



WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD

124TH SESSION

GENEVA, 19–26 JANUARY 2009

SUMMARY RECORDS

GENEVA
2009



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ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

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

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

PREFACE

The 124th session of the Executive Board was held at WHO headquarters, Geneva, from 19 to 26 January 2009. The proceedings are issued in two volumes. The present volume contains the summary records of the Board's discussions, list of participants and officers, and details regarding membership of committees and working groups. The resolutions and decisions and relevant annexes are published in document EB124/2009/REC/1.

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¹ As adopted by the Board at its first meeting (19 January 2009).

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EB124/1 Rev.1	Agenda ¹
EB124/1 Add.1	Proposal for supplementary agenda item
EB124/2	Report by the Director-General to the Executive Board at its 124th session
EB124/3	Report of the Programme, Budget and Administration Committee of the Executive Board
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EB124/12	WHO's role and responsibilities in health research: draft WHO strategy on research for health ³
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EB124/12 Add.2	WHO's role and responsibilities in health research Bamako Global Ministerial Forum on Research for Health

¹ See page ix.

² See document EB124/2009/REC/1, Annex 1.

³ See document EB124/2009/REC/1, Annex 4.

⁴ See document EB124/2009/REC/1, Annex 7.

EB124/13	International recruitment of health personnel: draft global code of practice
EB124/13 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly ¹
EB124/14 and EB124/14 Corr.1	Counterfeit medical products
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¹ See document EB124/2009/REC/1, Annex 7.

² See document EB124/2009/REC/1, Annex 5.

³ See document EB124/2009/REC/1, Annex 2.

⁴ See document EB124/2009/REC/1, Annex 3.

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EB124/26	Awards
EB124/27, EB124/27 Add.1 and EB124/27 Add.2	Provisional agenda for the Sixty-second World Health Assembly
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¹ See document EB124/2009/REC/1, Annex 6.

² See document EB124/2009/REC/1, Annex 7.

LIST OF MEMBERS AND OTHER PARTICIPANTS

MEMBERS, ALTERNATES AND ADVISERS

SRI LANKA

Mr N.S. DE SILVA, Minister of Healthcare and Nutrition, Colombo (**Chairman**)

Alternates

Dr D. JAYATILLEKA, Ambassador, Permanent Representative, Geneva

Dr R.W. JAYANTHA, Deputy Director-General (MS) II, Ministry of Healthcare and Nutrition,
Colombo

Mr S. EKANAYAKE, Counsellor, Permanent Mission, Geneva

Mr O.L. AMEERAJWAD, Counsellor, Permanent Mission, Geneva

Mrs M. MALLIKARATCHY, Second Secretary, Permanent Mission, Geneva

AFGHANISTAN

Dr H. AHMADZAI, Head, External Relations Department, Ministry of Public Health, Kabul

Alternates

Dr N. TARZI, Ambassador, Permanent Representative, Geneva

Mr O.K. NOORI, First Secretary, Permanent Mission, Geneva

Mr D. HACHEMI, Second Secretary, Permanent Mission, Geneva

Mr F. AMEL, Attaché, Permanent Mission, Geneva

BAHAMAS

Dr M. DAHL-REGIS, Chief Medical Officer, Ministry of Health, Nassau New Providence

BANGLADESH

Professor A.F.M.R. HAQUE, Minister of Health and Family Welfare, Dhaka

Alternates

Professor S.M. ALI, Advisor to the Prime Minister, Dhaka

Dr D. BHATTACHARYA, Ambassador, Permanent Representative, Geneva

Mr S.M. RAHMAN, Deputy Secretary, Ministry of Health and Family Welfare, Dhaka

Professor M. ABUL KALAM AZAD, Director (MIS), Directorate of Health Services, Ministry
of Health and Family Welfare, Dhaka

Mr M.E. MOWLA, Counsellor, Permanent Mission, Geneva

Mr K.M. TALHA, Counsellor, Permanent Mission, Geneva

Mr F.M. KAZI, First Secretary, Permanent Mission, Geneva

Dr F. QADRI, Senior Scientist, ICCDR, B., Dhaka

Mr M. RAHMAN, Minister, Permanent Mission, Geneva

BRAZIL

Dr P.M. BUSS, President, Oswaldo Cruz Foundation (FIOCRUZ), Rio de Janeiro RJ

Alternates

Ms M.N. FARANI AZEVÊDO, Ambassador, Permanent Representative, Geneva

Mr F. CAMPOS, Secretary of Management in Work and Education in Health, Rio de Janeiro

Mr S.J. DE ALBUQUERQUE E SILVA, Minister, Head of Division of Social Issues, Ministry of Foreign Affairs, Rio de Janeiro

Mr L.L. VIEGAS, Head of Division of Multilateral Affairs, Ministry of Health, Rio de Janeiro

Mr R.E. DE CARVALHO, First Secretary, Permanent Mission, Geneva

Ms J. VALLINI, Legal Assessor National Program on AIDS, Ministry of Health, Rio de Janeiro

Mr S. GAUDÊNCIO, Division of Multilateral Issues, Ministry of Health, Rio de Janeiro,

Mr M.F. LOBATO, Official, Division of Social Issues, Ministry of Foreign Affairs, Rio de Janeiro

CHINA

Dr REN Minghui, Director-General, Department of International Cooperation, Ministry of Health, Beijing (**Rapporteur**)

Alternates

Dr XING Jun, Division Director, Department of International Cooperation, Ministry of Health, Beijing

Ms HAN Jixiu, Program Officer, Department of International Cooperation, Ministry of Health, Beijing

Dr LIU Yong, Division Director, Department of Medical Service Supervision, Ministry of Health, Beijing

Dr LU Ming, Deputy Division Director, Bureau of Disease Prevention and Control, Ministry of Health, Beijing

Dr ZHANG Feng, Program Officer, Bureau of Food Safety Coordination and Health Supervision, Ministry of Health, Beijing

Dr ZHU Haidong, Division Director, Department of International Cooperation, State Administration of Traditional Chinese Medicine, Beijing

Mr JIN Song, Program Officer, Enforcement Bureau, State Food and Drug Administration, Beijing

Mr LI Baodong, Ambassador, Permanent Representative, Geneva

Ms LIU Hua, Counsellor, Permanent Mission, Geneva

Mr WANG Xiaoying, First Secretary, Permanent Mission, Geneva

Mr LIU Ming, First Secretary, Permanent Mission, Geneva

Ms WANG Dan, Attaché, Permanent Mission, Geneva

Mr TENG Fei, Attaché, Permanent Mission, Geneva

DENMARK

Mr J. FISKER, Director-General, National Board of Health, Copenhagen

Alternates

Mrs M.L. OVERVAD, Ambassador, Permanent Representative, Geneva

Dr C.M. JENSEN, Deputy Director General, National Board of Health, Copenhagen

Mr M. JØRGENSEN, Head of Department, Ministry of Health and Prevention, Copenhagen

Dr E. SMITH, Head of Centre for Prevention and Health Promotion, National Board of Health, Copenhagen

Advisers

Dr S.J. JØRGENSEN, Senior Adviser, National Board of Health, Copenhagen
Ms M. KRISTENSEN, Chief Adviser, National Board of Health, Copenhagen
Mrs A.C. CHRISTENSEN, Counsellor, Permanent Mission, Geneva
Ms H.E. KRARUP, Head of Section, Ministry of Health and Prevention, Copenhagen
Ms M.K. JØRGENSEN, Intern, Permanent Mission, Geneva

DJIBOUTI

M. A.A. MIGIUIL, Ministre de la Santé, Djibouti

Alternates

M. A.M. ABOUBAKER, Directeur des Etudes, de la Planification et de la Coopération internationale, Djibouti
Mme S.M. HADI, Cadre au Service d'Information sanitaire, Djibouti
M. A. MOHAMED ABRO, Premier Conseiller, Mission permanente, Genève

EL SALVADOR

Dr. B.F. LARIOS LÓPEZ, Ambador, Representante permanente, Ginebra
(alternate to Dr J.G. Maza Brizuela)

Alternates

Dr. R.L. HERRERA, Ministerio de Salud publica y asistencia social San Salvador C.A.
Dr. M.V. SERPAS MONTOYA, Director de Vigilancia de la Salud, Ministerio de Salud publica y asistencia social, San Salvador C.A.
Ing. M.A. ALCÁINE, Embajador Adjunto, Ginebra
Sra. L.A. DE OVERDIEK, Misión Permanente, Ginebra

HUNGARY

Dr M. KÖKÉNY, President, Health Committee of the Hungarian Parliament, Budapest

Alternate

Mr A. MÉSZÁROS, Deputy Head, Department of International and European Affairs, Ministry of Health, Budapest

Advisers

Mr L. SZÉKELY, Deputy Permanent Representative, Permanent Mission, Geneva
Ms N. KONDOROSI, Counsellor, Department of International and European Affairs, Ministry of Health, Budapest
Mr A. KOVÁCS, Deputy Chief Medical Officer, National Public Health Service, Budapest
Mr G. SOMOGYI, Attaché, Permanent Mission, Geneva

INDONESIA

Dr S.F. SUPARI, Minister of Health, Jakarta

Alternates

Dr W. LUKITO, Special Advisor to the Minister of Health on Public Health, Ministry of Health, Jakarta
Dr T.Y. ADITAMA, Director-General of Diseases Control and Environmental Health, Ministry of Health, Jakarta
Mr I.G.A.W. PUJA, Deputy Permanent Representative, Geneva

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

Advisers

Dr M. UTAMI, Chief, Division of Ministerial Office Secretariat, Bureau of General Affairs, Jakarta

Dr WIDIYARTI, Chief, Sub-Division of Bilateral and Regional, Bureau of Planning and Budgeting, Jakarta

Dr A. ISMAINI, Official, Bureau of Planning and Budgeting, Ministry of Health, Jakarta

Ms D. MELIANI, Staff, Division of Ministerial Office Secretariat, Bureau of General Affairs, Jakarta

Dr YUSHARMEN, Director, Noncommunicable Diseases Control, Ministry of Health, Jakarta

LATVIA

Dr V. JAKSONS, Adviser to the State Secretary for International Affairs, Riga

Advisers

Mr J. MAŽEIKS, Ambassador, Permanent Representative, Geneva

Mrs I. DREIMANE, First Secretary, Permanent Mission, Geneva

MALAWI

Dr K. KAMOTO, Head of HIV/AIDS Unit, Ministry of Health, Lilongwe

Alternate

Dr N. ALIDE, Lilongwe

MALI

M. O.I. TOURÉ, Ministre de la Santé, Bamako Koulouba (**Vice-Chairman**)

Alternates

M. S.L. SOW, Ambassadeur, Représentant permanent, Genève

Dr D.O.S. MAIGA, Conseiller technique au Ministère de la Santé, Bamako Koulouba

Professeur T. SIDIBE, Directeur national de la Santé, Bamako Koulouba

M. I. SANGHO, Chargé de Mission du Ministère de la Santé, Bamako Koulouba

M. A.H. MAIGA, Deuxième Conseiller, Mission permanente Genève

MAURITANIA

Dr A. OULD JIDDOU, Directeur des Services de Santé de Base, Ministère de la Santé, Nouakchott
(**alternate to Mr M.A. Ould Siyam**)

Alternates

M. T.K. OULD ABDI SALEM, Premier Conseiller, Mission permanente, Genève

M. A.O.M. BOUSSEIF, Chargé d'Affaires, a.i., Mission permanente, Genève

M. A. OULD ISHAQ, Premier Conseiller, Mission permanente, Genève

MAURITIUS

Dr N. GOPEE, Chief Medical Officer, Ministry of Health and Quality of Life, Port Louis

Alternates

Mr S.B.C. SERVANSING, Ambassador, Permanent Representative, Geneva

Mr V. MUNGUR, Minister-Counsellor, Permanent Mission, Geneva

Mr S. GUJADHUR, First Secretary, Permanent Mission, Geneva

Mrs T. PRAYAG-GUJADHUR, Second Secretary, Permanent Mission, Geneva

Miss R. WILFRID-RENÉ, Second Secretary, Permanent Mission, Geneva

NEW ZEALAND

Ms D. ROCHE, Deputy Director-General, Health and Disability Systems Strategy Directorate,
Ministry of Health, Wellington (**alternate to Mr T. Ryall**)

Alternates

Dr A. BLOOMFIELD, Chief Advisor Public Health and National Director Tobacco Control,
Sector Capability and Innovation Directorate, Ministry of Health, Wellington

Mr D. MACKAY, Permanent Representative, Geneva

Ms W. HINTON, Deputy Permanent Representative, Geneva

Adviser

Dr M. JACOBS, Director of Public Health, Health and Disability Systems Strategy Directorate,
Ministry of Health, Wellington

NIGER

Dr. A. DJIBO, Directeur général de la Santé publique, Ministère de la Santé publique, Niamey

Alternates

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

M. R. ISSAKA MOUSSA RAOUFOU, Conseiller, Mission permanente, Genève

OMAN

Dr A.J. MOHAMED, Advisor, Health Affairs, Directorate General of Health Affairs, Ministry of
Health, Oman

PARAGUAY

Dr. E. GIMENÉZ CABALLERO, Viceministro de Salud Publica, Asunción
(**alternate to Dr O. Martinez Doldan**)

Alternates

Sr. R. GAUTO VIELMAN, Representante Permanente, Misión Permanente, Ginebra

Sr. E. GARCIA DE ZUÑIGA, Ministerio de Salud Pública y Bienestar Social, Asunción

Sra. G. GAMARRA, Ministerio de Salud Pública y Bienestar Social, Asunción

Sra. M. MORENO, Misión Permanente, Ginebra

PERU

Sr. C. VALLEJOS, Jefe Institucional, Instituto Nacional de Enfermedades Neoplásicas, Lima
(Vice-Chairman)

Alternates

Sr. E. PONCE VIVANCO, Representante Permanente, Ginebra
Sr. C. CHOCANO BURGA, Ministro Consejero, Misión Permanente, Ginebra
Sra. C. GUEVARA, Primera Secretaria, Misión Permanente, Ginebra
Sr. G. LEÓN, Segundo Secretario, Misión Permanente, Ginebra
Sra. M.J. VALLEJOS, Misión Permanente, Ginebra

REPUBLIC OF KOREA

Professor SOHN Myong-sei, Vice-President, Korean Academy of Medical Sciences, Seoul

Alternates

Mr PARK Hun-Yul, Minister Counsellor, Permanent Mission, Geneva
Mr KIM Pil-woo, Counsellor, Permanent Mission, Geneva
Dr KWON Jun-wook, Director, Communicable Disease Control, Korea Center for Disease Control and Prevention, Seoul
Ms LEE Kyung-eun, Director of International Cooperation Division, Ministry of Health, Welfare and Family Affairs, Seoul
Mr LEE Hyung-hoon, Director of Policy Planning and Coordination Division, Ministry of Health, Welfare and Family Affairs, Seoul
Mr YOON Sang-uk, First Secretary, Permanent Mission, Geneva
Ms CHOI Chong-hee, Deputy Director of International Cooperation Division, Ministry of Health, Welfare and Family Affairs, Seoul
Dr LEE Seon-kui, Deputy Director of Health Promotion Division, Ministry of Health, Welfare and Family Affairs, Seoul
Dr LEE Hoon-sang, Researcher, Division of NIP and VPD Control, Korea Center for Disease Control and Prevention, Seoul
Mr HAHM Ki-hyun, Senior Researcher, Asian Institute of Bioethics and Health Law, Seoul

REPUBLIC OF MOLDOVA

Dr I. ABABII, Rector, Moldova Medical University, Chisinau

Alternates

Mrs R. GRAMMA, Counsellor, Programmes Coordinator, State University of Medicine and Pharmacy "N. Testimitanu", Chisinau
Mrs T. LAPICUS, Ambassador, Permanent Representative, Geneva
Ms C. CALUGARU, First Secretary, Permanent Mission, Geneva

RUSSIAN FEDERATION

Dr V.I. STARODUBOV, Director, Central Research Institute of Health, Management and Information Systems, Ministry of Health and Social Development, Moscow

Alternates

Mr V.V. LOSHCHININ, Ambassador, Permanent Representative, Geneva
Dr V.I. SKVORTSOVA, Deputy Minister of Health and Social Development, Moscow
Mr V.A. NEBENZIA, Deputy Permanent Representative, Geneva

Mr O.P. CHESTNOV, Deputy Director, Department of International Cooperation, Ministry of Health and Social Development, Moscow

Advisers

Mr V.M. ZIMYANIN, Senior Counsellor, Permanent Mission, Geneva

Dr A.V. PAVLOV, Counsellor, Permanent Mission, Geneva

Mr A.A. KOTELNIKOV, Adviser, Ministry of Health and Social Development, Moscow

Mrs D.O. MIKHAILOVA, Director, Department for the Development of the Pharmaceutical and Medical Technology Market, Ministry of Health and Social Development, Moscow

Dr M.P. SHEVYREVA, Director, Department of Health Protection and Human Sanitary and Epidemiological Welfare, Ministry of Health and Social Development Moscow

Mrs E.M. SHPILEVA, Director, Department of Finance, Ministry of Health and Social Development, Moscow

Mr N.N. SIKACHEV, Senior Advisor, Department of International Organizations, Ministry of Foreign Affairs, Moscow

Mr A.G. BASHKIN, Senior Counsellor, Permanent Mission, Geneva

Dr A.A. MELNIKOVA, Deputy Director, Epidemiological Surveillance Administration, Federal Service for Surveillance on Consumer Rights Protection and Human Well-being, Moscow

Mrs N.D. PAKSINA, Head, Epidemiological Surveillance Administration, Federal Service for Surveillance on Consumer Rights Protection and Human Well-being, Moscow

Dr A.N. SERGEEV, Deputy Director-General, "Vector" State Research Centre for Virology and Biotechnology, Novosibirsk Region

Dr M.S. TSESHKOVSKIY, Chief, Central Research Institute for Health Management and Information Systems, Ministry of Health and Social Development, Moscow

Mr M.V. BERDYEV, First Secretary, Permanent Mission, Geneva

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Mr A.V. MARKOV, First Secretary, Permanent Mission, Geneva

Mrs A.V. SMIRNOVA, Senior Specialist, Administration for Scientific Support and International Activity, Federal Service for Surveillance on Consumer Rights Protection and Human Well-being, Moscow

Ms M.V. CHURILOVA, Second Secretary, Permanent Mission, Brussels

Ms N.A. KULESHOVA, Chief Specialist, Department of International Cooperation, Ministry of Health and Social Development, Moscow

