHO's resources were used as seed money and were thinly spread. As other agencies were also involved, he wondered whether a results-based approach was practicable. He endorsed the statement by the member for Lesotho. The resource allocation strategy should have a needs-based approach taking into account disease burden, health status, socioeconomic level, the countries in greatest need and the needs of the least developed countries.

Ms GILDERS (Canada) said that the efforts to devise a transparent and accountable method of strategic resource allocation were commendable. The work was an important step in determining principles and methodology that recognized the need to support WHO's core mandate, the cost of a regional and country presence and the specific needs of different populations, as mentioned by the members for Lesotho and Bhutan. The issues raised during the discussion would be addressed by the results-based budgeting approach, and Canada would continue to be involved in further work on the issue.

Dr ANTEZANA ARANÍBAR (Bolivia) agreed that document EB116/5 was academic, and that it might be difficult for developing countries to apply the guiding principles. An analysis should nevertheless be made to see how the guiding principles could be applied to improve the health of those with least access to good health care. In that connection there was some correlation with the question underlying agenda subitem 5.2 (WHO country offices and country focus), namely: how should country offices operate and how should they manage resources with decentralization? It was important, therefore, to make the process understandable, and to see how it would work in practice at the country level with decentralization, bearing in mind also the tendency towards decentralization within countries. Transparency was important, but so also were fairness, equity, and understanding.

Dr WINT (Jamaica) said that the strength of document EB116/5 lay in its focus on countries, the use of objective criteria, the definition of guiding principles that facilitated transparency, and the results-based approach. He stressed the importance of equity and a needs-based approach in applying the concepts at country level. Among the criteria, the vulnerability of small island developing states should be taken into account. In paragraph 17, the fourth bullet referring to the needs of Member States should be placed above the one concerning their requests. Principle 5 was particularly important and should also be applied at the country level where successful performance was sometimes penalized by a shifting of the focus to other less successful countries. He supported the guiding principles.

Mrs NYAMBU (alternate to Dr Nyikal, Kenya) said that resource allocation did have a political dimension and therefore proposed that the Board should defer approval of the process until its next session to allow for thorough consultation with the regions and, in particular, formal consideration by the Regional Committee for Africa in August and September 2005.

Professor HOUSSIN (France) said that clear principles for strategic resource allocation and the basis for results-based management had been laid down, taking into account comments made in the Executive Board. France supported the views expressed by the member for Lesotho regarding the principle of equity and expressed the hope that further work would be done on means of implementing the guiding principles.

Dr MANDIL (alternate to Dr Abdulla, Sudan) applauded the guiding principles for resource allocation. Given that WHO's greatest successes, such as the campaigns against smallpox and onchocerciasis, had been achieved when there had been clear targets that applied to a wide geographical area, the key issue was how to incorporate the principles into WHO's programmes. Countries ought to stipulate the targets to which an external contribution could be made. Countries should therefore be asked to submit much more specific needs statements, leading to a new type of WHO Programme of Work.

The CHAIRMAN, referring to paragraphs 41 and 42 of document EB116/5, affirmed his understanding that there would be wide consultations on the subject.

Mr BAILÓN (Mexico) said that it was gratifying to note that both WHO and PAHO had been working towards transparency and the establishment of guiding principles. In PAHO, a method for distributing resources to countries in the Region of the Americas had been approved in September 2004. It would be interesting to see to what degree it coincided with the principles under discussion by the Board. One problem encountered by PAHO was the unavailability of relatively robust statistics: not all countries were able to provide the indicators needed for results-based analysis. The PAHO resolution had therefore not been as far-reaching as hoped. The same problem was referred to in the context of WHO in paragraph 36 of document EB116/5. Headquarters should work through regional offices to obtain such information and thereby to choose the indicators required for results-based management.

Dr VIROJ TANGCHAROENSATHIEN (adviser to Dr Supachai Kunaratanapruk, Thailand) welcomed the results-based approach to resource allocation and the principles and perspectives set out in document EB116/5. Application of Principle 5, however, would penalize poorly performing offices and programmes, especially at country level, and thus threaten the principle of equity. Principle 2 implied that extrabudgetary sources, of which 95% were unspecified, would be used to implement the Eleventh General Programme of Work and the medium-term strategic plan. How would the Secretariat ensure close dialogue with donor countries so that the necessary funds were made available? WHO's resources were limited compared with national and donor resources. If resource allocation was country-focused, ensuring WHO's performance in guiding programme implementation at country level would be a major challenge. Individual country offices should work to coordinate donors in relation to the medium- and long-term programmes of work.

He requested clarification on the significance of the figure at the end of paragraph 37 of the document, as the proportions of the budget allocated to headquarters and the regions would not be known until the medium-term strategic plan was proposed. Furthermore, he could see no justification for inclusion of the engagement component; it should be integrated into either the headquarters or the regional area, as the cost of monitoring that tiny component would be disproportionate. Turning to the "three perspectives" outlined in paragraphs 15-27, he fully endorsed the programmatic perspective as the upstream element. At midstream, however, there was some duplication between the core, engagement and needs-based components; the last component should be used to validate the upstream aspects. He asked how conflicts between upstream and midstream processes would be reconciled. Upstream budget proposals might result in some distortion which did not reflect the needs-based formula. The downstream was represented by performance indicators, as stated in Principle 5, which might be difficult to implement.

He welcomed the opportunity to participate in the ongoing consultative process.

Dr SHANGULA (Namibia) associated himself with those members who considered document EB116/5 to be "work in progress". The document should be revised in the light of the comments made in the current session and then considered at the regional committee meetings. The final draft should be submitted to the Board at its next session.

Dr HUERTA MONTALVO (Ecuador) said that the many comments indicated the importance of the work. Guiding principles were needed to overcome any lack of transparency, even if the guidelines were imperfect. For example, the decentralization of allocations should be a guiding principle and not a temporary measure used when considered necessary. WHO was sometimes thought to be no more than a provider of funds, but its function was to manage resources on the basis of needs, determined through a global vision that was coherent and coordinated, which could be adjusted according to changing circumstances. He agreed that the document should be revised but considered that it should be circulated to members as soon as possible.

Ms MAFUBELU (South Africa),¹ speaking also on behalf of Senegal, said that she fully supported the interventions made by the members for Bhutan, Kenya, Lesotho, Madagascar and Namibia. The Board should defer approval of the process for strategic allocation of resources until its next session. National health ministers should be involved in the process; that could occur in the context of the regional committee meetings. The form in which the guiding principles were adopted was critical, and she supported their adoption through a resolution of the Health Assembly.

Dr QI Qingdong (China)¹ agreed to the seven principles set out in document EB116/5 but was concerned about their implementation. In view of WHO's three levels, it was a guiding principle that implementation should be done with the full participation of each region and country. He was

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

concerned about how decentralization of resource allocation could be realized. He approved the principle of needs-based allocation; however, the reference indicators should be comparable, reliable and agreeable to all parties. Disagreement on indicators or their inappropriate use should be avoided, and the indicators should be regularly updated. As some 70% of WHO's resources came from outside the regular budget, a combination of regular and extrabudgetary funding should be used to ensure equitable programme development. Delays in obtaining extrabudgetary funds could hinder implementation of particular and regional programme activities. The validation process should ensure equity and rationality in resource allocation, and it was to be hoped that the process would be monitored by external, independent experts.

Dr NORDSTRÖM (Assistant Director-General), responding to comments made, underlined the commitment to making the Organization more effective and efficient. In terms of consultative process, drafts of the Eleventh General Programme of Work (2006-2015), and the medium-term strategic plan (2008-2013) would be submitted to the regional committees. The latter strategic plan would translate the overall strategy into specific objectives, and progress reports would be submitted to the Programme, Budget and Administration Committee in January 2006. For the first time, a longer-term financial plan showing the expected costs of implementing the strategy would also be prepared. He saw no contradiction between a results-based approach and the needs of Member States. The countries that needed improved health most were, in general, poorer or developing countries, which would therefore not be disadvantaged by a results-based approach. The proposal was that resources should be allocated according to need rather than geography. Policy discussions would be required to determine the desired results of WHO's activities, and resources could then be channelled into achieving those results. If the strategic plan were drawn up to reflect the needs and wishes of Member States, there should be no risk of developing countries losing out. WHO was a leader in using a results-based approach, and, since it owed much of its credibility to that aspect of its work, it should strive to demonstrate that achieving results and responding to needs were not incompatible. The "validation mechanism" would ensure that resources were reaching those most in need, and the Secretariat would report back in that regard.

Document EB116/5 reflected comments received at the 115th session of the Board, with more emphasis on country strategies in Principle 3. Principle 6 had been changed to highlight the importance of focusing on countries in greatest need, and paragraph 17 referred in stronger terms to country strategies and the needs of Member States. Poor performance was not related to the amount of financial resources available to a country; indeed, the Secretariat was committed to ensuring that performance was best where WHO's work was most needed, which was frequently in poor countries. The Organization could not, however, accept poor performance, and that should be clearly stated, along with the Secretariat's commitment to improving performance in all parts of the Organization.

The diagram at the end of paragraph 37 did not represent the proportion of regular budget funds to be allocated to each area. As various members had commented, it would be useful to consider a finance strategy for the Organization and its activities that would include the distribution of regular budget and extrabudgetary funds, and that could be examined in the context of drawing up the medium-term strategic plan. The engagement component had been included on the basis of experience from various regions, but its inclusion could be re-examined.

It was important to ensure that document EB116/5 was accessible and intelligible, without excessive academic detail or management jargon; nevertheless, it should sufficiently explain the implementation of the strategy. Neither the Secretariat nor the Board was yet ready to endorse the validation mechanism and all its associated details; however, the Board could ask the Secretariat to proceed with that work and report back to the Executive Board in January 2006.

The DIRECTOR-GENERAL, in response to the comment made by the member for Thailand regarding the earmarking of resources, said that most of both regular budget and extrabudgetary funds were contributed by a small number of Member States; it was therefore relatively easy to enter into dialogue with them about reducing the practice of earmarking extrabudgetary funds. For example,

several European countries had agreed to increase the proportion of non-earmarked resources they provided, and dialogue was continuing with other donors. Although extrabudgetary resources were not guaranteed, it had been the case for some time that most of the promised resources were delivered, and there was no reason to suppose that that would change. The amount of extrabudgetary funds raised had increased consistently over time. The financial situation of the Organization had improved immeasurably over the past 60 years, particularly in terms of openness regarding extrabudgetary funds. Better sharing of information undoubtedly brought with it challenges, such as the need for increased accountability, but that was not an excuse to return to the way things had been formerly.

Ultimately, it was WHO's role and mission that were at issue. The Organization was a technical agency, not a funding agency. If WHO were to be regarded merely as a source of funding, its work and budget process would be seriously compromised. The funding provided to Member States was in fact minor in comparison with the funds available from other sources and the budget of each Member State. His eventual – albeit ambitious – aim was that countries should accept funds only if they really needed them, and otherwise request that they should be re-allocated to countries with greater resource needs, as Thailand had done after the tsunami disaster of December 2004.

He was examining the process of allocating funds to see if it could be improved. He wanted WHO to be seen as one of the most efficient, transparent, effective and respected organizations within the United Nations system. It was essential to focus on WHO as a whole, rather than only on headquarters, in order to find an acceptable solution to the problem of resource allocation. The fact that Member States had voted to increase WHO's budget during a period of upheaval for the United Nations system was a vote of confidence in WHO and its work, and the Secretariat would continue its efforts in all areas.