Mr E.V. KALUGIN, Third Secretary, Permanent Mission, Geneva

Mr D.A. KHUDOV, Attaché, Permanent Mission, Geneva

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Alternate

Dr R. THOMSEN, ACEO, Medical and Allied Health Professional, Apia

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(alternate to Dr B Sadasivan)

Alternates

Mr TAN YORK CHOR, Permanent Representative, Geneva

Dr M. MANAV, Manager, Hospital Services Division, Ministry of Health, Singapore

Mr S.N. SYED HASSIM, Deputy Permanent Representative, Geneva

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Ministry of Health, Singapore

Ms Y. OW, First Secretary, Permanent Mission, Geneva

Mr T.S. SADANADOM, Health Policy Analyst, Industry Development and International
Cooperation Division, Ministry of Health, Singapore

Dr J. TAY, Deputy Director, Communicable Diseases Division, Ministry of Health, Singapore

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Alternates

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Advisers

Dr M. CIRAJ, Director, National Chemicals Bureau, Ljubljana

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Advisers

Mr J. WARLEY, Acting Head of Profession, Health Department for International Development, London

Ms M. DAVIES, Public Health Advisor, Department of Health, London

Mrs A. FERRAO, Scientific Policy Officer, Department of Health, London

Dr A. EL TURABI, Special Assistant to R& D Director-General, Department of Health, London

Mr N. MOORS, International Business Manager, Department of Health, London

Ms A. AKINFOLAJIMI, Deputy International Business Manager, Department of Health,
London
Ms S. DAVIDSON, International Business Officer, Department of Health, London
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London

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Dr A.I.G. EL DIN, Deputy Permanent Representative, Geneva
Dr M. GAD, First Secretary, Permanent Mission, Geneva
Dr R. EL SAYED EL ARABI, Medical Officer, Curative Care Sector, Ministry of Health and Population, Cairo

ESTONIA

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Ms U.-K. NURM, Head of the Public Health Department, Ministry of Social Affairs, Tallinn
Ms K. SIBUL, Third Secretary, Permanent Mission, Geneva

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Ms A.-I. HANSSON, Director-General, Ministry of Social Affairs and Health, Helsinki
Ms T. KOIVISTO, Ministerial Adviser, Ministry of Social Affairs and Health, Helsinki
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Mr P. PUSKA, Director-General, National Institute for Health and Welfare, Helsinki
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Mme G. BONNIN, Bureau de la Coopération internationale, Délégation aux Affaires européennes et internationales, Ministère de la Santé, de la Jeunesse, des Sports et de la Vie associative, Paris
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Mlle M. BOUATOUCH-LEGRAND, Chargé de Mission, Mission permanente, Genève
Mlle A.-C. BARD, Chargé de Mission, Mission permanente, Genève

GERMANY

Dr E. SEEBA, Director-General, “Personal, Budget, Organisation” and “European and International Health Policy”, Federal Ministry of Health, Berlin
Mr K.M. SCHARINGER, Deputy Permanent Representative, Geneva
Mr U. SCHOLTEN, Deputy Director-General, European and International Health Policy, Federal Ministry of Health, Berlin
Mrs D. REITENBACH, Head of Division, Multilateral Cooperation in the Field of Health, Federal Ministry of Health, Berlin
Mr B. KÜMMEL, Advisor, Federal Ministry of Health, Berlin
Mr W. WAGNER, Advisor, Federal Ministry of Foreign Affairs, Berlin
Mr T. IFLAND, Advisor, Federal Ministry of Health, Bonn
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INDIA

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Delhi

Mr S.V. CHAUDHRY, Joint Secretary, Ministry of Health and Family Welfare, Delhi

Dr S. CHAUHAN, Director (IH), Ministry of Health and Family Welfare, Delhi

IRAN (ISLAMIC REPUBLIC OF)

Dr B. SADRIZADEH, Senior Advisor to the Minister of Health for Health and International Affairs,
Tehran

Mr K. AHMADI, Minister Counsellor, Permanent Mission, Geneva

IRAQ

M. U.A.I. IBRAHIM, Troisième Secrétaire, Mission permanente, Genève

IRELAND

Mr B. INGOLDSBY, Principal Officer, Research, EU and International Unit, Department of Health
and Children, Ministry of Health, Dublin

Mr S. MCGOVERN, Assistant Principal Officer, Research, EU and International Unit, Department of
Health and Children, Ministry of Health, Dublin

Mr M. MULKERRIN, Higher Executive Officer, Research, EU and International Unit, Department of Health and Children, Ministry of Health, Dublin
Mr M. GALLAGHER, Permanent Representative, Geneva
Dr J. KIELY, Medical Adviser, Department of Foreign Affairs, Dublin
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Dr F. CICOGNA, Dirigeant médical du Bureau des Rapports avec l'Union européenne et les Rapports internationaux, Ministère de la Santé, Rome
Mme M.P. RIZZO, Direction générale pour la Coopération au Développement, Ministère des Affaires étrangères, Rome

JAPAN

Mr A. ISOMATA, Minister, Permanent Mission, Geneva
Mr H. ITAYA, Assistant Director-General for International Policy Planning, Minister's Secretariat, Ministry of Health, Labour and Welfare, Tokyo
Dr H. INOUE, Director, International Cooperation Office, Minister's Secretariat, Ministry of Health, Labour and Welfare, Tokyo
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Ms M. TOYOTA-IMAMURA, First Secretary, Permanent Mission, Geneva
Dr N. SHINOZAKI, Executive Director, Cornea Center, Tokyo Dental College, Tokyo
Dr K. YAMAMOTO, Deputy Director, International Affairs Division, Minister's Secretariat, Ministry of Health, Labour and Welfare, Tokyo

KAZAKHSTAN

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KENYA

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KYRGYZSTAN

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LITHUANIA

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Ms E. VAN WOERSEM, Desk Officer, United Nations and International Financial Institutions
Department, Ministry of Foreign Affairs, The Hague
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Ms T. WROLDSEN, Adviser, Department for Health and Welfare, Oslo
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Mrs V. PERSSON, Research Advisor, Swedish International Development Cooperation Agency (SIDA), Stockholm
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Lic. A.T. UZCÁTEGUI B., Asesora de la Oficina de Cooperación Técnica y Relaciones Internacionales, Ministerio del Poder Popular para la Salud, Caracas
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Directorate General Health and Consumers,
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Health, Directorate General Research,
Brussels
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Directorate General Health and Consumers,
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Department
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Ninth meeting, 14–15 January 2009: Dr M. Dahl-Regis (Bahamas, Chairman), Mr S.M. Rahman (alternate to Professor A.F.M.R. Haque, Bangladesh), Dr Ren Minghui (China), Ms M. Kristensen (alternate to Mr J. Fisker, Denmark), Dr M. Kökény (Hungary), Dr T.Y. Aditama (alternate to Dr S.F. Supari, Indonesia), Dr K. Kamoto (Malawi), Mr O.I. Touré (Mali), Ms D. Roche (alternate to Mr T. Ryall, New Zealand), Mr N.S. de Silva (Sri Lanka, member ex officio), Dr H. Abdesselem (Tunisia), Dr A.A. Bin Shakar (United Arab Emirates), Ms A. Blackwood (alternate to Mr J. Garcia, United States of America)

2. Standing Committee on Nongovernmental Organizations

Dr Ren Minghui (China), Dr A.J. Mohamed (Oman), Mr C. Vallejos (Peru), Dr J.M. de Carvalho (Sao Tome and Principe), Dr B. Voljč (Slovenia)

Meeting of 20 January 2009: Dr Ren Minghui (China), Dr A.J. Mohamed (Oman), Mr C. Vallejos (Peru), Dr J.M. de Carvalho (Sao Tome and Principe), Dr B. Voljč (Slovenia)

3. Léon Bernard Foundation Selection Panel

The Chairman of the Executive Board, Vice-Chairmen of the Executive Board, member of the Executive Board from a Member State of WHO Eastern Mediterranean Region.

Meeting of 21 January 2009: Mr N.S. de Silva (Sri Lanka, Chairman), Mr C. Vallejos (Peru, Vice-Chairman), Sir Liam Donaldson (United Kingdom of Great Britain and Northern Ireland, Vice-Chairman)

4. Jacques Parisot Foundation Selection Panel

The Chairman of the Executive Board, Vice-Chairmen of the Executive Board, member of the Executive Board from a Member State of WHO European Region

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.

Meeting of 21 January 2009: Mr N.S. de Silva (Sri Lanka, Chairman), Mr C. Vallejos (Peru, Vice-Chairman), Sir Liam Donaldson (United Kingdom of Great Britain and Northern Ireland, Vice-Chairman)

5. Ihsan Dogramaci Family Health Foundation Selection Panel

The Chairman of the Executive Board, a representative of the International Children's Centre, Ankara and the President of Bilkent University or his or her appointee.

Meeting of 21 January 2009: Mr N.S. de Silva (Sri Lanka, Chairman), Professor P.L. Erdogan (appointee of Professor I. Dogramaci, President of Bilkent University) and Professor T. Türmen (Representative of the International Children's Center, Ankara)

6. Sasakawa Health Prize Selection Panel

The Chairman of the Executive Board, a representative of the founder, and a member of the Executive Board.

Meeting of 22 January 2009: Mr N.S. de Silva (Sri Lanka, Chairman), Professor K. Kiikuni (representative of the founder), Professor Sohn Myong-sei (Republic of Korea)

7. United Arab Emirates Health Foundation Selection Panel

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

Meeting of 20 January 2009: Mr N.S. de Silva (Sri Lanka, Chairman) Mr N.K. Al Budoor (representative of the founder), Dr H. Abdesselem (Tunisia)

8. State of Kuwait Health Promotion Foundation Selection Panel

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

Meeting of 20 January 2009: Mr N.S. de Silva (Sri Lanka, Chairman), Mr N. Naman (representative of the founder), Dr A.A. Bin Shakar (United Arab Emirates)

9. Dr LEE Jong-wook Memorial Prize Selection Panel

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

Meeting of 22 January 2009: Mr N.S. de Silva (Sri Lanka, Chairman), Dr Jong-wha Park (representative of the founder), Ms P.T. Toelupe (alternate to Mrs G.A. Gidlow, Tonga)

SUMMARY RECORDS

FIRST MEETING

Monday, 19 January 2009, at 14:10

Chairman: Mr N.S. DE SILVA (Sri Lanka)

1. OPENING OF THE SESSION AND ADOPTION OF THE AGENDA: Item 1 of the Provisional agenda (Documents EB124/1 and EB124/1 (annotated))

The CHAIRMAN declared open the 124th session of the Executive Board and welcomed four new members: Professor Haque (Bangladesh), Dr Kamoto (Malawi), Mr Ould Siyam (Mauritania) and Dr Dos Ramos (Sao Tome and Principe). He said that the African Region had proposed that Mr Touré (Mali) be elected as Vice-Chairman, replacing Mr Ould Khilil (Mauritania), and the Western Pacific Region had proposed that Dr Ren Minghui (China) be elected as Rapporteur, replacing Mr Cunliffe (New Zealand). He would take it that, in the absence of any objection, the Board wished to approve those proposals.

It was so agreed.

The CHAIRMAN, turning to the provisional agenda, said that, further to the items that the officers of the Board had proposed to defer or exclude (as listed in document EB124/1 (annotated)), some other items might have to be deferred. He drew attention to document EB124/1 Add.1, containing a proposal by Tunisia to include, under Rule 10 of the Rules of Procedure of the Executive Board, a supplementary agenda item entitled "Discussion of the health situation in the Gaza Strip"; and to the request by several Board members to include an item on the election of the Director-General of the World Health Organization, which the officers of the Board had already proposed for the provisional agenda of the Sixty-second World Health Assembly. He understood, however, that several members of the Board wanted to discuss the latter item at the current session.

Mr STORELLA (alternate to Dr Wright, United States of America) could not support an additional item on the election of the Director-General because the process would involve electing a candidate on the basis of regional rotation, rather than on merit, and therefore would never achieve consensus.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) expressed agreement with the previous speaker.

Dr KAMOTO (Malawi) agreed that the proposed item on election should not be included in the Board's agenda provided that it was discussed at the Sixty-second World Health Assembly.

Dr KÖKÉNY (Hungary) agreed with the member for the United States of America on the issue of the election of the Director-General. He said that the agenda was too full to discuss traditional medicine as a separate item and suggested that it be considered under item 4.5, Primary health care, including health system strengthening.

The CHAIRMAN said that, in the light of the views expressed, consideration of the election of the Director-General should be deferred to the Sixty-second World Health Assembly.

It was so decided.

Dr REN Minghui (China), supported by Dr DJIBO (Niger) and referring to the WHO Congress on Traditional Medicine held in Beijing in November 2008, proposed that the Board consider the role of traditional medicine, either as a separate agenda item or under item 4.5 on primary health care. He nevertheless agreed with the member for Hungary that the latter option was preferable since there were already too many items on the agenda.

Mr CAMPOS (alternate to Dr Buss, Brazil) expressed concern that discussing traditional medicine under item 4.5 might detract from the matter of primary health care.

The CHAIRMAN said that, with cooperation, time would be found. In the absence of any further objection, he would assume that it was agreed to consider the subject of traditional medicine under item 4.5.

It was so agreed.

Dr REN Minghui (China) opposed the inclusion of the subjects of food safety and the International Food Safety Authorities Network under item 4.2, International Health Regulations (2005). Whereas the Network was a mechanism for providing technical services, food safety was sufficiently important to warrant separate consideration during the session.

In response to an enquiry from the CHAIRMAN and a request for clarification from the DIRECTOR-GENERAL, he said that, if members agreed that the agenda was too crowded, it would be better to discuss the International Health Regulations (2005) alone, without consideration of the International Food Safety Authorities Network. If the Board wanted to discuss food safety, there should be a separate agenda item. His proposal was to keep item 4.2, but without consideration of the Network.

It was so decided.

The CHAIRMAN took it that the Board wished to approve the proposed additions of a new agenda item on the health situation in the Gaza Strip and to adopt the agenda, as amended.

It was so decided.

Given the urgency of the health situation in the Gaza Strip, the CHAIRMAN, supported by Mr MIGUIL (Djibouti) who spoke on behalf of the Member States of the Eastern Mediterranean Region, proposed that the matter be taken up as one of the first items under agenda item 4 at the beginning of the following afternoon's meeting.

It was so agreed.

The CHAIRMAN, cautioning that evening meetings might be needed and time limits imposed on speakers in order to close the current session by 27 January 2009, informed the Board that, in compliance with Rule 7 of the Rules of Procedure of the Executive Board, items 7.1 and 7.2 on appointments of Regional Directors would be considered in an open meeting. In view of the importance of item 5.2 on the Medium-term strategic plan 2008–2013 and the Proposed programme

budget 2010–2011, he proposed that the debate should begin on Thursday morning regardless of progress on item 4.

It was so agreed.

2. ORGANIZATION OF WORK

The CHAIRMAN drew attention to the preliminary timetable contained in document EB124/DIV/2 and said that, in the absence of Mrs Gidlow, who was the Board member for Samoa and had been nominated to sit on the Dr LEE Jong-wook Memorial Prize Selection Panel, one of her alternates would sit on the Selection Panel on her behalf. He took it that that arrangement, and the schedule of meetings, were acceptable to the Board.

It was so agreed.

3. REPORT BY THE DIRECTOR-GENERAL: Item 2 of the Agenda (Document EB124/2)

The DIRECTOR-GENERAL, after welcoming the newly appointed Executive Director of UNAIDS, Mr Sidibe, and the new Director of IARC, Dr Wild, presented her report, which highlighted, inter alia, health action in crises. Crises such as the cholera epidemics occurring in the Democratic Republic of the Congo and Zimbabwe emphasized the need to strengthen health systems. The current humanitarian crisis in the Gaza Strip created the conditions for disease. Epidemics, disasters and conflicts recalled the primary purpose of public health: to protect populations from harm, whether from the microbial world, human behaviour or the environment. The items before the Board addressed the basics of public health: prevention, protection and equity. They also underscored the importance of good governance in public health. She expressed hope that the health sector would continue to demonstrate what good governance could mean, especially in crises.

Dr KÖKÉNY (Hungary), speaking on behalf of the Member States of the European Union, said that, despite the global financial crisis, all countries should strengthen their health systems. Investments therein were fundamental to human welfare. Referring to the threat posed by infectious diseases, he said that the surveillance mechanism connecting national and international institutions should be enhanced through on-line services and the sharing of information. He welcomed the progress towards a Pandemic Influenza Preparedness Framework and the strengthening of the global influenza surveillance network. The Secretariat and national programmes that dealt with antimicrobial resistance were important elements in the fight against infectious diseases. The European Union supported WHO's immunization initiatives and was assisting developing countries through the Global Fund to Fight AIDS, Malaria and Tuberculosis, the GAVI Alliance and the African Malaria Network Trust.

Progress had been made, but, achieving the health-related Millennium Development Goals could not be achieved without reducing health inequities, especially in respect of HIV/AIDS, malaria and tuberculosis, and maternal mortality. He expressed concern about the slow progress towards Goal 5; that called for a stronger role for WHO. The related work of the Commission on Social Determinants of Health was invaluable.

He welcomed WHO's initiatives on preventing the adverse health effects of climate change. Health systems must be strengthened in order to deal with environmental risks. In health research, the draft WHO strategy should be more ambitious with respect to content and guidance. A proactive research agenda should be elaborated by 2010.

WHO's activities against counterfeiting of medical products, including the International Medical Products Anti-Counterfeit Taskforce, were of the utmost importance. He also emphasized the revision of the WHO Guiding Principles on Human Organ Transplantation.

On the Proposed programme budget 2010–2011 and the draft amended Medium-term strategic plan 2008–2013, he emphasized consolidated budget levels; increased implementation capacity; reducing the accumulated carry-over; and partnerships in the financing of WHO's activities.

He expressed grave concern about the health situation and the suffering of civilians in the Gaza Strip and urged the parties to respect international humanitarian law. Israel should grant immediate and secure passage of humanitarian aid, including food, urgent medical supplies and fuel. Safe evacuation of the injured and access of humanitarian aid workers must be allowed. The European Union fully supported all WHO activities aimed at improving the health conditions of the Palestinian people.

The health crisis in Zimbabwe threatened health security in southern Africa. The number of confirmed cases of cholera, and the death toll, continued to rise. The European Union commended the work of WHO and the rest of the United Nations system to alleviate the suffering of the Zimbabwean people.

Mr TOURÉ (Mali), speaking on behalf of the Member States of the African Region, recalled the Director-General's inaugural address, the emphasis she placed on improving the health status of the African people and her priorities, such as reduced maternal, neonatal and infant mortality. He thanked WHO warmly for that commitment while emphasizing the African Region's need for further efforts. Significant events in the African Region in 2008 had included: the adoption in April of the Ouagadougou Declaration on Primary Health Care and Health Systems on accelerating progress towards the Millennium Development Goals; in August, the Libreville Declaration on Health and Environment, to reduce environmental risks to public health; and in June, the Algiers Declaration on Health Research in the African Region, to strengthen health research, information systems and knowledge management. In November, the Bamako Call to Action had been adopted during the Global Ministerial Forum on Research for Health and would lead towards strategies for improved management of health research. African countries hoped that the Secretariat would approve and oversee the implementation of the Bamako Call to Action, and asked about plans in that respect.

The Director-General had described major challenges for the African Region, with rabies, cholera, meningitis, dengue fever and yellow fever, and with epidemics of Ebola virus haemorrhagic fever in the Democratic Republic of Congo. The risk of transmission of wild poliovirus continued in Nigeria, and the spread of virus to neighbouring countries threatened progress towards the eradication of poliomyelitis. Maternal and infant mortality, and a high prevalence of malaria, HIV/AIDS and tuberculosis, all challenged health systems.

Strengthened information systems were essential in order to measure progress reliably. The crises affecting human resources for health and the global financial situation could only be overcome by international solidarity. Violence and accidents would cause the deaths of a large number of children. If national health systems could respond more effectively, the health-related Millennium Development Goals in the African Region might still be attained by 2015.

Health ministers who had met in Ouagadougou in April 2008 had agreed on the widest participation in the strengthening of primary health care. The Declaration had also emphasized: financing of health-care; availability of low-cost medicines; and strengthened training and health systems. He called on development partners to join with the countries concerned in order to prioritize progress in those areas listed in the Declaration.

Professor HAQUE (Bangladesh) welcomed the enhanced transparency and accountability in the Secretariat's activities and reporting, in particular the progress indicators used to evaluate the achievements of the Medium-term strategic plan 2008–2013, and the Proposed programme budget 2010–2011. Carrying over funds from one biennium to another was understandable, and might ensure the continuity of programmes, but Member States should cooperate with the Secretariat in order that

funds could be more evenly absorbed and utilized. It was unfair to attribute sole responsibility for under-performance to the Secretariat.

Funds should be apportioned across the strategic objectives equitably, and funds under strategic objectives 1 and 2 should be rationalized by giving increased weight to strategic objective 4. Bangladesh expected to attain most of the health-related Millennium Development Goals; however, even with intensified neonatal and prenatal care, rates of maternal mortality were unlikely to be reduced without sustained support from WHO.

Funds could be earmarked under three segments in the Proposed programme budget 2010–2011: WHO programmes; partnerships and collaborative arrangements; and crisis response, notably in cases such as avian influenza and cholera epidemics, or chemical contamination of food.

Building sustainable capacity would help to mitigate the impact of crises; the Secretariat could increase access by developing countries to innovations and technologies. His country's research on cholera and cholera vaccines would benefit from WHO's technical assistance, and affordable vaccines would benefit all developing countries.

The Organization should enhance its programmes on climate change and natural disaster mitigation, and the ensuing health challenges. Solutions were needed to problems associated with human organ and tissue transplantation, and also to counterfeit medicines.

He expressed grave concern regarding the humanitarian situation in the Gaza Strip, notably the targeting of medical installations and health services and the denial of access to humanitarian and medical supplies. Within the context of rehabilitation and reconstruction, WHO would be called upon to address health needs. He therefore urged the Director-General and the international community to begin mobilizing the resources required.

Dr REN Minghui (China) drew attention to challenges affecting public health, including global warming, environmental degradation, emerging communicable diseases, food safety, noncommunicable diseases and the global financial crisis. WHO would play an increasingly important role in developing the partnerships necessary to meet those challenges, including those for health systems.

The year 2008 had been exceptional for China. It had coped with the earthquake in Sichuan, with problems arising from contaminated milk, and was currently reforming its health system. He thanked WHO and donors who had provided financial, technical and moral support.

Referring specifically to *The world health report 2008*¹ and the final report of the Commission for Social Determinants of Health,² he said that many countries would not be able to cope with public health emergencies without multifactoral cooperation, effective reporting and surveillance systems, sound health delivery, and monitoring mechanisms. In 2009, his Government, in strengthening its cooperation with WHO and partners, would be organizing a conference on countries with a high burden of drug-resistant tuberculosis. On 3 and 4 April 2009, an international symposium on disaster management would also be held jointly with WHO, a forum for strengthening international cooperation, exchanging information and enhancing national capacities.

Professor SOHN Myong-sei (Republic of Korea) congratulated WHO on its efforts, notably in confronting pandemic influenza; climate change and health; HIV/AIDS and mental health; and prevention of avoidable blindness and visual impairment. He welcomed the Organization's expanding role in setting norms and standards including its work with the international recruitment of health personnel; counterfeit medical products; human organ and tissue transplantation; the Codex Alimentarius; the International Statistical Classification of Diseases and Related Health Problems; and

¹ *The world health report 2008: Primary health care – now more than ever*. Geneva, World Health Organization.

² World Health Organization, Commission for Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health*. Geneva, World Health Organization, 2008.

the Model List of Essential Medicines. Through the International Health Regulations (2005) and the WHO Framework Convention on Tobacco Control, the Organization had also fulfilled its role as an international law-making body. Its guidelines must continue to address future legal conflicts and cross-cultural clashes. It must provide the necessary oversight in order to prevent, inter alia, the trafficking of human organs and transplant tourism.

In the light of the world's current financial problems, an increase in assessed contributions would be justified in order to accommodate volatile currency markets. Although it was important to respect budgetary discipline, more flexible funding through core voluntary contributions would be required in order to enhance WHO's efficiency and responsiveness.

(For resumption of the discussion, see section 5 below.)

4. ORGANIZATION OF WORK (resumed)

Dr KÖKÉNY (Hungary), speaking on behalf of the Member States of the European Union, said that the European Community and the European Commission worked widely and closely with WHO. Under Rule 4 of the Board's Rules of Procedure, representatives of intergovernmental organizations were not automatically invited to participate in the work of subcommittees or other subdivisions of the Board, such as drafting groups and working groups. He requested that, as at previous sessions,¹ the European Commission should be invited to participate without vote in the meetings of subcommittees of the Board that addressed matters falling within the Community's competence, in particular agenda items 4.1 to 4.15.

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

It was so agreed.

5. REPORT BY THE DIRECTOR-GENERAL: Item 2 of the Agenda (Document EB124/2) (resumed)

Mrs NYAGURA (Zimbabwe)² said that her country was currently grappling with a cholera outbreak which had claimed more than 2000 lives and affected more than 40 000 persons. Her Government was cooperating closely with WHO, the international community, international and nongovernmental organizations, while also seeking long-term solutions to the underlying causes. She thanked the Regional Office for Africa, whose swift response had led to the establishment of the Cholera Command and Control Centre in Zimbabwe, and the international community for the human and material resources that Zimbabwe continued to receive.

Dr DROPPERS (Office International des Epizooties, OIE) said that, in 2005 OIE and FAO had established a network of expertise on avian influenza in order to support early development of human pandemic vaccines. WHO, FAO and OIE also cooperated through the Global Early Warning and Response System for Major Animal Diseases, including Zoonoses. The earlier that zoonoses could be

¹ See, for example, document EB122/2008/REC/2, summary record of the first meeting, section 1.

² Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

detected, the earlier action could be taken. He drew attention to the “One World, One Health” concept, developed by WHO and OIE, among others, and to WHO-OIE cooperation on antimicrobial resistance. A proposed amendment of the WHO-OIE agreement, adding a new Article 4.7, would remove the last legal obstacle to joint work on Codex Alimentarius food safety standards.

The Board noted the report.

6. REPORT OF THE PROGRAMME, BUDGET AND ADMINISTRATION COMMITTEE OF THE EXECUTIVE BOARD: Item 3 of the Agenda (Document EB124/3)

Dr DAHL-REGIS (Bahamas), speaking in her capacity as Chairman of the Programme, Budget and Administration Committee, summarized the findings of the report. She drew attention to recommendations on issues considered by the Committee but that were not on the Board’s agenda. Those included progress on WHO’s management reforms, including the Global Management System and staff security; the Programme budget 2008–2009; the report of the Office of Internal Oversight Services; implementation of the external and internal audit recommendations; the establishment of an oversight advisory committee, made up of independent experts; and the reports of the Joint Inspection Unit. She would report the Committee’s discussion of items on the Board’s agenda as those items were taken up.

Dr KAMOTO (Malawi), speaking on behalf of the Member States of the African Region, welcomed progress in the implementation of the Global Management System. She also welcomed the Secretariat’s declared intention to improve staff security, but expressed concern that, largely because of a lack of funds, WHO was only 60% compliant with the United Nations Minimum Operating Security Standards.

She was pleased that the insufficient budget allocation to strategic objectives 4, 7 and 9, which were crucial to attaining the Millennium Development Goals in the Region, would be reviewed and that the Proposed programme budget 2010–2011 would be adjusted accordingly before its submission to the Health Assembly. She commended the transparent budget and the appropriate checks and balances; the proposal to introduce an independent expert oversight advisory committee; the draft guidelines on partnerships, with the provision for the Board to consider any future WHO-hosted partnership. If endorsed, the Proposed programme budget 2010–2011 would clearly track partnership and collaborative arrangements. She called on WHO to support strong coordination between partnerships and national health systems, in line with the Paris Declaration on Aid Effectiveness.

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

Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits: Item 4.1 of the Agenda (Documents EB124/4 and EB124/4 Add.1)

The CHAIRMAN drew attention to the report on the resumed Intergovernmental Meeting on Pandemic Influenza Preparedness contained in document EB124/4 Add.1. The Intergovernmental Meeting intended to complete its mandate in a further resumed meeting in May 2009, in connection with the Sixty-second World Health Assembly.

Dr MOHAMED (Oman), speaking on behalf of the Member States in the Eastern Mediterranean Region, welcomed implementation of resolution WHA60.28; the Region would provide any necessary data. He called on the Director-General to assist in guaranteeing equitable and affordable access to the international vaccine stockpile. The Region favoured option 1 arrangements, analogous to those relating to WHO stockpiles of yellow fever and meningitis vaccines. He also called for increased WHO cooperation on the issue with FAO and other organizations at all levels.

The interface between animals and humans, and the health of wild animals and pets, were increasingly affecting health and the economy. The concept of “One World, One Health” was basic to combating H5N1 infection and to promoting preparedness for pandemic influenza.

The Intergovernmental Meeting required further work, in particular with regard to distribution of, and access to, vaccines. Reaching consensus was the only solution that would allow proper use of the stockpile by all. Poorer countries, or those countries that had already been affected by the H5N1 virus, should not be ignored; problems must be tackled in a spirit of partnership. Virus samples should be exchanged in a way that would circumvent risk. Equitable access to data and knowledge would be required if both influenza and other pandemics were to be avoided.

Dr KÖKÉNY (Hungary) said that he was speaking on behalf of the Member States of the European Union; the candidate countries Croatia, Turkey and The former Yugoslav Republic of Macedonia; the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro, Serbia, as well as Ukraine and Armenia.

The European Union emphasized WHO’s global leadership in pandemic influenza preparedness, and supported the work of the Intergovernmental Meeting, including the planned informal consultations. It called upon all Member States to commit to sharing influenza viruses in accordance with the International Health Regulations (2005). The Intergovernmental Meeting in December 2008 had provided guidance for the Director-General and for Member States. Steady progress was essential in order to submit a solution for consideration by the Sixty-second World Health Assembly.

The current functions of the Global Influenza Surveillance Network and national influenza reference laboratories should be retained. The terms of reference of national influenza centres, WHO collaborating centres on influenza, WHO H5 reference laboratories, and regulatory laboratories should all be clearly defined. The European Union remained strongly committed to influenza pandemic preparedness; to a more equitable and efficient system of virus-sharing; and access to vaccines and other benefits.

Dr REN Minghui (China) commended the Secretariat’s improvement of the influenza virus traceability mechanism; increased accountability in tracking the H5N1 virus worldwide; and facilitation of the use of virus information. He welcomed the creation of the Advisory Mechanism to facilitate the sharing of viruses and benefits. The international stockpile of vaccines would promote trust and accelerate virus sharing. China would continue to monitor and share influenza viruses, consistent with international treaties and national legislation. He emphasized the public health and economic benefits of sharing viruses, and of accessible and affordable vaccines and antiviral medicines. He called on the Secretariat to actively build consensus within the Intergovernmental Meeting, which was progressing slowly, in order to reach agreement before the next Health Assembly.

Dr WRIGHT (United States of America) said that information about influenza viruses with pandemic potential must be rapidly and transparently shared. Timely access to epidemiological data and clinical specimens was crucial for global health security. The Global Influenza Surveillance Network had worked well for decades, and should only be changed with caution. He supported the Intergovernmental Meeting process aimed at reaching consensus on virus sharing, ideally by the next Health Assembly. In the meantime, he called upon all Member States to continue to share influenza viruses. Failure to do so, or to report human cases of H5N1 influenza, would threaten global health

security and run counter to the spirit of the International Health Regulations (2005). His country would cooperate with other Member States towards the next Intergovernmental Meeting. He called upon the Secretariat and the WHO Strategic Advisory Group of Experts on Immunization to work with the relevant organizations in order to estimate international capacity for vaccine manufacturing and to evaluate options for an international stockpile of vaccines.

Dr SUPARI (Indonesia) said that the Intergovernmental Meeting at its resumed session in December 2008 had agreed to the use of a Standard Material Transfer Agreement for the transfer of avian influenza viruses and other viruses with human pandemic potential; to integrate benefit sharing into that agreement; and to consider benefit sharing and virus sharing as equally important. Her Government would work towards agreement on the outstanding issues before the session resumed again in May 2009.

Dr DJIBO (Niger), speaking on behalf of the Member States of the African Region, said that eight African countries had reported cases of avian influenza as of December 2008. His own country had brought under control its two outbreaks in 2006 and strengthened laboratory capacity for diagnosis.

In July 2007, four African countries had participated in the meeting of the Interdisciplinary Working Group on Pandemic Influenza Preparedness (Singapore, 31 July to 4 August 2007). The African Region had adopted a tracking mechanism to monitor all exchanges of H5N1 viruses and other viruses with human pandemic potential.

Nigeria had represented the Region in the Intergovernmental Meeting in November 2007. Ghana and Senegal had taken part in the Technical Consultation on the Development of a WHO Influenza Virus Traceability Mechanism in September 2008. The Regional Office had collected data from Member States for use in determining the composition of influenza vaccines and to identify financing for vaccine procurement.

Challenges included access to resources for national action plans against human and animal influenza and building national capacity for detection, risk assessment, laboratory confirmation and containment of the virus. Further challenges included equitable access by all countries to antiviral drugs and to any future vaccine, and the transfer of vaccine manufacturing technology.

Professor HAQUE (Bangladesh) said that vulnerable countries and those already affected by avian influenza should be given priority access to vaccines and other benefits. One human case of infection with H5N1 influenza virus had been reported in his country in 2008. A national influenza centre had been established with a polymerized chain reaction laboratory for the detection of the H5N1 virus. According to WHO guidelines, Bangladesh was in a pandemic alert phase, perceived as a threat by the poultry industry in his country. It was not clear how long the Government should wait, in the economic interests of the country, before downgrading the state of alert.

Mrs MIKHAILOVA (alternate to Dr Starodubov, Russian Federation) commended the progress made by the Intergovernmental Meeting in December 2008. However, the benefit-sharing system and the establishment of an international stockpile of vaccines required further consultation. Her country had technology for the manufacture of influenza vaccines and might supply vaccines to neighbouring countries. For the present, the Russian Federation did not intend to stockpile vaccines, but would begin manufacturing them after identifying any pandemic strains that emerged in the future. As part of the country's preparedness activities, the State Research Centre of Virology and Biotechnology (VECTOR) would operate as a WHO Collaborating Centre. It would train specialists from the Commonwealth of Independent States; conduct external assessments of the work of virology laboratories; and investigate the emergence of influenza virus strains in the Russian Federation and neighbouring countries.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) noted that the conventional approach to an influenza pandemic was to isolate the virus responsible and produce a vaccine, which took at least several months. A future pandemic might be caused by a virus related to the H5N1 subtype, in which case vaccines derived from that subtype would have some protective effect. However, they might be caused by a completely different subtype, rendering any stocks of H5N1 vaccine useless. Cellular immunity was a promising field of vaccine research. That could lead to a broad-spectrum vaccine that could be administered in advance of a pandemic and would protect against a number of subtypes of the influenza virus. He sought the Secretariat's views on the potential of such pluripotent vaccines.

Dr GIMENÉZ CABALLERO (Paraguay) said that the report should have given information on international funding for pandemic influenza preparedness activities, with details of expenditure in the countries at greatest risk and with weaknesses in their monitoring, laboratory capacity and health services. The report should also have suggested strategies to address those weaknesses.

Dr KWON Jun-wook (alternate to Professor Sohn Myong-sei, Republic of Korea) said that, if an influenza virus with pandemic potential should emerge, a procedure for sharing the virus should be launched immediately. However, a fair and transparent mechanism for the use of the virus strain must be ensured. A strain of H1N1 influenza A virus that was resistant to oseltamivir had been reported in Europe, the Americas and his own country. He called upon WHO to provide guidance on the stockpiling of oseltamivir and on measures to deal with drug resistance.

Dr HEYMANN (Assistant Director-General) stated that the H5N1 virus still occasionally caused human influenza infections and the threat of a pandemic remained at level 3 on the WHO pandemic scale, meaning the virus could infect humans and, in a limited number of cases, could spread to other humans. The H7 and H9 avian influenza viruses could also infect humans and were considered to have pandemic potential. A broad-spectrum vaccine therefore remained the ideal as it could be used to mitigate or prevent a pandemic. Research groups were working on such a vaccine but no human clinical trials had yet been conducted.

WHO would continue its activities in both virus sharing and benefit sharing, which included: developing a transparent traceability mechanism; stockpiling vaccines for the H5N1 virus; transferring vaccine production capacity to industries in developing countries; enlarging the WHO collaborating centre; widening networks for national influenza centres; and working with the GAVI Alliance and other mechanisms in order to procure pandemic vaccines. WHO would also continue with risk analysis: examining the patterns of resistance of viruses to antiviral agents; and studying virus strains that would be most appropriate for inclusion in vaccines.