The CHAIRMAN said that there was no doubt that transparency had increased at WHO. The Director-General was providing good leadership, both within the Secretariat and at global level; although some problems existed, the purpose of the Board was to address such problems. It was understandable that developing countries had concerns with regard to the issue of performance, and the Secretariat should respond to those concerns.

The DIRECTOR-GENERAL said that the results-based approach was not intended to punish or reward Member States on their performance. Nevertheless, if the intended results of activities were not achieved, he had to analyse the situation and take measures to improve performance at country level.

The CHAIRMAN confirmed that that appeared to have been the main concern of developing countries, especially those where performance was poor owing to factors beyond their control. The comments of the Director-General and his staff had provided much clarification, but he agreed that the Board was not yet ready to endorse the validation mechanism.

Dr VIROJ TANGCHAROENSATHIEN (adviser to Dr Supachai Kunaratanapruk, Thailand), drawing attention to paragraph 36 of document EB116/5, asked whether countries with an income above a certain level would still be eligible for WHO resources, especially technical cooperation.

Dr NORDSTRÖM (Assistant Director-General) assured members that their comments and those of Member States during the consultative process would be taken into account before a further draft was submitted to the Board in January 2006.

The CHAIRMAN took it that the Board wished to take note of the report and to follow the recommendations of the Programme, Budget and Administration Committee to continue the process for the strategic allocation of resources, returning to the matter in January 2006.

It was so agreed.

WHO country offices and country focus: Item 5.2 of the Agenda (Document EB116/6)

Dr ANTEZANA ARANÍBAR (Bolivia) said that his experience as a WHO Representative and a health minister had made him familiar with both roles. He stressed the importance of WHO's presence in countries. During the discussion on strategic resource allocation under the previous agenda item, Board members had stressed its role in the conversion of policies and strategies into specific activities in line with the priorities, available resources and economic, social and cultural situations prevailing in each country. Every country was unique, and an organization like WHO must respect its special features and its sovereignty.

The useful report showed areas where progress had been made and others where work remained to be done and where decisions needed to be made about the allocation of WHO resources. WHO was not a funding agency. Its technical support was much more important, but, if technical support concerned something that countries could do themselves, it was clearly not the most suitable use of resources. Scientific, technical and professional assistance was intended to fill gaps, strengthen any areas of weakness and improve the performance of those receiving such assistance.

The reprofiling of country teams referred to in the report (paragraph 6) was therefore the most notable aspect of activities to improve WHO's presence at country level. A second important aspect was that of decentralization and how much of a reality it was. Merely managing the scarce resources of the Organization at country level was not real decentralization, which called for an analysis of the technical and scientific situation in each country and its needs for support – not only from the Secretariat, but from collaborating centres, expert committees and all the other technical resources at the Organization's disposal.

WHO had for several years been doing valuable work at country level. The report proposed a way of reprofiling and restructuring the country offices to match the situation and priorities of each country. Decentralization should therefore be consistent with the country's needs and not confined to administrative matters.

Dr SÁ NOGUEIRA (Guinea-Bissau), speaking on behalf of the African group, recalled that the Health Assembly had just adopted resolution WHA58.25, which requested the Director-General to make WHO's country presence more effective and coordinate its activities with those of other organizations of the United Nations system working at country level. He had three recommendations to increase effectiveness and efficiency in country programmes. First, priorities should be defined by the country concerned to meet its most urgent needs, in line with WHO resolutions. The country office could contribute to that strategic process by providing guidance about the interpretation of decisions of the governing bodies. Secondly, flexibility was essential at three levels: among country staff, enabling them to adapt to any environment, including institutional instability and conflict situations; in programming, leaving the head of the country team free to adapt to evolving priorities following changes in government policy; and in resource allocation, so that funds could be switched between budget headings whenever necessary. Financial flexibility would also give countries more responsibility in their policy choices. Thirdly, harmonization with other agencies should be a basic principle, in order to maximize WHO's strengths and avoid duplication and wastage of funds. It would ensure that WHO's country-level activities were visible, while remaining effective and efficient.

Dr ACHARYA (Nepal) said that an effective country office enhanced WHO's image, whereas a weak, badly managed one harmed the Organization's credibility with Member States and national and international development partners. WHO should give country offices more authority in programme and administrative matters to enable them to provide Member States with effective technical and policy support.

Country offices received 5.7% of the Secretariat's budget and increasing levels of resources from voluntary contributions. Their performance must, therefore, be regularly assessed to determine how far they had implemented their strategies, achieved their expected results and provided high-quality and timely support for Member States and other partners. The Secretariat should develop a

framework for assessing the performance of country offices and conduct assessments of a few of them, reporting thereon to the Executive Board by January 2007. The country focus initiative should be given the highest priority, emphasizing results as well as needs.

Mr EINARSSON (alternate to Mr Gunnarsson, Iceland) said that the recommendations in resolution WHA58.25 should be added to the priority actions in the report.

Dr MANDIL (alternate to Dr Abdulla, Sudan) noted with satisfaction the progress described in the report. He requested more details of the activities concerning “information and knowledge management to and from countries”, referred to in paragraph 2, which stated that, in 2004, 36 offices had managed their own country web sites. Did that mean that there were no national web sites on the same subject? The paragraph stated further that access to knowledge-management systems was still variable; he wondered therefore why improving access was not one of the priorities listed in paragraph 8.

Mrs LE THI THU HA (Viet Nam), welcoming the country focus policy, said that administration costs must nevertheless be reduced to raise operational expenditure at country level. WHO’s strengths lay in technical assistance, but that should be coupled with funding. The need was for better coordination with other partners in mobilizing resources and strengthening country staffing profiles. Human and financial resources could be better managed. Since recruitment procedures were time-consuming, country offices should be given more authority and flexibility so that consultants could be found faster.

WHO should develop criteria for deciding whether to establish an office in a particular country. In addition, the respective roles of headquarters, regional offices and country offices should be clarified.