The CHAIRMAN took it that the Board wished to take note of the report on pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits.

The Board noted the report.

Implementation of the International Health Regulations (2005): Item 4.2 of the Agenda (Document EB124/5)

Dr WRIGHT (United States of America) expressed his country's support for the efforts to revise the International Health Regulations (2005); they were essential to surveillance, reporting, and response to global outbreaks of disease.

The Secretariat must help Member States to develop the capacities needed and to implement the Regulations. Member States should fulfil their obligations by transparently sharing information on outbreaks of diseases, such as the H5N1 avian influenza virus strain. Withholding such data would

contravene the spirit of the Regulations and could threaten global health security. His country would share its valuable experience in implementing the Regulations with its international partners.

Mr TOURÉ (Mali), speaking on behalf of the Member States of the African Region, said that they had applied the International Health Regulations (2005) within the context of the Region's strategy for integrated disease surveillance and response. All Member States had established national focal points with updated information; 35 Member States had trained personnel to access the WHO web pages on event management for international public health security and 42 countries had reported to the Sixty-first World Health Assembly. In 2007, the Regional Office had organized information sessions for national focal points and staff responsible for disease prevention in the country offices. National plans for implementing the Regulations had included: advocacy; mobilization of resources and evaluation of national surveillance systems; laboratory networks; and building capacity in order to deal with international public health events.

WHO country representatives had trained online on the International Health Regulations (2005) which had been incorporated into the technical guidelines. The Regional Office had also organized workshops and assisted countries in their evaluation of those capacities. Implementation of the Regulations would require resources, strengthened capacity, government commitment and intersectoral collaboration.

Dr REN Minghui (China) said that China had reported on implementation of the International Health Regulations (2005) in 2008. It had invested in the infrastructure, training and coordination between sectors; informed the Organization of public health emergencies; and collaborated with neighbouring Member States in the implementation of the Regulations.

He looked forward to the continued functioning of WHO networks such as the Global Outbreak Alert and Response Network; analysis by WHO of the public health emergencies that were of global concern; the establishment of a database with guidelines and training manuals based on case analysis.

WHO should take into account the levels of resources and capacity in each country when developing indicators in respect of surveillance and response, as set out in Annex 1 to the Regulations. Contracting Parties should be surveyed by WHO and plans thus adapted to local conditions.

Mrs PAKSINA (alternate to Dr Starodubov, Russian Federation) said that implementing the Regulations was a priority in her country where the Consumer and Health Protection Agency was the national coordinator. National legislation had been harmonized, providing a basis for training officials; laboratory services, together with sanitary and quarantine control points, had all been strengthened.

However, Member States were obliged to report to WHO on extreme health situations that had an international impact and such reporting could give rise to issues of confidentiality. A regular review of information was needed by WHO on instances of real or potential international impact on health, such as outbreaks of communicable diseases.

She emphasized exchange of information between the Secretariat and Member States concerning sanitary and health risks resulting from radioactive materials and waste, and on biological and chemical substances. The Secretariat should standardize both the certification of international transportation of such substances and the checks on how such certification was issued. The Russian Federation was ready to participate in preparing such a document.

International standards and research laboratories were needed in all Member States. The training of national officials should be prioritized in accordance with a universal WHO programme.

Dr BIN SHAKAR (United Arab Emirates), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that all countries within the Region had been implementing the Regulations, establishing focal points and border crossings, within the timeframe set.

The Region called on WHO to provide the technical support needed by Member States to assess their implementation of the Regulations. Guidelines were needed in order to assess staff training, and understanding of the Regulations.

Approval of the Regulations had led to a rise in the number of crises reported; WHO should support the establishment of further collaborating centres and certified laboratories.

Training was expensive and exceeded the capacities of Member States. The Secretariat was urged to develop finance mechanisms that would support the implementation of the Regulations, improve traceability and early detection of outbreaks.

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union, emphasized the role of WHO in promoting partnerships between Member States and relevant partners. The WHO Lyon Office for National Epidemic Preparedness and Response was furthering that important work. Resources had been mobilized within the European Union in order to implement the Regulations and those challenges had been discussed.

The European Union was committed to the Regulations, a cornerstone for global health security, and to support for WHO activities which furthered their implementation.

Dr HEYMANN (Assistant Director-General) said that relevant activities would continue within WHO in order to implement the Regulations and broaden the coverage, to include infectious diseases, and coverage of chemical and nuclear disasters. Such activities would emphasize reporting, risk assessment and risk management. The Secretariat would continue to support Member States in strengthening and assessing their capacities; identify partners and resources; provide training and technical guidance.

The Board noted the report.

The meeting rose at 17:40.

SECOND MEETING

Tuesday, 20 January 2009, at 10:10

Chairman: Mr N.S. DE SILVA (Sri Lanka)

An open meeting was held from 09:00 to 10:05 and resumed in public session at 10:10.

1. STAFFING MATTERS: Item 8 of the Agenda

Appointment of the Regional Director for South-East Asia: Item 8.1 of the Agenda (Document EB124/28)

Dr REN Minghui (China), Rapporteur, read out the following resolution adopted by the Board in open session:¹

The Executive Board,
Considering the provisions of Article 52 of the Constitution of WHO;
Considering the nomination made by the Regional Committee for South-East Asia at its Sixty-first session,

1. REAPPOINTS Dr Samlee Plianbangchang as Regional Director for South-East Asia as from 1 March 2009;
2. AUTHORIZES the Director-General to issue a contract to Dr Samlee Plianbangchang for a period of five years from 1 March 2009, subject to the provisions of the Staff Regulations and Staff Rules.

The CHAIRMAN congratulated Dr Samlee Plianbangchang on his reappointment and conveyed the Board's best wishes for his continued success in the South-East Asia Region.

Dr SAMLEE PLIANBANGCHANG (Regional Director for South-East Asia) said that he was honoured to be reappointed as Regional Director and grateful to all who had placed their trust in him. He pledged to meet their high expectations, and looked forward to continued guidance and support from Member States, the Director-General and colleagues.

Since 2004, he had emphasized reduced inequities in health for the people of South-East Asia; promoted sustainable development, self-reliance in health, and availability of basic health services for all, especially the most vulnerable; and prioritized health in public policy. Tackling the remaining obstacles to achieving those goals would necessitate still closer collaboration between the Secretariat and Member States, including: greater and more decentralized resources to more countries; delegating greater authority to WHO country representatives; and enhancing the capacity of the Regional Office and country offices through training of national staff.

Despite considerable progress, South-East Asia still bore a high burden of diseases. Natural disasters and the effects of climate change were compounding that problem as would the effects of the global financial crisis.

¹ Resolution EB124.R1.

Through close collaboration with the Secretariat, Member States could overcome those challenges and meet the expectations of the people of South-East Asia, thereby confirming WHO's role as promoter of the world's health.

Dr JAYANTHA (Sri Lanka) and Professor HAQUE (Bangladesh) congratulated Dr Samlee Plianbangchang on his reappointment. They looked forward to working closely with him on health programmes in the Region.

The DIRECTOR-GENERAL congratulated Dr Samlee Plianbangchang on his reappointment and looked forward to their continued fruitful collaboration.

Appointment of the Regional Director for the Western Pacific: Item 8.2 of the Agenda
(Document EB124/29)

Dr REN Minghui (China), Rapporteur, read out the following resolution adopted by the Board in open session:¹

The Executive Board,
Considering the provisions of Article 52 of the Constitution of WHO;
Considering the nomination made by the Regional Committee for the Western Pacific at its Fifty-ninth session,

1. APPOINTS Dr Shin Young-soo as Regional Director for the Western Pacific as from 1 February 2009;
2. AUTHORIZES the Director-General to issue a contract to Dr Shin Young-soo for a period of five years from 1 February 2009, subject to the provisions of the Staff Regulations and Staff Rules;
3. AUTHORIZES the Director-General to amend the conditions of employment of Dr Shin Young-soo as follows: "you will not participate in the United Nations Joint Staff Pension Fund but will instead receive as a monthly supplement the contribution that the Organization would have paid each month to the Pension Fund had you been a participant."

The CHAIRMAN congratulated Dr Shin Young-soo on his appointment as Regional Director for the Western Pacific and conveyed the Board's best wishes for his success.

At the invitation of the CHAIRMAN, Dr SHIN Young-soo took the oath of office contained in Staff Regulation 1.10.

Dr SHIN Young-soo (Regional Director-Elect for the Western Pacific) said that he was deeply honoured to be appointed as Regional Director. He summarized key challenges for the public health sector and the crucial role for WHO: the global financial crisis, climate change, re-emerging diseases and the global epidemic in noncommunicable diseases.

As the first Regional Director of the Western Pacific Region to be elected from outside the Organization, he would look at the Organization's working methods with fresh eyes, build on its

¹ Resolution EB124.R2.

strengths, and create space for flexible responses to both the new and the traditional challenges to public health.

He expressed sincere appreciation to his predecessors as Regional Director, and pledged to build on their excellent leadership and achievements.

He would continue to consult with Member States and national leaders in order to find solutions to public health problems through collaboration, trust and mutual respect.

He outlined four priority areas in the Region: response to public health emergencies and risks; progress towards the health-related Millennium Development Goals through strengthened health infrastructure and workforce development; addressing the social, economic and political determinants of health in order to promote access and equity; and strong leadership within WHO.

He expressed profound gratitude to the Member States and the Board and said he would strive to repay the trust shown in him.

Expression of appreciation to Dr Shigeru Omi

Dr REN Minghui (China), Rapporteur, read out the following resolution adopted by the Board during the open session:¹

The Executive Board,

Desiring, on the occasion of the retirement of Dr Shigeru Omi as Regional Director for the Western Pacific, to express its appreciation of his services to the World Health Organization;

Mindful of his lifelong devotion to the cause of international health, and recalling especially his 10 years of service as Regional Director for the Western Pacific;

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

The DIRECTOR-GENERAL joined others in expressing her deepest appreciation and admiration to Dr Omi, for his years of outstanding leadership, exemplified by his skilful work that ranged from the study of the molecular biology of the hepatitis B virus to managing the outbreaks of severe acute respiratory syndrome and influenza H5N1 virus infections.

Dr Omi had initially joined WHO as the responsible officer for the Expanded Programme on Immunization and had spearheaded the regional drive to eradicate poliomyelitis, a goal achieved under his leadership. As Regional Director, he had prioritized tuberculosis control and currently countries in the Western Pacific surpassed the global targets for tuberculosis control. Recently, the Western Pacific had become the only region in which all Member States had ratified the WHO Framework Convention on Tobacco Control. Dr Omi's recognized contribution to public health was deeply appreciated.

She congratulated Dr Shin on his appointment and looked forward to continued excellent relations with the Western Pacific Region.

¹ Resolution EB124.R3.

Ms TOELUPE (Samoa), Ms ROCHE (New Zealand), Dr REN Minghui (China), Professor CHEW SUOK KAI (Singapore), Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) and Mr ISOMATA (Japan)¹ paid warm tribute to the achievements of Dr Omi during his two terms as Regional Director for the Western Pacific, highlighting his outstanding contribution to the global eradication of poliomyelitis. They wished Dr Omi every success for the future and congratulated Dr Shin on his appointment.

Mr HERZOG (Rotary International), speaking at the invitation of the CHAIRMAN, said that Dr Omi had become a founding member of the Polio Eradication Advocacy Task Force in the Western Pacific Region in 1990 when close to 6000 cases of poliomyelitis had been reported and around 60 000 cases suspected each year. He had played a critical role in convincing officials in China of the need to conduct national immunization days, begun in 1994, reaching more than 80 million children – an encouragement to other countries.

The Western Pacific Region had remained free of poliomyelitis thanks largely to the acute flaccid paralysis surveillance system developed there, a model for other regions. There were fewer cases of poliomyelitis in the entire world than there had been in China alone when Dr Omi had launched his efforts.

In recognition, he had pleasure in presenting Dr Omi with Rotary's Polio Eradication Champion Award.

Dr Omi was presented with the Polio Eradication Champion Award.

Dr OMI (Regional Director for the Western Pacific) thanked Board members and the Director-General for their kind words. He had been humbled by the Polio Eradication Champion Award, which he had received on behalf of all those who were working for the global eradication of poliomyelitis.

In 1990, many had questioned the feasibility of eradicating poliomyelitis: scarce funds for vaccines; populations scattered in remote areas; and peace and order issues in some countries had complicated the task further. The last indigenous case of poliomyelitis in the Region had been reported on 19 March 1997; three years later, the Western Pacific Region had been certified poliomyelitis-free.

Other tangible progress had been made in the Region in areas including tuberculosis, tobacco control, and the fight against severe acute respiratory syndrome. He was confident of WHO's continued success: the Executive Board provided clear direction, and the Director-General, the Regional Directors and WHO staff worked very hard to fulfil their mandate.

The international community had invested much time, energy and resources in the eradication of poliomyelitis globally, and nearly all countries in the world were poliomyelitis-free. Eradicating poliomyelitis in the four countries in which it remained endemic would be difficult, but the battle against poliomyelitis was one that the world could not afford to lose. He urged the international community to make that final forceful effort to eradicate the poliovirus.

His thanks went to the Director-General for having developed a strong sense of unity within the Organization, to fellow Regional Directors and dedicated WHO staff for their support.

Finally, he congratulated Dr Shin on his appointment and wished him every success in the future.

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

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

HIV/AIDS and mental health: Item 4.3 of the Agenda (Document EB124/6)

Dr GIMÉNEZ CABALLERO (Paraguay) said that the issue of HIV, in particular its relation to mental disorders arising from drug use, was a challenge for Member States. Society's response had led to a management approach based on intersectoral participation and consensus, on both minor and major matters, and involving sectors of the government, civil society, cooperating bodies and persons living with HIV. Such a response led towards universal access to integrated care based on human rights and non-discrimination. Health institutions must play a predominant role as regulators and makers of public policies intended to generate effective, national response to HIV/AIDS and other sexually transmitted infections.

Networks had to be created for prevention and for integrated care, and within that integrated approach the mental health aspect had perhaps been neglected. Such networks must share a vision within a strategic and operational plan for each country, with clear functions and responsibilities for the sectors and actors involved, including their financial commitments. Management by results was essential.

Paraguay had seen recent progress, particularly in the prevention of mother-to-child transmission of HIV; access to antiretroviral therapy; in the provision of prevention measures; and assistance to priority populations. Monitoring and health systems must be strengthened in order to ensure that the resources invested served their purpose.

Dr JAKSONS (Latvia) said that the issue of mental health would become increasingly important in the context of the economic crisis, with a possible increase in unhealthy behaviours and the use of mood-altering drugs. In prisons in particular, use of drugs, unsafe behaviours and mental disorders could encourage HIV transmission. He emphasized preventive measures: the early treatment of mental disorder, harm reduction and HIV testing.

Dr AHMADZAI (Afghanistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that harm reduction needed to be incorporated into all comprehensive packages of care for substance and alcohol abuse. The efforts of stakeholders must be harmonized in order to produce coherent messages and efficient responses.

He stressed broader mental health issues, beyond those of substance abuse, particularly in relation to persons living with HIV. He urged the Secretariat to advise countries on coordination strategies and mechanisms in order to integrate approaches to those conditions.

As prevalence rates of HIV infection in mentally ill patients were unrecorded in many developing countries, WHO should help to generate disaggregated data from those countries that could show which mental illnesses were most likely to occur and the contributing factors. Such evidence could then inform policies and programmes, and thus enable prioritizing and targeting of mental health disorders.

Dr DOS RAMOS (Sao Tome and Principe), speaking on behalf of the Member States of the African Region, said that sub-Saharan Africa was home to 67% of all people living with HIV. Infection with HIV exposed individuals and their immediate circle to the risk of psychological distress and mental disorder, which might lead to poverty, alcoholism, drug addiction or domestic violence. Other outcomes were a lack of social support, stigmatization and discrimination.

Conversely, mental disorders, including those related to the use of harmful substances, were risk factors for HIV. The link between compliance with antiretroviral therapy and mental health factors had been demonstrated: failure to follow treatment reduced its effectiveness and could also lead to the development of drug-resistant strains of HIV, disease progression into AIDS, and death.

Consequently, care for persons infected with HIV and suffering from mental disorders must combine the efforts of patients, their families, their communities and the health-care providers.

Within Africa, links between countries promoted the sharing of experience and knowledge about HIV/AIDS, in particular partnerships that linked nongovernmental organizations and civil society to medical support for persons infected with HIV or affected by HIV/AIDS. During its fifty-sixth session, the WHO Regional Committee for Africa had adopted a strategy to intensify HIV prevention in Africa, with extension of screening and counselling services and promotion of policies and laws based on human rights, taking age and gender into account and covering exposure to risky behaviours.

The Region proposed to reduce stigmatization and discrimination towards infected persons to the minimum; to increase antiretroviral treatment; to invest in prevention among sexually active persons; to reduce homophobia and stigmatization of people living with HIV/AIDS and suffering mental disorders; to promote behavioural change in the context of the HIV/AIDS epidemic and mental disorders; to promote participation by the patient's circle, community and civil society; to incorporate management of HIV/AIDS in mental health service; to research into HIV and mental health, and related effects on children, particularly orphans; to examine the problems of sero-discordant couples, in whom depression and suicidal tendencies had been diagnosed; and to strengthen mental health systems.

Professor HAQUE (Bangladesh) said that his country had a low prevalence of HIV infection, which was nevertheless rising among injecting drug users. In Bangladesh, the mental health aspect could be integrated into the care of HIV-positive patients. Problems related to drugs were largely handled by psychiatrists or clinical psychologists, who could identify mental disorders or detect people with HIV/AIDS suffering from mental problems and abusive behaviours. The relationship between HIV/AIDS and mental disturbance should enable specialists in both areas to pursue approaches to integrated treatment.

He recommended assessment of mental health and substance-use disorders; review of national strategies for HIV/AIDS in order to incorporate mental health care therein; training for service providers, including counselors, on mental health and substance use, using modules developed by WHO; combined antiretroviral and mental health therapies; establishment of referral mechanisms; and research into the interaction between HIV and mental disorders that would include service delivery and management models.

Ms MELNIKOVA (alternate to Dr Starodubov, Russian Federation) highlighted the relevance of the issues of HIV/AIDS and mental health for the Russian Federation. Patients with a triple diagnosis of HIV/AIDS, drug dependency and psychological disorders presented a challenge in the provision of health, social and psychological assistance. The disease-based approach was not always conducive to patients' compliance with treatment. That problem could be solved by an approach to prevention and treatment that integrated patients with their somatic, psychological, social and family situation. Patients should be involved in drawing up individual treatment plans that responded to their needs, an approach already being implemented in her country. Given the importance of counselling in preventing HIV infection and high-risk behaviours, she supported WHO's comprehensive approach, one that brought together HIV/AIDS services, mental health-care providers, and social services.

Dr ABABII (Republic of Moldova) said that the financial crisis could result in increased mental health problems. The incidence of both HIV infection and mental health problems was already rising in some eastern European countries, including his country. He highlighted the situation in Transnistria, where the rate of new cases of HIV infection registered (63.8 per 100 000 population) was five times higher than elsewhere in the Republic of Moldova.

In his country, medical treatment for patients with mental health problems was moving from a centralized to a community-based approach. Psychiatric hospitals saw cases of comorbidity with HIV:

8% of patients with drug or alcohol problems were also HIV-positive, and levels would rise unless preventive measures were taken. Such patients were often less aware of the threats from HIV infection. Preventive measures needed a developed network of community mental health centres in which family doctors participated. The Secretariat's report had set appropriate priorities.

He highlighted the growing number of patients with HIV infection and tuberculosis, particularly multidrug-resistant strains of *Mycobacterium tuberculosis*. Also of concern were extensively drug-resistant strains, which were present in many countries and should be a priority for WHO.

Dr DAHL-REGIS (Bahamas) welcomed the attention paid to comorbidities among those affected by HIV/AIDS and to data on injecting drug users. She agreed with the members for Paraguay and the Republic of Moldova on the need for the integration of health services. In her region there were relatively few drug-using HIV patients; most cases of HIV infection were the result of alcoholism and other risk behaviour. A major difficulty for those infected with HIV and needing mental health services was stigmatization. Social and environmental factors could be managed more effectively if HIV/AIDS treatment, care and support were integrated into a public health setting and with more trained personnel. Unfortunately, many programmes were developed vertically, probably because of funding arrangements.

Dr REN Minghui (China) welcomed the detailed report, which illustrated the importance of the links between HIV/AIDS and mental health. China had responded to problems relating to mental disorders, such as the despair and anxiety experienced when patients discovered their HIV infection, by strengthening the counselling services provided in its treatment centres.

In regard to injecting drug users, China's efforts were based on treatment in the community: 643 clinics had been approved in 2008 and some 1.7 million patients treated. His Government planned to strengthen counselling for those with HIV/AIDS. It was promoting research on the subject and looked forward to support from WHO in that regard.

Dr BUSS (Brazil) welcomed the report. The Brazilian programme to combat HIV/AIDS had focused on vulnerable groups. His country had developed strategies based on harm reduction among drug users which had had some success in preventing HIV infection. WHO should make the prequalification process for medicines more flexible so that countries could obtain products of quality more cheaply. It was important for national regulatory agencies to be strengthened and involved in the prequalification process. Brazil would support the tabling of a resolution on the subject for submission to the Health Assembly.

Mr VALLEJOS (Peru) agreed with the report. HIV/AIDS had devastating effects, and in his country it increasingly affected women and young people. Peru had responded to problems arising from mother-to-child transmission of HIV through standard-setting, assistance, education and communication. It had also drawn up a multisectoral strategic plan 2007–2011 to combat HIV/AIDS; approved a national plan to combat vertical transmission and congenital syphilis; and introduced a sixth round project of the Global Fund to Fight AIDS, Tuberculosis and Malaria on national prevention and control of sexually transmitted infections and HIV/AIDS. It had implemented a complete HIV package for pregnant women, attaining a coverage of 69%; and free antiretroviral treatment had been guaranteed to 8644 patients in the country.

Ms TOELUPE (Samoa) agreed with the report's linking of HIV/AIDS and mental health, drug dependence and use of alcohol. Samoa was reforming its health system, which had also led to greater involvement by civil society in HIV/AIDS prevention, education and mental health. The proper integration of mental health and HIV/AIDS services would require the use of WHO modules at regional and national levels as well as existing strategic plans. The training of professionals in clinical, counselling and mental health-care skills needed to continue. A Mental Health Act had been passed in 2007

and a mental health policy had been defined in 2008. Samoa continued to build capacity among health professionals and care providers in order to implement policy on HIV/AIDS prevention and control. Further research and evidence were needed on the links with mental disorders.

Samoa's progress owed much to WHO and to its development partners. In recognizing the relevance of international frameworks, such as the Convention on the Elimination of Discrimination against Women, and the Convention on the Rights of the Child, she emphasized the challenge of harmonizing and integrating programmes.

Dr WRIGHT (United States of America) said that mental disorders could increase risky behaviour as well as hinder HIV prevention. Paragraph 3 of the report identified injecting drug users as a risk group but did not articulate the connection with mental disorders. The report needed greater clarity and concrete recommendations in, for example, its discussion of mental health disorders and substance use, both of which could hinder healthy behaviour but concerned different populations. Similarly, paragraph 5 referred to "alcohol use disorders" and "alcohol consumption", although they were separate issues calling for different responses. The United States recognized the importance of adherence and counselling about adherence to HIV treatment. It supported increased research on interactions between mental illnesses and compliance in low- and middle-income countries, where contacts with the medical infrastructure were weaker. The data cited in the report were not drawn consistently from developing countries, making recommendations difficult. Paragraph 8 highlighted the effects of HIV on the central nervous system. His Government was a leader in clinical research and recommended further technical discussion, especially in regard to children receiving or not receiving antiretroviral treatment.

Dr ALVIÁREZ (Bolivarian Republic of Venezuela)¹ fully agreed with the report. Venezuela considered that the connection between mental health and HIV/AIDS was a public health priority. It had a strategy of information, education and communication aimed at young people and pregnant women; a programme for the provision of condoms; compulsory HIV screening for all pregnant women, and prophylactic treatment for those who tested positive; biosafety resources for health personnel; a programme of free distribution of antiretroviral medicines; and emphasis on the human rights of persons living with HIV/AIDS.

A great many HIV/AIDS patients received medicines for mental illnesses. The provision of such medicines was a matter of urgency, and flexibilities should be allowed with respect to any patents on them.

Mr NOLAN (European Commission) expressed his appreciation of the report, which addressed hitherto neglected linkages between HIV/AIDS and mental health. Mental health problems increased vulnerability to HIV and complicated treatment and support. The problems were exacerbated by drug and alcohol use. The Commission welcomed the attention paid to the psychological burden imposed by HIV/AIDS and to the direct effects of the virus on the central nervous system. It supported the integration of mental health into HIV/AIDS programmes, especially as the expansion of antiretroviral treatment had led to cuts in comprehensive care and support services. It was vital to provide such services and to integrate effectively the links between HIV/AIDS and mental health.

Dr ALWAN (Assistant Director-General) thanked members for their excellent contributions, which the Secretariat would take into account in future work. He welcomed the importance accorded by the member for Paraguay to a multisectoral, human approach involving government agencies and civil society. Reliable surveillance was also important to the prevention advocated in the report.

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

Regarding the comments by the member for Afghanistan, harm reduction was integral to the recommended approach and supported by scientific evidence and a consensus within the United Nations system. On the subject of training for primary health care professionals, WHO had produced a series of training modules and materials for the integration of mental health into antiretroviral therapy programmes, as well as training materials to help HIV counsellors to recognize and treat common mental disorders and substance abuse. Further research was needed, especially in regard to service delivery, cost-effectiveness and evaluation of interventions for mental and substance-use disorders in the context of HIV/AIDS. The member for the Republic of Moldova had raised the important issue of comorbidity. There was much evidence of non-compliance with both tuberculosis treatment and antiretroviral treatment among patients who also had mental disorders. He thanked the member for the United States for his comments and said that the Secretariat intended to develop concrete strategies in several areas relating to HIV and mental health in the coming months.

Dr NAKATANI (Assistant Director-General) said that, thanks to countries, civil society and health partners, HIV treatment coverage was expanding, but some important areas, such as the linkages between HIV and mental health and HIV-tuberculosis comorbidity, deserved greater attention. A comprehensive and integrated approach was needed. WHO was committed to working on such an approach with colleagues in the field of mental health and with partners in the United Nations system.

The DIRECTOR-GENERAL highlighted the complexity of the challenge of HIV comorbidity for the health sector. Policy coherence and an integrated approach at national level, for example between health ministries and ministries responsible for prisons, were essential in providing effective health services for HIV patients. The Secretariat would encourage and support Member States in building models for communities in order to tackle the multidimensional problems associated with HIV/AIDS. The views expressed by the Board had already given the Secretariat sufficient guidance for it to pursue its work on the issue without necessarily preparing a draft resolution to submit to the Health Assembly, which would expend time and resources that could be used elsewhere. Nevertheless, if Member States would prefer that a draft resolution be prepared, the Secretariat would abide by their wishes.

The Board noted the report.

The meeting rose at 12:30.

THIRD MEETING

Tuesday, 20 January 2009, at 14:05

Chairman: Mr N.S. DE SILVA (Sri Lanka)

TECHNICAL AND HEALTH MATTERS: Item 4 of the Agenda

Discussion of the health situation in the Gaza Strip: Item 4.16 of the Agenda (Document EB124/35)

Dr ABDESSELEM (Tunisia) said that the serious health and humanitarian situation in the Gaza Strip had made a review essential for the Board. The Fourth Geneva Convention relative to the Protection of Civilian Persons in Time of War, of 12 August 1949, stipulated, in Article 18, that civilian hospitals organized to give care to the wounded and sick, the infirm and maternity cases, could in no circumstances be the object of attack. The Health Assembly in resolution WHA55.13 urged organizations of the United Nations system to promote actions that ensured the safety of health personnel.

The collapsing health-care system in the Gaza Strip could break down entirely. Great numbers of women, children and elderly persons had been killed and injured, as had medical workers providing care to the civilian population. Much damage had been done. Additional details on the difficulties in providing assistance owing to the destruction of health infrastructure could be found in the report.

Injured persons and medical personnel could not circulate freely. Medical teams could not reach those needing assistance and the evacuation of patients had been hindered by the ongoing violence and by the closure of border crossings. Medical and paramedical teams were exhausted.

His Government urged the Director-General and the Board to take steps to improve the health and humanitarian situation in the Gaza Strip to include: the provision of care to the injured; the delivery of medical care and equipment wherever needed; the full assessment of the general health and humanitarian situation, particularly the operating status of primary health-care centres and hospitals, and their return to normal functioning; and training of health personnel. The draft resolution being proposed had been elaborated by several members of the Board.

Dr DJIBO (Niger), speaking on behalf of the Member States of the African Region, read out the following draft resolution on the grave health situation caused by Israeli military operations in the occupied Palestinian territory, particularly in the occupied Gaza Strip:

The Executive Board,

Guided by the principles and objectives of the Charter of the United Nations, the Constitution of WHO, international law and international humanitarian law and the Universal Declaration of Human Rights;

Affirming that all human rights are interdependent and complementary and that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

Reiterating the applicability of the Fourth Geneva Convention relative to the Protection of Civilian Persons in Time of War, of 12 August 1949, to the occupied Palestinian territory;

Referring to the reports and statements issued by the World Health Organization, the International Committee of the Red Cross and Red Crescent Societies and the United Nations Relief and Works Agency, the United Nations Office for the Coordination of Humanitarian Affairs, the United Nations Children's Fund and other international and regional organizations,

relating to the deteriorating health and humanitarian situation in the occupied Gaza Strip as a result of Israeli military operations;

Recognizing also that the Israeli siege imposed on the occupied Gaza Strip and prevention of the passage and delivery of humanitarian supplies of medicines, food and fuel will lead to grave health and humanitarian consequences;

Expressing its deep concern regarding the consequences of Israeli military operations in the occupied Gaza Strip, which have, thus far, resulted in the killing of more than 1300 persons and injured thousands of Palestinian civilians, more than half of whom are women, children, infants and elderly persons;

Expressing its deep concern about the serious deterioration of the health conditions of all Palestinians in the occupied Palestinian territory and in the Gaza Strip in particular;

Asserting the right of patients as well as Palestinian and other medical personnel to access Palestinian health institutions,

1. WELCOMES and emphasizes the respect of the ceasefire from both parties and calls for the withdrawal of Israeli military forces from the currently occupied Gaza Strip, the lifting of the siege, and the opening of all borders to allow access and free movement of humanitarian aid to the occupied Gaza Strip, including the immediate establishment of humanitarian corridors to ensure the delivery of humanitarian medical and food aid and facilitate the passage of medical teams and the transfer of the wounded and injured;
2. CALLS for avoiding of targeting of hospitals, clinics, medical centres, ambulance and emergency crews and food and medicine warehouses;
3. STRESSES avoiding targeting civilians and residential areas in accordance with the Fourth Geneva Convention relative to the Protection of Civilian Persons in Time of War;
4. CALLS for providing Palestinian people with the protection in order to live securely on their land, allow them free movement and work, facilitate the tasks of medical teams and ambulances, and emergency relief efforts, and enabling them to continue to provide health services;
5. CALLS for the urgent provision of necessary support for the Palestinian people in making available the urgent and immediate needs of ambulances and medical teams, medicines and medical supplies, as well as necessary coordination measures to facilitate the passage of this assistance to the Gaza Strip in support of the health sector and preventing the collapse of health institutions;
6. CALLS for contribution to the reconstruction of the health infrastructure in the Gaza Strip, which has been destroyed by the Israeli military operations;
7. REQUESTS the Director-General to dispatch a special mission to identify the urgent health and humanitarian needs and assess the destruction that has occurred in the occupied Palestinian territory, particularly in the Gaza Strip and to submit a report on the direct and indirect effects of the Israeli military operations to the Sixty-second World Health Assembly.

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union and its 27 Member States, said the European Union welcomed the ceasefire but was deeply concerned by: the civilian casualties, particularly women and children and health personnel; the grave humanitarian and health situation; and the information from WHO that fragile health services were collapsing. Medical supplies could

not reach those in need; access to care was compromised; hospitals were overwhelmed; health workers were exhausted; and there was a constant threat of power failures.

The shelling of hospitals and medical facilities was of serious concern. International humanitarian law, in its protection of medical personnel and facilities during armed conflict, must be respected as must the ceasefire, in accordance with Security Council resolution 1860 (2009). The European Union called on the parties, in particular Israel, to grant immediate and secure passage of humanitarian aid and health-care services to the inhabitants of the Gaza Strip.

The European Union stood ready to convene a donors' conference and to consider the reconstruction in the Gaza Strip. He supported WHO's medical assistance to the work in the Gaza Strip, and commended work done by aid organizations and Palestinian health workers. Many of the European Union's Member States and the European Commission had been responding with financial support.

The European Union encouraged the Organization's efforts, inter alia as Health Cluster coordinator, in its assistance to the Palestinian people. It was ready to discuss the draft resolution with a view to reaching consensus, but, as the text had been received only that day and he understood that a revised version was to be circulated, he requested that the current discussion be limited to the report and that consideration of the draft resolution be postponed.

Professor AYDIN (Turkey) said that his country welcomed the ceasefire but remained concerned about the grave humanitarian situation caused by the Israeli military operations in the Gaza Strip. Hospitals, primary health-care centres and health personnel were under serious pressure. Shortages of power and medical supplies stretched the weak health infrastructure. A vaccination programme should be immediately instituted in health centres in order to prevent disease outbreaks in the dire living conditions. The reconstruction of health infrastructure and access to humanitarian assistance should be the new focus of the international community.

Turkey had intensified deliveries of humanitarian and medical assistance to the Gaza Strip, including five ambulances, 11 000 food parcels, 13 tonnes of medicines and medical supplies, 330 tonnes of flour and 5000 blankets. It had admitted wounded Palestinians to hospitals in Ankara. He thanked WHO Representatives for their cooperation in those deliveries. Their coordinating role in medical supplies was essential in order to avoid duplication and to channel aid.

Turkey would support a text to emerge from the present discussion, However, humanitarian assistance and special missions were only temporary relief, not a cure for the suffering of the people in the Gaza Strip. A comprehensive settlement, as envisaged in Security Council resolution 1860 (2009), needed intensified efforts.

Dr JAYANTHA (alternate to Mr de Silva, Sri Lanka) said that the international community had a duty to ensure that the affected population in the Gaza Strip was provided with the necessary preventive and curative health care. He reaffirmed his country's solidarity with the people of the Gaza Strip and urged the international community to alleviate their suffering and meet their essential needs.

Dr REN Minghui (China) expressed deep concern that Israel's offensive in the Gaza Strip had resulted in civilian casualties and deteriorated health services, and welcomed the ceasefire. The international community should promptly ease the humanitarian crisis and efficiently channel aid. China had already provided US\$ 1 million in emergency assistance and would consider providing more.

It had always opposed the use of force to resolve disputes. Both sides should abide by the relevant United Nations resolutions, the principle of land for peace and the road map, and should work to achieve the coexistence of two States. China supported diplomatic efforts to promote peace and a political settlement. He thanked Tunisia for putting forward the draft resolution.

Mr DE ALBUQUERQUE E SILVA (alternate to Dr Buss, Brazil) said that his country regretted the loss of life, the suffering and destruction caused by the conflict in the occupied territories. His country's Foreign Minister had reiterated to officials there the need for full compliance with Security Council resolution 1860 (2009). Brazil welcomed the progress made, and commended the work done by the United Nations system, particularly UNRWA. His country had sent 14 tonnes of food and medicine. He supported the draft resolution, and recognized the relevance of requesting the Director-General to dispatch a mission to identify the urgent health and humanitarian needs and to assess destruction.

Mr MIGUIL (Djibouti) expressed deep concern regarding the humanitarian situation in the Gaza Strip. The draft resolution should be adopted without delay, a WHO mission dispatched, the situation assessed and urgent medical supplies, ambulances and medical teams arranged. Every moment lost increased the suffering of the people in the Gaza Strip.

Professor HAQUE (Bangladesh) joined previous speakers in emphasizing the humanitarian aspects of the crisis. He welcomed the ceasefire; however, human suffering in the Gaza Strip continued. The targeting of medical facilities and health workers, and the denial of access to international health personnel and deliveries of medical supplies, were matters of concern. The health needs of the population must be addressed within the context of reconstruction. WHO should mobilize resources in response to the enormous challenges. He urged the Board to call for support and assistance.