Dr SINGAY (Bhutan) welcomed efforts to strengthen country offices. In the Regional Office for South-East Asia, there had been considerable decentralization of authority, with 75% of the regular budget being allocated to countries. If country offices were to have more authority and more funding, however, they would also need the capacity and skills to implement their programmes. Careful attention should be given to the balance between the technical backstopping provided at country level and that provided by the regional offices or headquarters, in particular to avoid situations where overstaffing of country offices starved activities of funds.

Mr PALU (adviser to Ms Halton, Australia) welcomed the emphasis on strengthening the core competencies and capacities of country teams. The Secretariat should accelerate its efforts to improve the effectiveness and efficiency of country offices, including the reprofiling of country teams. Staff must be recruited to meet agreed needs for certain skills, and strategies were required for the timely and efficient recruitment of national and international core staff and to remedy unsatisfactory performance. He supported the priority actions listed in the report, and asked for a progress report to be submitted to the next session of the Board in January 2006.

Dr ALI MOHAMMED (Iraq), expressing regret that WHO had no country office in Iraq, suggested that activities within the country should be carried out by contractors, under the supervision of the Regional Office for the Eastern Mediterranean, as had been done in other countries with security concerns in Africa and the Americas.

Ms SOLTANI (Algeria)¹ said that her country strongly supported WHO’s decentralization policy. It was essential to strengthen country offices if the strategic goals and policies of the Organization together with national health and development objectives were to be achieved.

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

Algeria had reformed its hospital system over the past few years, with the assistance of the WHO country liaison office. Unfortunately, however, credit shortages and administrative red tape, had delayed many projects. The current status and capacity of the liaison office prevented it from responding fully to the needs and concerns of the health ministry. It was to be hoped that WHO's action to strengthen its country offices would likewise increase the capacity of the Algerian liaison office.

Mr MARTIN (Switzerland)¹ recalled that his delegation had acted as facilitator in the process leading to the adoption of resolution WHA58.25. Speaking on behalf of sponsors of that resolution, he stressed that WHO should further improve coordination of its activities at local level with the health-related activities of other organizations in the United Nations system and bilateral and multilateral donors within the framework of the priorities set by national authorities. The report's priority actions could be supplemented with a reference to the resolution, which was in some sense a follow-up to United Nations General Assembly resolution 59/250 in that it called on donor countries to act in line with the commitments and guidance set forth in the Rome Declaration on Harmonization (2003) and reaffirmed in the Paris Declaration on Aid Effectiveness: Ownership, Harmonization, Alignment, Results and Mutual Accountability (2005). Resolution WHA58.25 also requested the Director-General, taking into account the triennial comprehensive policy review of operational activities for development of the United Nations system, to submit a detailed report. That would no doubt be a useful contribution to activity follow-up at country level.

Dr LEITNER (Assistant Director-General), in response, said that enhancement of technical and scientific capacity at the country level demanded a delicate balance between country needs, existing national capacities and priorities set for technical programmes globally. In that regard, country cooperation strategies served as the lynchpin; they should reflect whether technical and scientific capacity was best provided at the country or regional level or from WHO headquarters. No single model, however, was equally applicable to all technical areas of work.

To meet the need for greater flexibility, regional offices had devolved programmatic authority, and some degree of administrative authority, to country offices. The challenge was to achieve technical and administrative decentralization while still remaining informed about activities at the country and regional levels, for which purpose performance assessment was an indispensable tool. The monitoring and evaluation currently provided for in the programme budget and the medium-term strategic plan should also form a component of country cooperation strategies, with linkages aimed at avoiding duplication of time and effort by country offices and national authorities.

Knowledge management was indeed a priority area at the country level. All country information appearing on the web sites of WHO country offices would always be harmonized with national data sources, generally by providing links to those sources as they became available.

She had noted the suggestions concerning performance reports, for which appropriate plans would be made, and the views about the added value of WHO's country presence. WHO should indeed coordinate, and harmonize with, national efforts and those of other external partners, including the larger donor community, to enhance the effectiveness of health development programmes.

The DIRECTOR-GENERAL said that he had gained first-hand experience of some of the issues surrounding flexibility, recruitment and harmonization of work during the years he had spent working at the country and regional levels. He was therefore aware that concerns might arise at country level that were not openly voiced: for example, the fact that country allocations included staff and administrative costs might create a feeling on the part of the country concerned that a more direct form of financial support would offer better value. In the interest of genuine dialogue, however, he urged less formality and greater frankness during the discussion of such issues. As he well knew, it was a

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

humbling experience for WHO consultants to visit a country only to meet experts who were more knowledgeable than themselves about the subject in question. It was important that staff should be given adequate training and that they should not remain too long in the same post to maintain flexibility. It was true that the process of recruitment was lengthy, but that was because it was designed to guarantee that the best applicants were appointed, at the same time taking into account the need for balanced geographical representation.

He acknowledged the growing demand for better harmonization of WHO's work with the work of other organizations at the country level, particularly in view of the closeness in some areas of work to that of other technical agencies such as UNICEF and UNFPA. Despite the fear that WHO might lose some of its "turf" in the process of harmonization, the challenge to the Organization was to see what services it could provide not only to Member States but also to other agencies. He welcomed resolution WHA58.25 as a positive development.

The CHAIRMAN thanked the Director-General for his candid and forthright comments on the questions raised.

The Board took note of the report.

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

International trade and health: Item 4.2 of the Agenda (Document EB116/4) (continued from the second meeting)

The CHAIRMAN invited the Executive Board to consider the draft resolution proposed by Benin, Bhutan, Bolivia, Brazil, Canada, China, Iraq, Jamaica, Kenya, Nepal, Sudan, Thailand, Tonga and Viet Nam, which read:

The Executive Board,
Having considered the report on international trade and health,¹

RECOMMENDS to the Fifty-ninth World Health Assembly the adoption of the following resolution:

The Fifty-ninth World Health Assembly,
Recalling resolutions WHA52.19, WHA53.14, WHA56.23, WHA56.27, WHA57.14 and WHA57.19;

Recognizing the demand for information about the possible implications of international trade and trade agreements for health at national, regional and global levels;

Mindful of the need for ministers of health and their colleagues in ministries of trade, commerce and finance to work together constructively in order to ensure that the interests of trade and of health are appropriately balanced,

1. URGES Member States:

(1) to promote dialogue at national level to consider the interplay between international trade and health;

¹ Document EB116/4.