Dr MOHAMED (Oman) commended WHO and the contribution of the Regional Office for the Eastern Mediterranean towards relieving suffering in the Gaza Strip. The number of injuries and deaths continued to rise. The disruption of health services must be addressed and the injured helped. The draft resolution responded to health needs in the Gaza Strip and was non-political in tone. The Board should adopt it immediately in order to expedite delivery of assistance.

Dr STARODUBOV (Russian Federation) stressed the provisions of United Nations Security Council resolution 1860 (2009). His Government would do everything it could in order to bring about a political settlement and a normalization of the situation. He supported the draft resolution and commended WHO personnel who were striving to provide medical services; however, the situation warranted an urgent, comprehensive response and a WHO mission should be dispatched to the Gaza Strip without delay.

Mr STORELLA (alternate to Dr Wright, United States of America) said that he shared the concerns expressed by previous speakers regarding the loss of innocent life and the dire humanitarian situation in the Gaza Strip. He welcomed the ceasefire and praised efforts engaged in advancing peace. The people of the Gaza Strip must have supplies, sanitation and medical help. However, a sustainable ceasefire must ensure the security of both Israelis and Palestinians. The normalization of life for people in the Gaza Strip would require a principled political approach that re-established the Palestinian Authority's legitimate control. His Government recognized the need for the safety of relief workers and would support sending a WHO mission to Gaza in order to identify and assess health and humanitarian needs. However, the Board's authorization of such a mission should be straightforward and free of one-sided rhetoric. The Director-General, in her opening address, had outlined the severe health problems affecting civilians. She had avoided any political references and had concentrated on the Organization's core competencies. WHO must follow that approach in addressing the health needs of the population in the Gaza Strip. While appreciating the urgency of the situation, he associated himself with the statement made by the member for Hungary; the Board should postpone action on the draft resolution until members had had time to consult their governments.

Dr SUPARI (Indonesia) said that the humanitarian crisis in the Gaza Strip violated the human rights of the people in the occupied Palestinian territory and could hamper global health security. The lives of the Palestinian people were threatened by hunger and lack of access to clean water. The issue before the Board was a humanitarian one. The economic blockade of the Gaza Strip had led to a rise in mortality, morbidity and poverty. Health infrastructure had been destroyed and levels of health care and basic sanitation reduced. Progress by the Palestinian people towards the Millennium Development Goals had been curtailed.

Indonesia had responded with humanitarian aid teams and would support future reconstruction work in the Gaza Strip. She expressed appreciation of WHO's humanitarian aid to the Gaza Strip; a unit for humanitarian rapid-response should be considered in order to assist in future crises. She urged the Board to adopt the draft resolution without delay. Her country wished to join the list of sponsors of the draft resolution.

Dr OULD JIDDOU (Mauritania) expressed support for the comments made by the member for Niger. Considering the urgency of the situation in the Gaza Strip, the Board should adopt the resolution without delay.

Dr BIN SHAKAR (United Arab Emirates) said that there was consensus that the Palestinian people needed immediate assistance. By delaying adoption of the draft resolution, the Board would place WHO, as the lead agency in matters related to health, in an awkward situation. He endorsed the comments made by the members for Djibouti and Indonesia and urged the Board to adopt the resolution.

Mr ADAM (Israel)¹ said that his Government was deeply pained by the number of Palestinian civilians who had been killed or wounded during the recent conflict in the Gaza Strip. Israel would do what it could to help the wounded and return their lives to normal. He drew attention to recent comments by the United Nations Secretary-General concerning Israel's efforts to establish a humanitarian operations centre, noting that the Secretary-General had also condemned the Hamas rocket attacks on Israeli civilians.

The Executive Board was not the place to discuss the Middle East conflict, or the peace process, or to reach a political solution. It was not the role of WHO to call on Member States to act or cease to act in matters of peace and security. The Board should not allow WHO to be deflected from its mandate. He urged members to avoid political, one-sided text in the draft resolution which would not improve Israel's cooperation with WHO. There was no precedent for such a political discussion and resolution within WHO.

The draft resolution was outdated and disconnected from reality. Israel had agreed to the conditions proposed by the President of Egypt; the ceasefire was being kept by both sides; rocket attacks on Israeli towns had finally ceased after eight years; the Israeli army would have left the Gaza Strip before the Board completed its discussion of the resolution; and Israel was facilitating access for all humanitarian and medical assistance and equipment, including that provided by WHO.

Israel was providing medical care for Palestinians through its treatment centre near the Erez crossing. More than 41 900 tons of food and medical aid had been delivered to the Gaza Strip. The United Nations Office for Coordination of Humanitarian Affairs had reported that no further medical teams were needed in the region. The United Nations Secretary-General had indicated that he intended to send a United Nations inter-agency mission to Gaza in order to assess humanitarian needs.

He called on the Board to avoid politicizing its discussions and resolutions and to focus on health solutions, not conflict resolutions. Other United Nations forums existed for that purpose.

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

Mr KHRAISHI (Palestine),¹ emphasizing that he did not wish to politicize the Board's discussion, expressed regret on behalf of the Palestinian people that four civilians had been killed in Israel by rocket attacks and that people had been wounded.

He drew attention to casualty estimates, including large numbers of children and women, in the Secretariat's report. Bombing of 60 000 homes had left thousands of Palestinians homeless. Schools, hospitals and medical facilities had been damaged or destroyed.

The Board was not being asked to act in contravention of WHO's Constitution or outside WHO's terms of reference. He encouraged the Board not to delay adoption of the resolution. Further deterioration of the humanitarian situation in the Gaza Strip must be avoided. Electricity supplies needed to be restored, acute health needs provided for, and newborn children protected.

Surely the Board could adopt a resolution that emphasized the need to send a technical mission to the Gaza Strip in order to assess health and infrastructure needs? He was not asking for condemnation of Israel. Palestine sought to protect and promote the values of international humanitarian law. He urged Israel to conduct itself as a member of the international community. The issue before the Board was not a political one; Palestine was simply asking for assistance and medicines for sick and injured people. He urged the Board to adopt the proposed resolution.

Mr BADR (Egypt)¹ expressed grave concern about the humanitarian and medical crisis in the Gaza Strip; Israeli aggression had pushed fragile health services there to the point of collapse and blocked access to medical supplies and equipment. Health facilities in the Gaza Strip were in a dire state. He called on the Director-General to send a mission in order to report on the crisis, including civilian casualties, destruction of civilian and medical infrastructure, and the use of internationally prohibited weapons. He asked the Board to support rehabilitation and reconstruction of medical and health facilities and infrastructure, and to call for continued observance of Security Council resolution 1860 (2009), in particular paragraphs 2 and 3 related to health issues. Any delay in adopting the draft resolution would send the erroneous message that the Organization was not united in the face of such calamities.

Dr ALVIÁREZ (Bolivarian Republic of Venezuela)¹ supported the comments made by the members for Brazil and Indonesia and affirmed that the draft resolution should be adopted immediately. Lasting peace must be established as the only way to ensure health. WHO should call for the lifting of the blockade; assess the harm done to human beings, infrastructure and health-care facilities in the Gaza Strip; and call on the United Nations to take measures so that Israel's destructive actions never occurred again.

Mr SAMRI (Morocco)¹ expressed his country's shock at the suffering inflicted on the Palestinian people. He supported previous speakers' calls for the immediate adoption of the purely humanitarian draft resolution. He urged WHO to act quickly to protect the remaining health infrastructure in the Gaza Strip: a mission was needed in order to assess the scale of the damage, and lead to reconstruction.

Mr AHMADI (Islamic Republic of Iran)¹ thanked the Director-General for her statement on the situation in the Gaza Strip and commended the Secretariat's report. There was an urgent need to assist civilians, to lift the siege and sustainably redress the dire health and humanitarian situation. His Government supported the draft resolution. He emphasized the last paragraph, the dispatch of a specialized health mission to the Gaza Strip in order to assess the health effects of Israeli aggression on civilians. There had been reports of the use of phosphorus shells and bombs, and also ammunition containing depleted uranium, which, if true, would have long-lasting health effects.

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

Ms HUDQ (Libyan Arab Jamahiriya)¹ said that the conflict in the Gaza Strip was unequal. The deteriorating health situation would permit no delay: it was essential to send aid swiftly, and she called for the immediate adoption of the draft resolution.

Mrs ABBAS (Syrian Arab Republic)¹ said that, in the light of the health situation in the Gaza Strip created by Israeli aggression, the international community must help to restore the dignity of the Palestinian people and their right to life and health. Attacks on hospitals, health facilities and ambulances violated humanitarian principles and tenets of international law. Israel had reportedly used internationally banned weapons and WHO should send a mission to monitor the health situation in the Gaza Strip and determine the causes of the injuries and deaths which had occurred, in order to identify the weapons used. Other United Nations agencies should further investigate the banned weapons used, and their effects on the environment, on people of the Gaza Strip and future generations.

Dr GIMÉNEZ CABALLERO (Paraguay) said that the draft resolution was confined to humanitarian considerations; for that reason, his Government supported the draft resolution, especially its paragraph 7.

Dr MUÑOZ (Chile)¹ said that topics discussed by the Board included the social determinants of health which currently could be seen in their most adverse form in the Gaza Strip. For that reason, his Government supported the draft resolution as a contribution to the reconstruction of health infrastructure that would mitigate some of the harm to the health of the Palestinian people.

The meeting was suspended at 15:30 and resumed at 16:25.

Dr ABDESSELEM (Tunisia) read out a revised version of the draft resolution. In the third preambular paragraph, the word “reiterating” should be replaced by “confirming”. In the fifth preambular paragraph, the word “siege” should be replaced by “blockade”. In the seventh preambular paragraph, the phrase “in the Gaza strip in particular” should be replaced by “in particular in the Gaza Strip”.

Paragraph 1 should be amended to read “... and calls on Israel for an immediate, durable and fully respected ceasefire leading to full withdrawal of Israeli forces from the Gaza Strip, to lift its blockade and to open all border crossings ...”.

Paragraph 4 should read “Calls upon [*sic*] providing Palestinian people with the protection to live in security on their and, allowing them free movement, and facilitating the tasks of medical teams, ambulances and emergency relief efforts, ...”.

Paragraph 5 should read “... support for the Palestinian people by making available the urgent and immediate needs of ambulances and medical teams, medicines and medical supplies, ...”.

Paragraph 7 should read “... dispatch an urgent specialized health mission to ... assess the destruction of medical facilities ... and to submit a report on current, medium- and long-term needs on the direct and indirect effects of the Israeli military operations to the Sixty-second session of the World Health Assembly”.

He requested a roll-call vote on the draft resolution.

Dr DAHL-REGIS (Bahamas) said that she supported the report by the Secretariat. The draft resolution had both political and humanitarian aspects, and provided for a specific role for WHO. Her Government would support the revisions introduced by the member for Tunisia, except for the

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

revision to paragraph 1. However, she needed further time for study. A resolution was urgently needed.

Ms ROCHE (New Zealand) said that she concurred with previous speakers that the health situation in the Gaza Strip was critical and action imperative. Like other members of the Board, she needed time to consult with her Government on the resolution. Consensus might be reached following consultations. She asked whether the Director-General had planned a mission to assess the health situation in the Gaza Strip.

The DIRECTOR-GENERAL said that there had not been sufficient time to discuss the matter with all members and that, therefore, she was expressing the view of the Secretariat only. She had listened carefully to the discussion and heard no dissenting voices with regard to WHO sending a mission to assess the urgent needs of the Palestinian people. Many members had stated that a decision could not wait.

She therefore suggested, as a way forward, that the Board should take a decision instructing her to send a mission to the Gaza Strip in order to carry out the assessment, thereby fulfilling its duty of care to all people. Once a decision had been taken, such a mission could be dispatched within 24 hours. In the meantime members could consult with their capitals and resume discussions with a view to adopting a resolution.

Dr KÖKÉNY (Hungary), speaking on behalf of the Member States of the European Union, welcomed the spirit of compromise shown by the Director-General. The European Union agreed that a decision should be taken to dispatch a special mission in order to identify the urgent health and humanitarian needs and assess the destruction, particularly in the Gaza Strip, and to submit a report on direct and indirect effects on health of the Israeli military operations to the Sixty-second World Health Assembly. That decision was in line with paragraph 7 of the draft resolution proposed by the member for Tunisia, with one small amendment, namely, to insert the words “on health” after “direct and indirect effects”.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) agreed with the suggestion put forward by the Director-General. His Government would not have wished to be in the position of having to abstain on a roll-call vote, when it so strongly agreed with the spirit and intention of the proposed resolution. He looked forward to reaching consensus the following day on the wording of the text.

Mr DE ALBUQUERQUE E SILVA (alternate to Dr Buss, Brazil) said that he supported the Director-General’s wise and balanced solution to the current impasse.

Mr MIGUIL (Djibouti) aligned himself with the Director-General’s suggestion. It would be wise to act first and then to finalize a text based on a broad consensus. Consensus existed on the need for urgent action in the Gaza Strip, yet some members were asking for time to consult their capitals. The Board must first resolve the urgent matter of sending a mission to the Gaza Strip. Then a draft resolution must be adopted before the end of the session.

Dr GIMÉNEZ CABALLERO (Paraguay) said that the world gave WHO a responsibility not to disappoint humanity. The Director-General’s suggestion to dispatch a special mission as a first step was wise. Consideration of the draft resolution should be resumed at the current session.

Dr ADITAMA (alternate to Dr Supari, Indonesia) asked whether, in the light of the plan to postpone the adoption of the resolution, assurances could be given that consensus would be reached on

the following morning. He sought assurances that the WHO special mission could count on the cooperation of the parties concerned.

The CHAIRMAN, replying to the first question raised by the member for Indonesia, said that if the Board agreed to postpone consideration of the draft resolution, discussions could resume within the following two days.

The DIRECTOR-GENERAL, replying to the second query from the member for Indonesia, said that she had the ability to dispatch a mission, but that she first needed discussion with the relevant authorities in order to ensure that the mission would have safe passage and free access. The situation in the Gaza Strip had recently improved; however, if the mission were not allowed access, it would be for the Board to decide how to respond.

Ms ROCHE (New Zealand) expressed her support for the Director-General's two-stage approach which allowed members of the Board to act immediately on the urgent health issues that had been discussed.

Dr BIN SHAKAR (United Arab Emirates) expressed support for the point raised by the member for Indonesia and said that discussion of the draft resolution should take place on the following morning at the latest.

Mr STORELLA (alternate to Dr Wright, United States of America) concurred with the Director-General that there was a strong consensus for the Board to take action on the issue, which was of dire concern. The Director-General's two-step approach was wise; it would allow the Board to take action immediately, by consensus, without prejudice to consideration of the proposed resolution.

Dr KÖKÉNY (Hungary), speaking on behalf of the Presidency of the European Union, said that the 27 Member States of the European Union needed time to hold consultations in order to agree on a clear position, and that discussion of the draft resolution should be resumed on Thursday morning.

Mr KHRAISHI (Palestine)¹ said that he did not understand how the draft resolution could be adopted in stages. The shedding of blood in the Gaza Strip had given the Executive Board an opportunity to reach an agreement, and his colleagues in the Arab States and various regional groups had assured him that that was possible. He therefore suggested that the Board return to the draft resolution the following day, when it might be adopted by consensus as currently worded.

Dr KAMOTO (Malawi) agreed with the member for Hungary that Member States needed time to consult and that it would be better to wait until Thursday.

Dr ABDESSELEM (Tunisia), stressing the urgency of the situation in the Gaza Strip, supported the proposal by the representative of Palestine that the Board should try to reach a decision by consensus the following day.

The CHAIRMAN, noting how close the Board was to an agreement, appealed to the members for Hungary and the United States of America to reconsider their position.

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

Mr STORELLA (alternate to Dr Wright, United States of America) said that he had appreciated the views expressed by the representative of Palestine and the member for Tunisia, in particular, and that his delegation would do its utmost to consult overnight and reach a firm position by the following day.

Dr KÖKÉNY (Hungary), speaking on behalf of the Presidency of the European Union, said that the Member States of the European Union would hold urgent consultations. He consequently requested the Board to resume consideration of the matter the following afternoon, by when it was to be hoped that an agreement would have been reached.

Dr STARODUBOV (Russian Federation), observing that the Board was gradually moving towards consensus, endorsed the view expressed by previous speakers that a solution must be found the following day.

The CHAIRMAN said that the Director-General would make the necessary arrangements for a special mission to visit the Gaza Strip.

(For adoption of the resolution, see the summary record of the fifth meeting.)

Prevention of avoidable blindness and visual impairment: Item 4.4 of the Provisional agenda (Documents EB124/7 and EB124/7 Corr.1)

The CHAIRMAN drew attention to the report by the Secretariat and opened the floor for comments.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) strongly supported action to prevent avoidable blindness and visual impairment. However, the centralist approach advocated in paragraphs 40 and 41 of the draft action plan might hinder rather than help implementation; moreover, the language could be made more flexible.

Mr VALLEJOS (Peru) described an active campaign by his Government to promote eye health. A national plan had been launched in 2007 in response to estimates showing that the 80 000 cases of visual loss related to cataract, mainly affecting people in the poorest parts of the country, were set to double by 2020. After one year, 7704 people had recovered their eyesight; and the following year, surgical services had been extended to more than 20 000 others, many of whom had been flown to Lima for an operation free of charge.

Dr DJIBO (Niger), speaking on behalf of the 46 Member States of the African Region, drew attention to key figures mentioned in the report, not least that 90% of people with visual impairment lived in developing countries. Prevention and treatment were crucial, in reducing the prevalence of avoidable blindness and visual impairment, which could otherwise have a global economic impact of US\$ 100 000 million by 2020, and in making progress towards achieving the Millennium Development Goals.

Reporting on his Region, he said that, since the launch of VISION 2020, 38 Member States had drawn up national plans, 25 had begun implementing those plans; and 29 had set up national committees for eye health and the prevention of blindness. Cataract interventions had increased in many countries. National plans for prevention of blindness included the control of uncorrected refractive errors and provision of glasses of high quality at affordable prices. Extending measles vaccination had contributed to a reduction in the childhood blindness caused by corneal ulceration; training in paediatric ophthalmology had become more widely available; and a WHO working group had recommended public health interventions for diabetic retinopathy.

However, challenges remained. In most African countries, sustainable, high standards of eye health-care were still relatively scarce, limited in scope, and had yet to be incorporated into national health systems. The commitment of political managers and health workers to eye health and prevention of blindness was still low. More effective investment in health systems and health services would be needed if the Member States of the African Region were to achieve the goal of eliminating avoidable blindness and visual impairment by 2020.

Dr MOHAMED (Oman), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that in his Region several of the national committees for eye health and prevention of blindness received little or no support from the authorities, especially in the least developed countries, and therefore lacked the funding needed to operate properly. Greater political commitment was needed in order to combat avoidable blindness and visual impairment. He welcomed the report and urged implementation of the proposals.

Dr REN Minghui (China) said that his Government attached great importance to combating blindness, which affected 12.3 million people in his country. Some 80% of cases were avoidable. China had had a national VISION 2020 plan in place since the initiative was first launched in 1999 and was running a Vision First-China Action programme and a Health Express project. Endorsing the draft action plan, he said that WHO should provide support to developing countries.

Dr BIN SHAKAR (United Arab Emirates) said the draft action plan should be approved by the Executive Board and submitted to the Sixty-second World Health Assembly. As one of the first to set up a national VISION 2020 committee, his country had begun applying the principles of the action plan and developing the necessary infrastructure. It had also drawn up a national plan for prevention of blindness in keeping with international standards, and was striving to raise basic awareness in that respect. A unit for the prevention of avoidable blindness and visual impairment had been set up; some 4000 people had been treated free of charge; and specialized training was being provided for professionals in eye health-care, which the United Arab Emirates would be willing to extend to other countries.

The meeting rose at 17:30.

FOURTH MEETING

Wednesday, 21 January 2009, at 09:10

Chairman: Mr N.S. DE SILVA (Sri Lanka)

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

Prevention of avoidable blindness and visual impairment: Item 4.4 of the Agenda (Documents EB124/7 and EB124/7 Corr.1) (continued)

Professor ALI (alternate to Professor Haque, Bangladesh) said that his country was committed to providing ophthalmic care for its citizens and had created infrastructures in both the public and the private sectors. However, expanding those services to cover the entire population would require more technical assistance.

Although diabetic retinopathy and trachoma were referred to in the report, corneal opacities were not covered. WHO's and global and national initiatives did not adequately address that issue, notably the identification of cases, the promotion of eye donation, the establishment of eye banks or the organization of corneal transplants. Those specialized measures were difficult for developing countries to implement without international technical assistance. He therefore requested that corneal opacities and related measures be included in the draft action plan. He stressed that nutritional blindness caused by diarrhoeal diseases was a problem in many countries, including his own, and the report should not have ignored that issue.

In the South-East Asia Region, the prevalence of visual impairment among people over the age of 40 was as much as 25.1%. Much could be done with relatively little investment if a proper plan of action was developed and implemented. Regrettably, despite the development of VISION 2020: the Right to Sight, no significant step had been taken in the Region since 2001 when countries had held consultations in New Delhi. Moreover, in the Regional Office, the unit dealing with eye care emphasized injury and other areas of disability.

WHO should therefore accord more importance to eye care in order to achieve the objectives of VISION 2020. More information was needed on how best to integrate basic eye care into primary health care. Furthermore, the recommendations of the VISION 2020 regional consultation, concerning the planning of human resources in eye care, should be fully implemented.

Dr JAYANTHA (alternate to Mr de Silva, Sri Lanka) said that under VISION 2020 his country had significantly reduced avoidable blindness. WHO's support in developing human resources and the infrastructure for eye care was welcome. He expressed support for the draft action plan and its earliest implementation.

Dr WRIGHT (United States of America) welcomed WHO's success in combating avoidable blindness and expressed support for the draft action plan as it stood. His country continued to break new ground in its vision research and to develop nascent care and treatment options for the visually impaired around the world. It had been contributing to the global efforts to help people retain their vision since 1979. Cataracts affected the ageing population of both developed and developing countries: in the United States an estimated 20.5 million people over the age of 40 had cataracts in either eye. Furthermore, the growing prevalence of diabetes in the United States and globally, and its visual impairment complications, remained a concern.

Dr ADITAMA (alternate to Dr Supari, Indonesia) said that his country had developed a strategic plan for VISION 2020 and set up a committee for the prevention of blindness. Activities included the establishment of eye clinics throughout the country; collaboration with professional societies; and a prevention and control programme. He called on WHO to prioritize the prevention of avoidable blindness and visual impairment in health programmes, and also drew attention to the importance of research, prevention and treatment.

Dr AL RAJHI (Saudi Arabia)¹ welcomed the report and the evidence relating to the causes of visual impairment, the emphasis on activities to prevent blindness in the alleviation of poverty and improved quality of life, and the prompt response by the Secretariat in its elaboration of the action plan. The draft plan sought to increase the efforts of Member States, the Secretariat and international partners in preventing blindness and visual impairment by means of comprehensive national and local programmes for eye-health; and to support the implementation of WHO's Eleventh General Programme of Work and the Medium-term strategic plan 2008–2013. It was an important step in implementing resolutions WHA56.26 and WHA59.25. He joined other speakers in supporting the draft action plan, which should be submitted to the Sixty-second World Health Assembly for final adoption.

Dr SOPIDA CHAVANICHKUL (Thailand),¹ expressing support for the draft action plan, said that a national survey in 2006 had shown the prevalence of blindness to be 2.18%. The major causes identified were cataracts and glaucoma; macular degeneration had been identified as an emerging eye disease that impeded the independence of affected individuals, and retinopathy of prematurity remained a major eye problem among children. She stressed efforts against eye conditions that were related to age, in particular diabetic retinopathy, through screening, treatment and follow-up programmes. Since in many cases glaucoma was asymptomatic, intensive efforts should be made to detect the condition, to follow-up clinical assessment and ensure adherence to treatment.

The challenge was to translate action plans into reality and to prevent blindness among populations with few resources. The problem of access to expensive medicines for glaucoma needed to be addressed.

Dr ALVIÁREZ (Bolivarian Republic of Venezuela)¹ said that his country sought to meet the objectives outlined in the draft action plan: political, financial and technical commitment was being increased; national policies had been strengthened; research capacities had been increased; and cooperation and international alliances had been improved. Programmes were in place, inter alia for the promotion of visual health in schools, the community and the workplace; the provision of medication for glaucoma and diabetic retinopathy and of corrective lenses; the training of human resources; and the rehabilitation of patients with visual impairment. In order to achieve universal primary education, glasses were provided to patients on literacy programmes. He described the achievements in prevention and treatment.

Venezuela had also forged alliances with international organizations, and had established a VISION 2020 committee. It had increased access to health services and promoted coordination across sectors. Since 2006, considerable investment had been made in training human resources in ophthalmology. Venezuela had, together with Cuba and other Latin American countries, launched Mission Miracle, an anti-blindness programme. Results included the establishment of a modern ophthalmic centre in Venezuela that treated some 150 patients a day; some 200 000 surgical operations had been performed in Venezuela (regional estimates totalled 750 000). He emphasized coordination, cooperation and solidarity with neighbouring countries, particularly in the prevention of

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blindness; the decrease in the level of blindness in the country over the previous five years had promoted growth and development.

Mr GARMS (International Agency for the Prevention of Blindness), speaking at the invitation of the CHAIRMAN, recalled that his organization was WHO's joint partner in the VISION 2020 global initiative. Implementation of resolutions WHA56.26 and WHA59.25 had led to an unprecedented focus on the strengthening of eye-care services. He emphasized committed international partnership for improved eye health. The draft action plan would lend new momentum to global efforts. Resources must be made available at WHO headquarters and regionally for technical support to Member States. His organization would continue support to WHO in the shared objective that would benefit millions of needlessly blind people. He looked forward to endorsement of the draft action plan by the Sixty-second World Health Assembly.

Dr ALWAN (Assistant Director-General) thanked participants for their contributions, which would guide the Secretariat in strengthening and finalizing the draft action plan to be submitted to the Sixty-second World Health Assembly. With regard to the comments made by the member for the United Kingdom, he said that the language of paragraphs 40 and 41 of the revised draft action plan would take into account the organizational structures and implementation approaches in different Member States. Referring to the remarks made by the member for Bangladesh, he said that corneal opacities were included under trachoma and nutritional causes of blindness. However, the draft action plan, in particular paragraph 58, would be amended to indicate that corneal opacities were also a significant cause of blindness and visual impairment. Turning to the comments on nutritional causes, he said that vitamin A deficiency had been included in paragraph 52 of the draft action plan; nutritional issues tended to be covered under strategies relating to childhood blindness. He fully agreed with the member for Niger about the importance of integrating eye health into national health systems, which had always been the basic approach recommended by WHO; that would be reflected in the revised version of the draft action plan. He appreciated the comments by the representative of Thailand and other speakers on the need to emphasize age-related macular degeneration and noncommunicable disease-related causes of blindness and visual impairment. Age-related macular degeneration had already been included in the action plan for the global strategy for the prevention and control of noncommunicable diseases that had been endorsed at the Sixty-first World Health Assembly.

Additional resources would be needed to implement the action plan for the prevention of avoidable blindness and visual impairment. WHO would mobilize resources to cover its component of the plan and work closely with the partners of VISION 2020 to that end. The recommended interventions of Member States under the five objectives set out in the action plan would have to be prioritized according to local situations and needs.

The CHAIRMAN said that he took it that the Board wished to endorse the action plan.

It was so agreed.

Primary health care, including health system strengthening: Item 4.5 of the Agenda (Document EB124/8)

The CHAIRMAN drew attention to two draft resolutions on primary health care, including health system strengthening, proposed respectively by Afghanistan, Oman, Tunisia and United Arab Emirates and by Argentina, Australia, Canada, Chile, Japan, Kazakhstan, Monaco, Republic of Korea, Russian Federation, Singapore, Turkey and Venezuela (Bolivarian Republic of), which read as follows:

The Executive Board,
Having considered the report on Primary health care, including health system strengthening,¹

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

The Sixty-second World Health Assembly,
Having considered the report on Primary health care, including health system strengthening;

Recalling the Declaration of Alma-Ata (1978) and subsequent resolutions of WHO regional committees and the Health Assembly;

Recalling the discussions at the series of international, regional and national conferences that have reaffirmed the commitment of Member States to primary health care and strengthening health systems;²

Noting the analyses contained in *The world health report 2008*,³ the report of the Commission on Social Determinants of Health,⁴ and the report on monitoring of the achievement of the Millennium Development Goals;⁵

Gravely concerned by the potential effects on health and health systems, of the international financial and food crises and climate change as well as the impact of global economic conditions on national budgets and international funding for health,

1. STRONGLY REAFFIRMS the primary health-care values and principles of equity, solidarity, social justice, universal access to services, community participation and intersectoral action as the basis for strengthening health systems;

2. URGES Member States:

(1) to apply the values and principles of primary health care in health policies and the structuring and functioning of health systems at all levels, including the rehabilitation and strengthening of health systems in countries facing complex emergencies;

(2) to protect health budgets in response to the current economic crisis and to seize the opportunity of crisis in order to accelerate the rate of change towards strengthening their health systems on the basis of the values and principles of primary health care;

(3) to strengthen health ministries, enabling them to provide inclusive, transparent and accountable leadership of the health sector and to work with other sectors in order to address the social, economic, environmental and cultural determinants of health;

¹ Document EB124/8.

² Buenos Aires 2007, Beijing 2007, Bangkok 2008, Tallinn 2008, Ouagadougou 2008, Jakarta 2008, Almaty 2008, Doha 2008.

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

⁴ Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health*. Geneva, World Health Organization, 2008.

⁵ Document EB124/10.

- (4) to put people at the centre of health care, adopting delivery models focused on the local or district level that provide preventive, promotive and curative services, integrated and coordinated according to need;
- (5) to ensure people's participation, including community leaders and young people, in action to improve health and health care, and to engage civil society organizations in policy development for the renewal of primary health care;
- (6) to accelerate action to achieve universal coverage and equitable access to services according to need, ensure social protection, especially for the vulnerable, avoid catastrophic expenditures and impoverishment, and improve health equity through the development of health financing systems, human resource policies and service delivery models;
- (7) to take advantage of opportunities presented by new health-related partnerships and initiatives to improve health outcomes and strengthen health systems based on primary health care;
- (8) to ensure political commitment and leadership at the highest levels of government in order to address major determinants of health through relevant sectoral policies and intersectoral action to improve health outcomes;
- (9) to design and implement information systems for monitoring and measuring the development and impact of health systems based on primary health care, which include use of the Millennium Development Goals indicators and make better use of information and communications technology;

3. REQUESTS the Director-General:

- (1) to provide support to Member States in strengthening capacities to develop and implement health systems based on the values and principles of primary health care;
- (2) to facilitate consolidation and sharing among stakeholders at all levels of lessons learnt and successes in strengthening health systems based on primary health care, including public health programmes such as those for disease control, maternal and child health and essential medicines, in order to support the drive for universal access to health services;
- (3) to promote networks of institutions and provide appropriate skills and experience to Member States in developing and strengthening their health policies and systems based on primary health care;
- (4) to strengthen WHO's methodologies and capacities, enabling the Organization to respond to Member States' requests for technical and policy support in strengthening health systems based on primary health care and to measure and evaluate progress;
- (5) to align the Secretariat's support to Member States and strengthen cooperation with partners in order to be consistent with national policies and plans for strengthening health systems based on primary health care, thereby improving coordination and harmonization of international cooperation with countries, in keeping with the principles of the Paris Declaration on Aid Effectiveness: ownership, harmonization, alignment, results and mutual accountability (2005);
- (6) to propose frameworks and tools that can be used for sectoral policy reviews and for monitoring and evaluating of performance of health systems based on primary health care and to provide support to countries in adapting and implementing them.

The Executive Board,
Having considered the report on primary health care, including health system strengthening,¹

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

The Sixty-second World Health Assembly,
Having considered the report on primary health care, including health system strengthening;

Recalling resolutions WHA54.13, WHA57.19, WHA58.17, WHA58.33, WHA60.22, WHA60.27, and WHA61.17 calling for health system strengthening in various contexts, as well as resolution WHA61.18 on monitoring of the achievement of the health-related Millennium Development Goals, and resolution WHA60.24 on health promotion in a globalized world;

Reaffirming the values and principles of the Declaration of Alma-Ata (1978), the Ottawa Charter for Health Promotion (1956) and the United Nations Millennium Declaration (2000);

Welcoming, in this regard, *The world health report 2008*,² published on the 30th anniversary of the international conference at Alma-Ata, which identifies four key policy areas: tackling health inequalities through universal coverage, putting people at the centre of care, integrating health into broader public policy, and providing inclusive leadership for health, and also welcoming the Commission on Social Determinants of Health's final report;³

Reaffirming the need to build sustainable national health systems, strengthen national capacities, and fully honour financing commitments made by national governments and their development partners in order to better fill the resource gaps in the health sector; to take concrete, effective and timely action in implementing all agreed commitments on aid effectiveness; and to increase predictability of aid, while respecting recipient countries' control and ownership of their health system strengthening;

Recognizing the structural changes of the current global health architecture which require collaborative, multi-stakeholder approaches to policy-making, including intergovernmental organizations, nongovernmental organizations and private foundations, as seen in the International Health Partnership and related initiatives, including International Health Partnership Plus (IHP+), the Providing for Health Initiative (P4H), and Health Eight (H8);

Recognizing the critical role of research on health systems in generating evidence for policy-making to achieve national and international health-related goals, especially the Millennium Development Goals as reported by the High-Level Task Force for the Global Ministerial Forum on Research for Health (Bamako, 17–19 November 2008);

Welcoming the substantive contributions from global, regional and national conferences on health system strengthening, including the G8 Summit (Hokkaido, Japan, 7–9 July 2008), the International Conference on Global Action for Health System

¹ Document EB124/8.

² *The world health report 2008: Primary health care – now more than ever*. Geneva, World Health Organization, 2008.

³ Commission on Social Determinants of Health. *Closing the gap in a generation – health equity through action on the social determinants of health*. Geneva, World Health Organization, 2008.

Strengthening (Tokyo, 3 and 4 November 2008), Almaty (2008), and WHO regional meetings; as well as the conferences on health promotion, including those in Ottawa (1986), Adelaide (1988), Sundsvall (1991), Jakarta (1997), Mexico City (2000) and Bangkok (2005);

Recognizing the need to revitalize primary health care and strengthen health systems, with the core values of equity, solidarity, universality and social justice, built upon the principles of multisectoral action and community participation;

Recognizing also the need for a comprehensive approach to primary health care based on the integration of vertical and horizontal health-care programmes that reduce fragmentation and improve the efficiency and effectiveness of existing health systems;

Concerned by the potential effects on health and health systems of the international financial and food crises and climate change;

Noting the growing consensus in the global health community, as exemplified at the G8 Summit in Hokkaido, that both disease-specific and health systems approaches are mutually reinforcing and contribute to achieving the health-related Millennium Development Goals;

1. URGES Member States:

- (1) to continue sustaining high-level political commitments and work with development partners to strengthen health systems based on the primary health care approach, by putting people at the centre of care, towards achievement of the Millennium Development Goals;
- (2) to secure and strengthen the commitment of political leadership at all levels to take responsibility for health system strengthening, and establish functional structures for multisectoral approaches to address effectively the social, economic, environmental, and cultural determinants of health throughout the life course;
- (3) to secure multisectoral action by incorporating health considerations within policies among all government sectors, such as by ensuring drinking water, safe food, decent work, a healthy environment, and adequate shelter for all;
- (4) to accelerate the progress towards universal and comprehensive health coverage through equitable public and private financing mechanisms, and by developing national capacity for assessing and developing health financing policy relevant to the national context, mindful of the need to protect health budgets in the wake of the current financial crisis;
- (5) to develop and improve the quality and quantity of health workforces by implementing, where appropriate, the WHO's code of practice and supporting global commitments;
- (6) to emphasize the need for integration of vertical and horizontal health-care programmes in the development of health systems;
- (7) to develop appropriate national mechanisms for providing essential medicines, health products, and appropriate technologies, including access to traditional medicines that are proven safe and effective, through equity-based health service networks, ensuring continuity and integration of people-centred care;
- (8) to develop and strengthen health information and surveillance systems for conducting research in health systems, enabling policy-makers to base their decisions on accurate health information;
- (9) to develop and implement health promotion strategies especially for those most vulnerable;

2. REQUESTS the Director-General:
- (1) to strengthen the capacity for health system strengthening based on the primary health-care approach to address the achievement of the health-related Millennium Development Goals, particularly in the areas of health workforce, health financing, and health information, across the Organization in order to provide better support to Member States by advancing knowledge and actively engaging appropriate bodies of the United Nations system and other international organizations;
 - (2) to provide guidance to Member States towards the integration of vertical and horizontal health care programmes in the development of national health systems;
 - (3) to facilitate the exchange of information on good practices in health system strengthening in collaboration with donor and partner countries, international organizations, foundations, development banks, the private sector, nongovernmental organizations, and civil society;
 - (4) to provide support to enhance national capacities for assessing and developing health financing policy based on sound evidence;
 - (5) to provide support to strengthen the capacity of Member States to plan, implement, and evaluate programmes to improve the health workforce;
 - (6) to facilitate coordination and development of global and national health information systems to monitor and evaluate health systems and programmes;
 - (7) to actively engage and provide guidance to the international community on coordinated and cohesive long-term technical support for strengthening health systems based on the primary health-care approach;
 - (8) to improve alignment and coordination of interventions for health system strengthening based on the primary health-care approach, in collaboration with Member States, relevant international organizations, international health initiatives, and other stakeholders, in order to increase synergies between international and national priorities;
 - (9) to report to the Sixty-third World Health Assembly, and subsequently to the Health Assembly every two years, through the Executive Board, on progress in implementing this resolution.