- (2) to adopt policies, laws and regulations that address issues identified in that dialogue and take advantage of the potential opportunities, and mitigate the potential risks, that trade and trade agreements may have for health;
 - (3) to create constructive and interactive relationships across the public and private sectors for the purpose of generating coherence in their trade and health policies;
 - (4) to continue to develop capacity at national level to track and analyse the potential opportunities and risks of trade and trade agreements for health-sector performance and health outcomes;
2. REQUESTS the Director-General:
- (1) to provide support to Member States, at their request and in collaboration with the competent international organizations, to frame coherent trade and health policies;
 - (2) to respond to Member States' requests for support of their efforts to build the capacity to understand the implications of international trade and trade agreements for health and to address relevant issues through policies and legislation that take advantage of the potential opportunities, and mitigate the potential risks, that trade and trade agreements may have for health;
 - (3) to continue collaborating with the competent international organizations in order to support policy coherence between trade and health sectors at regional and global levels and to foster the development of a global evidence base on the effects of international trade and trade agreements on health;
 - (4) to report through the Executive Board to the Sixty-first World Health Assembly on progress made in implementing this resolution.

Dr HUERTA MONTALVO (Ecuador) expressed full support for the draft resolution. He proposed that for paragraph 1(1) the word "URGES" should be replaced by "INVITES". However, for subparagraphs 1(2), 1(3) and 1(4) the existing wording "URGES Member States" should be retained.

Mrs NYAMBU (alternate to Dr Nyikal, Kenya) proposed that subparagraph 1(1) should be followed by an additional subparagraph reading: "to establish national coordination mechanisms involving ministries of finance, health, and trade, as well as other relevant institutions, to address public health-related aspects of international trade". She further proposed that in subparagraph 2(1) the words "trade and health policies" should be replaced by "trade-related health policies".

Dr LEITNER (Assistant Director-General) recalled that the Health Assembly had asked for information to be provided on the financial implications of resolutions. The Secretariat did not expect that the draft resolution as it stood would lead to any further administrative changes beyond those incorporated into the Programme budget 2006-2007. In addition, within the Secretariat there was a unit on globalization, trade and health in whose work the regional offices participated, so that no further costs would be incurred on that score. (The unit employed two fixed-term and two short-term professional staff and one fixed-term general service staff.) Concerning support to countries, the cost of preparing, implementing and following up the two country missions undertaken during the current biennium by WHO together with WTO had amounted to US\$ 25 000 per mission. In all, 15 requests for similar missions were pending, and would be budgeted for in the context of country cooperation strategies, although not on the same scale as the first two. A total of US\$ 270 000 had been spent during the current biennium on the development of tools and training for capacity building, and an increase to US\$ 380 000 was expected. As for knowledge-based development and dissemination, spending during the current biennium had amounted to US\$ 190 000 and an increase to US\$ 330 000 was expected. Such increases, however, had already been factored into the Programme budget.

Ms HALTON (Australia) proposed the following amendments: insertion in the second preambular paragraph of “and health policy” between “health” and “at national”; insertion in subparagraph 1(2) of “consider” after “to” at the beginning of the subparagraph and replacement of “adopt” with “adopting” and “risks” with “impacts”; replacement in subparagraph 1(4) of “potential opportunities and risks” with “implications”; and the merging of subparagraphs 2(1) and 2(2) by the addition of “and” at the end of subparagraph 2(1) and deletion of “(2) to respond to Member States’ requests for” at the beginning of subparagraph 2(2). She further proposed deleting in subparagraph 2(2) the word “of” between “support” and “their”, inserting “full” between “take” and “advantage”, and replacing “mitigate” with “address” and “potential risks” with “implications”; inserting in subparagraph 2(3) a comma after “global levels”, replacing “and to foster” with “including”, replacing “base” with “based”, inserting “approach” between “evidence based” and “on”, and adding “health policy” after “health”.

Dr WINT (Jamaica) proposed insertion in the third preambular paragraph of “and foreign affairs” between “finance” and “to work”.

Mr AITKEN (Office of the Director-General) read out the amendments proposed by the member for Australia encompassing minor changes to the second preambular paragraph, subparagraphs 1(2), 1(4), 2(2), 2(3) and the merging of subparagraphs 2(1) and 2(2); by Jamaica to the third preambular paragraph; by Ecuador to paragraph 1; by Kenya for the addition of a new subparagraph 1(1bis) and a replacement in subparagraph 2(1).

Dr HUERTA MONTALVO (Ecuador) said that he had made his proposal for subparagraph 1(1) because “INVITES” might be more acceptable to any Member State that considered that “URGES” encroached on their sovereignty. He was strongly opposed, however, to the proposed replacement in subparagraph 1(2) of “to adopt” with “to consider adopting”, which would water down the text. Since the Board’s task was to promote health interests over trade interests, the resolution’s main purpose should be to encourage Member States to implement policies on international trade and health, particularly those countries currently without such policies. Negotiations were under way in many countries, including Ecuador, where those involved needed a broad knowledge of and competence in a wide range of fields. For example, the health minister had been working with the trade and industry minister to reach agreement over intellectual property rights relating to medicines.

Given the importance of the draft resolution, it was essential to avoid an anodyne form of words that simply elicited consensus without offering the prospect of concrete results. It was crucial to ensure that health issues were not jeopardized by the outcomes of international trade agreements. Should no agreement be reached, Ecuador would have to withdraw its support for the draft resolution.

Ms GILDERS (Canada) said that the amendment proposed to subparagraph 2(1) by the member for Kenya would alter the sense of the paragraph, which had been worded with the intention of helping Member States to collaborate in order to ensure that both trade and health policies were coherent.

Dr SUPACHAI KUNARATANAPRUK (Thailand), supported by Dr MANDIL (alternate to Dr Abdulla, Sudan), said that to substitute the word “implications” in subparagraph 1(4) for the word “risks” would weaken the draft resolution. He endorsed the comments made by the member for Canada with regard to subparagraph 2(1).

The CHAIRMAN, speaking in his capacity as the member for Pakistan, suggested that in view of the importance of the draft resolution further debate should be deferred to the 117th session of the Board.

Dr SUPACHAI KUNARATANAPRUK (Thailand) said that, as the Board was close to reaching agreement, it should be possible to adopt the draft resolution before the close of the meeting.

Dr HUERTA MONTALVO (Ecuador) shared that view. He suggested that a drafting group should be set up to produce a revised text that could be adopted during the current session.

Professor FIŠER (Czech Republic) pointed out that, as the draft resolution would have to be submitted to the Fifty-ninth World Health Assembly, the Board would have time to discuss it further at its 117th session. Adoption could therefore be deferred.

Dr COLEMAN (Liberia), Professor PEREIRA MIGUEL (Portugal) and Dr HANSEN-KOENIG (Luxembourg) supported that view.

Dr ALI MOHAMMED (Iraq) asked whether deferring adoption of the draft resolution would be likely to have any negative consequences for the Secretariat and Member States.

Dr PHOOKO (Lesotho) said that, taking into account the implications of the draft resolution for international trade agreements, it would be wise to postpone a decision.

Dr SHANGULA (Namibia) also supported postponement. He proposed that the third preambular paragraph should read: "Mindful of the need for ministers responsible for health, trade, commerce, finance and foreign affairs ...".

Dr SINGAY (Bhutan) pointed out that, regardless of whether the draft resolution was adopted during the current session or further consideration deferred to the 117th session, upon submission to the Health Assembly it would undoubtedly be amended further.

Professor HOUSSIN (France) said that there were certain technical issues concerning the role of international organizations and the agreements that would have to be entered into within the European Union which still had to be clarified. More time should be given to discussion of the draft resolution with a view to its adoption by the Board in January 2006.

The CHAIRMAN said that he took it that the Board wished to defer consideration of the draft resolution to its 117th session.

It was so agreed.

The meeting rose at 12:40.

FOURTH MEETING

Friday, 27 May 2005, at 14:00

Chairman: Mr M.N. KHAN (Pakistan)

1. MANAGEMENT AND FINANCIAL MATTERS: Item 5 of the Agenda (continued)

Committees of the Executive Board: membership: Item 5.3 of the Agenda (Documents EB116/7 and EB116/7 Add.1)

The CHAIRMAN drew the Board's attention to the report on membership of committees of the Board contained in document EB116/7 and the proposals contained in document EB116/7 Add.1 for vacancies to be filled.

Standing Committee on Nongovernmental Organizations

Decision: The Executive Board appointed Dr A.B. Insanov (Azerbaijan) and Dr H.N. Acharya (Nepal) as members of its Standing Committee on Nongovernmental Organizations for the duration of their term of office on the Executive Board, in addition to Dr F. Huerta Montalvo (Ecuador), Dr A.B. Osman (Sudan) and Mrs Le Thi Thu Ha (Viet Nam), already members of the Committee. It was understood that if any member of the Committee were unable to attend, his or her successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Committee.¹

Programme, Budget and Administration Committee

Decision: The Executive Board appointed as members of the Programme, Budget and Administration Committee Dr Jigmi Singay (Bhutan), Dr A.M. Ali Mohammed (Iraq), Mr J. Junor (Jamaica), Professor J. Pereira Miguel (Portugal), Dr J.D. Ntawukuliryayo (Rwanda), Dr V. Tangi (Tonga) for a two-year period or until expiry of their membership on the Board, whichever occurs first, Mr I. Shugart (Canada) for a one-year period, in addition to Ms J. Halton (Australia), Dr N.A. Haffadh (Bahrain), Professor D. Houssin (France), Dr M. Phooko (Lesotho) and Professor Suchai Charoenratanakul (Thailand), already members of the Committee, and Mr M.N. Khan (Pakistan), Chairman of the Board, member ex officio, and Dr D. Hansen-Koenig (Luxembourg), Vice-Chairman of the Board, member ex officio. It was understood that if any member of the Committee were unable to attend, his or her successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Committee.²

¹ Decision EB116(1).

² Decision EB116(2).

Foundation committees

The CHAIRMAN noted that, as the Board members on the committees or panels were continuing on the Board for at least one more year, there was no vacancy to fill during the current session for those of the Darling Foundation Prize, Léon Bernard Foundation Prize, Jacques Parisot Foundation Fellowship, Ihsan Dogramaci Family Health Foundation Fellowship and Prize, the State of Kuwait Prize for Research in Health Promotion, Sasakawa Health Prize or United Arab Emirates Health Foundation Prize.

Representatives of the Executive Board at the Fifty-ninth World Health Assembly

Decision: The Executive Board, in accordance with paragraph 1 of resolution EB59.R7, appointed its Chairman, Mr M.N. Khan (Pakistan), ex officio, and its first three Vice-Chairmen, Dr H.N. Acharya (Nepal), Dr K. Shangula (Namibia) and Ms J. Halton (Australia), to represent the Board at the Fifty-ninth World Health Assembly. It was understood that if any of those members were not available for the Health Assembly, the other Vice-Chairman, Dr D. Hansen-Koenig (Luxembourg), and the Rapporteur, Mr M. Bailón (Mexico), could be asked to represent the Board.¹

Future sessions of the Executive Board and the Health Assembly: Item 5.4 of the Agenda (Document EB116/8)

The CHAIRMAN pointed out that the last phrase of the last paragraph of the report should end: “and that it should close no later than Saturday, 27 May 2006.”

Dr SHANGULA (Namibia) said that he was pleased to note that the Fifty-ninth World Health Assembly would last only six days. However, there were two further ways in which time management at the Health Assembly could be improved. The question of Taiwan and its representation should be avoided at all costs in future plenary meetings. Member States spent money and time on attending the Health Assembly. Those resources must be used wisely and sparingly. The issue of Taiwan was highly divisive, and soured the start of the Health Assembly.

Speakers in the debate on the Director-General’s report had failed to limit their remarks to five minutes. If they overran the time limit, they should be required to stop speaking. The first two days of the Health Assembly were not being put to optimal use; it was time to remedy that situation.

The CHAIRMAN agreed. Difficult though it might be to interrupt a health minister, everyone should respect the time limit.

The DIRECTOR-GENERAL observed that time management at the Fifty-eighth World Health Assembly had improved substantially by comparison with the previous Health Assembly. Under a Memorandum of Understanding between the People’s Republic of China and WHO, a mechanism had been established to enable Taiwanese experts to participate in the Organization’s technical activities and staff members of WHO to be sent there in the event of a public health emergency. He was committed to using that mechanism to promote exchanges and technical cooperation with Taiwan, and to demonstrate that, contrary to claims by Member States, there were no gaps in the Organization’s work. The political issue must of course be resolved in New York and Beijing. Time would undoubtedly be saved by refraining from debating it at the Health Assembly.

¹ Decision EB116(3).

Date, place and duration of the 117th session of the Executive Board

Decision: The Executive Board decided that its 117th session should be convened on Monday, 23 January 2006, at WHO headquarters, Geneva, and should close no later than Saturday, 28 January 2006.¹

Place, date and duration of the Fifty-ninth World Health Assembly

Decision: The Executive Board decided that the Fifty-ninth World Health Assembly should be held at the Palais des Nations, Geneva, opening on Monday, 22 May 2006, and that it should close no later than Saturday, 27 May 2006.²

2. STATEMENT BY THE REPRESENTATIVE OF THE WHO STAFF ASSOCIATIONS:
Item 6 of the Agenda (Document EB116/INF.DOC./1)

Ms LALIBERTÉ (representative of the WHO staff associations) reiterated the staff associations' request for participation in the Programme, Budget and Administration Committee when it examined matters of staff policy. The Committee's decisions on the budget and human resources policies had been taken without heed to the views of the staff associations, whose input came too late. Yet a major part of the contributions of Member States was spent on staff, and the Committee would benefit from hearing their views. For many staff the conditions of employment would be unacceptable or illegal in the countries represented by Board members or in the host country, Switzerland. WHO's contracts denied staff proper employment security. Short-term, 11-month contracts prevented highly-qualified staff from performing at their best. Participation of WHO staff associations in the work of the Committee would assist its members with their decisions on staff matters. Basic human resource mechanisms had to be in place and functioning, including the Grievance Panel and the Classification and Reassignment committees, with appropriate power to fulfil their mandates. Staff needed a proper safety net, which would qualify WHO as a socially-responsible employer.

Dr NORDSTRÖM (Assistant Director-General) said that the commitment of the staff associations and their dedication to ensuring that the views of the staff were heard when decisions were taken were much appreciated. Progress was being made in setting up appropriate and effective mechanisms. The Global Staff/Management Council had evolved into an efficient forum for interaction between the management and staff; both headquarters and regional offices were working hard to improve that interaction. The Programme, Budget and Administration Committee was not a decision-making committee but rather it advised the Board. Resolution EB57.R8 enabled the staff associations to submit their views to the Board. The other points raised were under review, and there was a strong commitment to making further progress on them.

The CHAIRMAN said that the Board appreciated the hard work done by WHO's staff. He took it that the Board wished to note the statement by the representative of the WHO staff associations.

The statement was noted.

¹ Decision EB116(4).

² Decision EB116(5).

3. MATTERS FOR INFORMATION: Item 7 of the Agenda

Implementation of resolution WHA55.16 on global public health response to natural occurrence, accidental release or deliberate use of biological and chemical agents or radionuclear material that affect health: Item 7.1 of the Agenda (Document EB116/9)

Ms GILDERS (Canada) said that much progress had been made since the adoption of resolution WHA55.16. WHO had strengthened international capacity to respond to chemical, biological and radionuclear events, whatever their origin. WHO had also taken a leading role in the Global Health Security Initiative, in which her country participated. The adoption of the International Health Regulations (2005) had likewise done much to address the issues. Her Government firmly believed in the principles outlined in the report and was in favour of further work by the Secretariat. Increased collaboration between institutions, organizations and sectors that had not cooperated so closely in the past was a welcome outcome of WHO's involvement.

Dr GOMES TEMPORÃO (Brazil) said that several issues covered in resolution WHA55.16 had been raised during the arduous negotiations leading to adoption by the Fifty-eighth World Health Assembly of the International Health Regulations (2005). The Brazilian position had been fully explained in the Montevideo and Buenos Aires consensus documents circulated at the second session of the Intergovernmental Working Group on Revision of the International Health Regulations. He stressed that in implementing resolution WHA55.16, the Secretariat must not take any action that would cause it to overstep the Organization's mandate, but must focus on the public health consequences of events, irrespective of their origin. Moreover, WHO's initiatives aimed at strengthening the Global Outbreak Alert and Response Network must always be closely coordinated with Member States.

Mr HOHMAN (United States of America)¹ commended the efforts to coordinate the detection and verification of, and response to, the many disease outbreaks of potential international concern during recent years, a core function of the Organization. Resolution WHA55.16 was especially important as it addressed national and international preparedness in the face of threats, natural or deliberate, to public health. The International Health Regulations (2005) underscored the importance of such preparedness, and the current challenge was to ensure their successful implementation. In that regard, the activities outlined in the report were critical. The Secretariat must be able to support Member States in carrying out their mandate of effective surveillance, reporting and responsible management of public health emergencies. Such an event could overwhelm communication systems, and plans must be in place to deal with sudden increases in demand for information and response capabilities. The report could have gone further in describing WHO's input and role as a central coordinator in such situations – a role, including its collaboration with other international organizations, set out in the International Health Regulations (2005).

The United States was working to upgrade public health infrastructure and related capabilities; it was also looking at opportunities to assist other countries in developing those capacities. It looked forward to future WHO reports in those areas.

Dr SHINOZAKI (Japan) welcomed the adoption of the International Health Regulations (2005), which would make it possible to establish a framework for controlling diseases posing a potential international public health threat. It was vital that all Member States responded promptly to such threats in accordance with the Regulations. Japan would strive to implement the Regulations and would cooperate internationally by providing human resources and technology. It was also relying on WHO's initiatives to encourage technical advances and due observance of the Regulations by Member

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

States, in particular in relation to surveillance and follow-up. Japan was collaborating with other members of the Global Health Security Action Group to improve global health security, and terrorism preparedness and response; chairing the chemical terrorism working group, it was compiling information on the harmful health effects of chemical terrorism and relevant technologies.

Dr ASAMOA-BAAH (Assistant Director-General) thanked Board members for their comments and guidance. Responding to the member for Brazil, he said that the adoption of the International Health Regulations (2005) was empowering, but at the same time the Secretariat recognized the challenge of implementation and understood that Member States wished the Organization to remain within its mandate and sphere of competence.

The DIRECTOR-GENERAL noted that responses in relation to the release of biological or chemical agents or radionuclear material had been one of the most sensitive issues in the negotiations on the revision of the International Health Regulations. WHO had no intention of overstepping its mandate or becoming involved in activities that were the province of organizations such as IAEA. Nevertheless, it was clear from historical precedents that the health sector had a key role to play in responding to events that constituted public health emergencies, regardless of the source or causative agent. Sixty years earlier in Japan, for example, the first response to the events of Hiroshima and Nagasaki had come from the health sector. At the practical level, therefore, it was relevant that WHO should be involved in responding to biological, chemical or radionuclear events.

The Board noted the report.

WHO Commission on Intellectual Property Rights, Innovation and Public Health: progress report: Item 7.2 of the Agenda (Document EB116/10)

Dr MANDIL (alternate to Dr Abdulla, Sudan), alluding to the section in the report on key issues, pointed out that an information technology corporation had recently opened access to more than 500 of its software patents, which would invigorate the informatics and communications technology market and benefit consumers. A dialogue could be initiated with owners of intellectual property rights in the health field with a view to persuading them to make a similar gesture, thereby expanding access to certain health-related products, procedures and protocols.

Dr GOMES TEMPORÃO (Brazil) acknowledged that the issues covered by the Doha Declaration on the TRIPS Agreement and Public Health were included implicitly in the progress report; however, the importance of using the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights in the development and execution of public health policies should be expressly mentioned in the Commission's final report, particularly in relation to diseases affecting developing countries. The final report should also include a reference to the discussions at the Commission's meeting in Brazil in February 2005. He supported a transparent, coherent, comprehensive and integrated approach to the process that would culminate in the final report of the Commission. It was to be hoped that the report would meet the expectations raised on the occasion of the Commission's establishment and be guided by the principle of promotion of access to medicines for all.

Dr ANTEZANA ARANÍBAR (Bolivia) endorsed the comments made by the previous speaker. The concept of intellectual property should be expanded to include not just medicines but also clinical procedures, secondary uses for currently patented products and protection of information and data. The Commission should examine those issues. It should also consider the extent to which existing intellectual property mechanisms could be used for the protection of natural medicines derived from medicinal plants and traditional medical knowledge and practices. He looked forward to the Commission's final report.

Dr SHINOZAKI (Japan) said that the Commission should continue to ensure the neutrality and transparency that had characterized its work thus far. Appropriate protection of intellectual property rights was an important incentive for innovation and for the development of new medicines. Potential market size should be taken into account in utilizing public funding for the promotion of drug research and development. For small markets, public funding had an important role to play in drug development; where a significant market existed, the private sector should mobilize the necessary resources. The Commission's discussions were focusing on the impact of the patent system on access to new medicines; however, reinforcement of social infrastructure, including medical institutions, medical staff and transport, was also important for improving access.

Dr TÜRMEŒEN (Representative of the Director-General) assured the Board that the Commission was working hard to produce a good final report, maintaining neutrality and objectivity and ensuring the transparency of its working methods. The report would indeed contain information on the conclusions of the Brazil meeting and on the implications of the Doha Declaration on the TRIPS Agreement and Public Health. The whole topic of traditional knowledge and practices would also be covered. Full documentation of the Commission's activities was available on the WHO web site. She had taken careful note of the comments made and would transmit them to the Commission.

The CHAIRMAN welcomed the suggestion by the member for Sudan, and invited the Board to note the report.

The Board noted the report.

Expert committees and study groups: Item 7.3 of the Agenda (Document EB116/11)

The CHAIRMAN invited the Board to consider document EB116/11, which contained the reports of two expert committees.

The Board noted the report.

4. CLOSURE OF THE SESSION: Item 8 of the Agenda

The DIRECTOR-GENERAL said that, to ensure greater continuity in the Board's work between sessions, he planned to communicate with members electronically each month, sending them an update on WHO's activities and on public health in general. Members should feel free to raise questions or request further information if they so desired.

He had perhaps been unusually candid during the current session, but he had wanted to set the tone for meaningful dialogue within the Board. Such frank and honest discussion would help guide the Secretariat in its work and enable it better to serve Member States.

After the customary exchange of courtesies, the CHAIRMAN declared the session closed.

The meeting rose at 15:05.