He also drew attention to a third draft resolution, on traditional medicine, proposed by China, which read as follows:

The Executive Board,

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

The Sixty-second World Health Assembly,

Having considered the report on Primary health care, including health system strengthening;¹

Recalling resolutions WHA22.54, WHA29.72, WHA30.49, WHA31.33, WHA40.33, WHA41.19, WHA42.43, WHA54.11 and WHA56.31;

Recalling the International Conference on Primary Health Care at Alma-Ata 30 years ago and noting that people have the right and duty to participate individually and

¹ Document EB124/8.

collectively in the planning and implementation of their health care, which may include access to traditional medicine;

Noting that the term “traditional medicine” covers a wide variety of therapies and practices, which may vary greatly from country to country and from region to region, and that traditional medicine may also be referred to as alternative or complementary medicine;

Recognizing traditional medicine as one of the resources of primary health care services to increase availability and affordability and to contribute to improve health outcomes, including those mentioned in the Millennium Development Goals;

Recognizing that Member States have different domestic legislation, approaches, regulatory responsibilities and delivery models;

Noting the progress of many governments to date in integrating traditional medicine into their national health systems;

Noting that progress in the field of traditional medicine has been obtained in a number of Member States through implementation of the WHO Traditional Medicine Strategy 2002–2005;¹

Expressing the need for action and cooperation by the international community, governments, and health professionals and workers, to ensure proper use of traditional medicine as an important component contributing to the health of all people, in accordance with national capacity, priorities and relevant legislation;

Noting that the WHO Congress on Traditional Medicine took place from 7 to 9 November 2008, in Beijing, and that the Beijing Declaration on Traditional Medicine was adopted by the Congress on 8 November 2008;

Noting that African Traditional Medicine Day is commemorated annually on 31 August, in order to raise awareness and the profile of traditional medicine in that African region, as well as to promote its integration into national health systems,

1. URGES Member States:

- (1) to adopt and implement the Beijing Declaration on Traditional Medicine in accordance with national capacities, priorities, relevant legislation and circumstances;
- (2) to respect, preserve, promote and widely communicate the knowledge of traditional medicine, treatments and practices, appropriately based on the circumstances in each country;
- (3) to recognize the government’s responsibility for the health of their people, and to formulate national policies, regulations and standards, as part of comprehensive national health systems to ensure appropriate, safe and effective use of traditional medicine;
- (4) to take action to integrate traditional medicine into their national health systems based on national capacities, priorities, relevant legislation and circumstances;
- (5) to develop further traditional medicine based on research and innovation in line with the Global strategy and plan of action on public health, innovation and intellectual property adopted in resolution WHA61.21 – governments, international organizations and other stakeholders should collaborate in implementing the global strategy and plan of action;

¹ Document WHO/EDM/TRM/2002.

- (6) to establish systems for the qualification, accreditation or licensing of traditional medicine practitioners and to assist traditional medicine practitioners to upgrade their knowledge and skills based on national requirements;
- (7) to strengthen communication between conventional and traditional medicine providers and to establish appropriate training programmes for health professionals, medical students and relevant researchers;
- (8) to commemorate Traditional Medicine Day on days as individual Member States may decide, in order to provide education and understanding of traditional medicine as one of the resources of primary health-care services,

2. REQUESTS the Director-General:

- (1) to support Member States in implementing the Beijing Declaration on Traditional Medicine;
- (2) to update WHO's strategy on traditional medicine based on countries' progress and current new challenges in the field of traditional medicine;
- (3) to implement the Global strategy and plan of action on public health, innovation and intellectual property, particularly through starting the agreed parts of the plan of action related to traditional medicine without prejudice to the existing mandates;
- (4) to continue providing policy guidance to countries on how to integrate traditional medicine into health systems, step by step, especially to promote the use of traditional medicine for primary health care;
- (5) to continue providing technical guidance in order to support countries to ensure the safety, efficacy and quality of traditional medicine;
- (6) to strengthen cooperation with WHO collaborating centres, research institutions and nongovernmental organizations in order to share evidence-based information and to organize various training programmes for national capacity-building in the field of traditional medicine;
- (7) to provide support to the traditional medicine programme to implement above-mentioned requests.

Professor SOHN Myong-sei (Republic of Korea) said that the draft resolution proposed by China on traditional medicine in the context of primary health care did not overlap with the draft resolution on primary health care proposed by his country and 11 cosponsors, and could therefore be discussed separately. However, the first draft resolution did seem to be parallel. Confident that collaboration between the two sides would result in consensus, he proposed that an informal group should be formed to work on merging the two drafts.

Dr KÖKÉNY (Hungary), speaking on behalf of the Member States of the European Union, supported the proposal to merge the draft resolutions so that a strong resolution on primary health care would be sent to the Health Assembly. He emphasized, however, that the draft resolution on traditional medicine should be treated separately.

Dr OULD JIDDOU (Mauritania), speaking on behalf of the Member States of the African Region, supported the proposal to merge the draft texts. One or two members for African States should join the informal group to ensure that Africa's basic concerns were taken into account.

Dr AHMADZAI (Afghanistan), Dr BUSS (Brazil), Dr REN Minghui (China), Dr SERPAS MONTROYA (alternate for Dr Larios López, El Salvador), Ms ROCHE (New Zealand), Dr MOHAMED (Oman), Dr GIMÉNEZ CABALLERO (Paraguay), Professor Aydin (Turkey),

Dr BIN SHAKAR (United Arab Emirates) and Dr WRIGHT (United States of America) expressed support for the proposal.

The CHAIRMAN drew attention to the report in document EB124/8.

Dr KÖKÉNY (Hungary) said that he spoke on behalf of the European Union and that the candidate countries Croatia, The former Yugoslav Republic of Macedonia and Turkey; the countries of the Stabilisation and Association process and potential candidates Albania, Armenia, Bosnia and Herzegovina, Montenegro and Serbia; the Republic of Moldova as well as Ukraine, aligned themselves with his statement. The European Union recognized the importance of WHO in coordinating global activities relating to primary health care. Measures were needed to address inadequate human resources and to provide sustainable financing in health, key factors in achieving the health-related Millennium Development Goals. The European Union encouraged well-coordinated and integrated action, notably regarding health determinants within primary health care. He emphasized the development of professional skills in the field of health promotion and disease prevention in order to deal with the contemporary health challenge of noncommunicable diseases. Strengthening primary health care was crucial to reducing health inequalities. The European Programme for Action, which aimed to deal with the shortage of health workers in developing countries, could serve as a model for regional cooperation and exchange of best practices with a view to improving national health systems.

Dr STARODUBOV (Russian Federation), welcoming the Director-General's support for primary health care, said that the Russian Federation prioritized primary health care, which would be fully funded despite the current financial crisis.

Given that importance, he was surprised that the report confined itself to recommending that the Board take note of the document. The absence of a draft resolution until the start of the Board's session called the purpose of the report into question. Was there really a need to reopen the debate on the principles of primary health care, which had been set out so clearly in Alma-Ata 30 years previously? The report did not seem to reflect fully the complexities of the situation at country level, nor was its analysis sufficiently detailed. Despite the Director-General's repeated emphasis, learning from the past was not mentioned in the report. Open and unbiased analysis, which explained the difficulties associated with primary health care, was needed in order to convince a new generation of health-care managers of the importance of learning from past lessons. Health systems should be effective and should respond to the needs of a changing world. Primary health care could do both.

A previous report to the Health Assembly had highlighted that a failure to develop primary health care could be attributed not only to lack of political will, resources and leadership, but also to unrealistic expectations.¹ That, together with different interpretations of primary health care, must be avoided. The same report had noted that many countries had then perceived primary health care as just one element of health policy. Six years on, the Secretariat's position on the issue must be clarified. Perhaps the inclusion of the strategic function of primary health care into national policy-making should be considered, even if operative matters were still decided locally.

Dr BIN SHAKAR (United Arab Emirates) said that the Member States of the Eastern Mediterranean Region reaffirmed their respect for the principles of equity, solidarity and social justice mentioned in the report and intended to ensure that the whole of society benefited from those principles. More than 20 million people of the Region had been provided with primary health-care services to which they had not had access before. The Member States had taken account of the social

¹ Document A56/27.

determinants of health and increased available resources; they had taken gender issues into account and improved the primary health care available to women.

In the United Arab Emirates, there were 200 primary health-care centres in operation, particularly in rural and remote areas. Additional programmes had emphasized maternal and child health, mental health, and health problems specific to the elderly. Remaining true to the principles of Alma-Ata, his country supported the four broad policy areas in the report's agenda for action. Carrying out that work would constitute an enormous challenge for the country, for all the Member States of the Region and would require cooperation between sectors and systems. There was no panacea, solutions would have to be tailored to the needs of each Member State, for which WHO could and should take a leadership role.

Ms ROCHE (New Zealand) commended the Director-General's leadership and the report on primary health care, and emphasized the thirtieth anniversary of the Declaration of Alma-Ata, improved health outcomes and cost-effective systems. As stated by the member for Hungary, primary health care had important links with the social determinants of health and with the strengthening of health systems. She supported the draft resolution on traditional medicine, which, while included under item 4.5, was sufficiently distinct to be considered separately.

Dr MOHAMED (Oman) thanked the Director-General for emphasizing the importance of primary health care. The four principles and directions for primary health care in the report would guide countries wishing to revitalize their systems, were relevant at all levels and sectors of economic development and should be adapted to each country's situation. The draft resolution should avoid the implication that primary health care was a matter for low-income and developing countries only: it was indeed a global issue. Countries expected the renewal of primary health care to lead to changes. The draft resolution should emphasize the leading role of WHO and the importance of primary health care in all countries and at all stages of development.

Professor HAQUE (Bangladesh), welcoming the report, said that the improved quality of life in most parts of the world owed much to primary health care, to which his country was fully committed. It had built a network of 12 000 community clinics, with the aim of one for every 6000 inhabitants, backed up by hospitals. A harmonized health system was needed, with an integrated approach and coordination with stakeholders and donors. However, countries like Bangladesh needed continued support to expand its infrastructure and services.

The alarming increase in cholera, with high fatality rates, called for a special focus where proper prevention and treatment were lacking. Only about 10% of cases were reported to WHO owing to lack of surveillance and the fear of sanctions. The lifting of embargoes on travel and trade in 2005 had gradually improved the situation. The prevention and control of cholera depended on public health tools, including affordable vaccines through cooperation between developing countries. The possibility of manufacturing such vaccines through the transfer of technology was being explored. Given the size of the problem, he urged the revival of the Global Task Force on Cholera Control established in the 1990s and the submission of a comprehensive report on the global situation, together with possible control measures, to the Sixty-second World Health Assembly. WHO support and technical assistance were needed by countries at risk in order to set up effective surveillance systems and to produce vaccines locally. A report from the Global Task Force would be helpful in guiding future work and Bangladesh wished to contribute actively to the process.

Ms TOELUPE (Samoa) commended the Director-General's visionary leadership in reviving global commitment to primary health care, whose principles and values were the most effective approach for Samoa's particular needs and essential to achieving the Millennium Development Goals. Its primary health care and national health system had recently focused on health financing, human

resources, health information, governance and delivery. A more harmonized approach to donor contributions was also being pursued with partners.

Dr ADITAMA (alternate to Dr Supari, Indonesia) said that the success of primary health care owed much to community participation, solidarity and social justice. His country supported the outcomes of the Regional Meeting on the Revitalization of Primary Health Care held in Jakarta in 2008. Indonesia had established a national programme of “Alert Villages” in which local communities took responsibility for maternal and child health, nutrition and basic surveillance, with a backbone of primary health centres. The system covered more than 70 000 villages and had strengthened the health system at the local level. A social system to provide for health security assisted low-income and middle-income communities in meeting their health service needs. The Director-General and Member States should maintain their commitment to primary health care, strengthening of health systems and the sharing of information nationally, regionally and internationally.

Dr OULD JIDDOU (Mauritania), speaking on behalf of the 46 States of the African Region, said that primary health care was closely linked to health systems and had been decisive in improving the health of the Region’s populations since the 1980s. The strengthening of primary health care and health systems constituted major challenges for countries of the Region. However, the goal of “Health for All” had not been attained, for reasons that included structural adjustment programmes, civil strife and natural or human-made disasters. Progress included declarations and resolutions on health financing, human resources and community involvement. With resolution AFR/RC56/R6, the Regional Committee for Africa had approved use of the primary health-care approach for revitalizing health services in order to speed up progress towards the Millennium Development Goals.

The Declaration of Ouagadougou, adopted in April 2008, on primary health care and health systems in Africa had subsequently been endorsed by the Regional Committee. Implementation would prioritize eight selected areas: leadership and governance for health; provision of services; human resources; funding; information systems for management; community involvement; partnerships; and research. The renewal of primary health care and traditional medicine would require the strengthening of fragmented health services weakened by the poor coordination and use of resources. Inappropriate approaches for strengthening community involvement, in the demand for health services and in their availability, accessibility and use, had been aggravated by inadequate funding. He looked forward to a proposed resolution, to be adopted by consensus, that would take into account new factors, such as the financial crisis and the need to safeguard health budgets. The countries of the African Region were ready to take part in drafting the resolution.

Mr TOURÉ (Mali) said that African health ministers, deeply concerned by the health situation in the Region, had agreed, through the Declaration of Ouagadougou, on the need to strengthen primary health care, with the participation of all parties concerned, since it was essential to the strengthening of health systems and accelerated achievement of the Millennium Development Goals. For that reason the key points of the Declaration should be taken into account in the proposed resolution, and the African group should be associated with its preparation, as suggested by the member for Mauritania. He invited all partners to join forces with African countries and tackle the priority areas listed in the Declaration.

Professor AYDIN (Turkey) suggested that, rather than primary health-care activities being performed in line with a policy-based definition, the health needs of societies should be determined on the basis of real evidence. The basis of primary health-care services was the provision of support through the health system as a whole, rather than support to just one or more areas. The global community had not yet succeeded in achieving the goals set in the Declaration of Alma-Ata, which had set out the general principles of primary health care in order to achieve “Health for All.” After 30 years of experience, WHO had documented the progress of primary health care, and *The world health report 2008* had highlighted the need for reforms in: universal coverage; service delivery,

reorganized around people's needs and expectations; public policy; and inclusive, participatory leadership, as required by the complexity of contemporary health systems.¹

Dr WRIGHT (United States of America) said that primary health care was crucial to national health systems for developed and developing countries alike. His Government remained committed to promoting a primary health-care approach, particularly by developing national capacity and producing the data and evidence needed to inform future health policy. He encouraged all countries to expand primary health-care services in all communities. Renewed commitment to primary health care was needed, both financially and politically. However, many Member States lacked the resources and political will to enact many of the policy changes suggested in the report, which failed to determine how Member States could increase the domestic funding that they needed in order to expand health-care delivery systems and infrastructure. Nor did the report acknowledge that containment of costs was an issue for both high-income and low-income countries. He also questioned why the report did not specifically mention health research and the development of robust systems of health information. Many Member States lacked quality data when making decisions on public health priorities or improvements to health-care delivery and infrastructure. In addition, a number of the terms used in the report, such as "close-to-client networks", or "primary care teams", required additional explanation.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) expressed strong support for WHO's goal of universal health service coverage. To achieve that, investment in health systems must be increased and the barriers to use of health services, particularly financial, removed. The United Kingdom had supported a number of countries in their efforts to remove health user fees, which in every case had led to increased utilization of health services, with proportionately greater benefits for the poor. He encouraged other countries and donors to adopt the same approach. WHO's role in taking forward the International Health Partnership and Related Initiatives (IHP+) was central in reducing fragmentation and transaction costs in external assistance for health, and he supported the efforts of WHO and the World Bank in that regard. In addition, all Board members should engage in the work of the High Level Task Force for Innovative International Financing for Health Systems.

Any draft resolution on primary health care should emphasize its core values, especially equity; should request WHO to help Member States to apply equity as the test for deciding on policy options, particularly financing and delivery of health care; and should request the Director-General to monitor the Secretariat's effectiveness in its support to countries and to their implementation of primary health-care values, standards and approaches.

Dr DAHL-REGIS (Bahamas) said that strengthening health systems through primary health care would allow Member States to meet important health goals, and enable WHO to implement its strategic objectives and programme of work more effectively. More remained to be done and the report should provide quantitative evidence to demonstrate to governments and donors that investment in primary health care represented value for money, and reduced the need for curative interventions in the future.

Many positive policies, such as strengthening immunization infrastructure through the GAVI Alliance, had directly or indirectly helped to strengthen health systems. She encouraged WHO to lead the way in reforming or monitoring financing structures with major partners, which would assist with the realignment of resources needed to promote primary health care. A good communications strategy was essential in order to inform those with control of financial resources about the choices they must make.

¹ *The world health report 2008: primary health care - now more than ever*. Geneva, World Health Organization, 2008.

Dr REN Minghui (China) welcomed WHO's efforts at all levels to revitalize primary health care, strengthen health systems and eliminate health inequities. His Government had invested in primary health care that was adapted to the country's particular needs and challenges. Two 10-year plans had achieved good results in improving primary health care in rural areas. Universal access to primary health care was an important goal, as the protection of people's health and social equality was an essential responsibility of governments. All sectors should be involved in promoting primary health care, of which traditional medicine was an important part, and approaches should focus on national circumstances.

Dr ABABII (Republic of Moldova) said that primary health-care reforms in his country had improved health indicators and aided progress towards achieving the Millennium Development Goals. In emphasizing human and financial resources, he highlighted needs for: management training in primary health-care; greater participation by society in health-care programmes; and improved access by disadvantaged groups to basic services, for which social protection mechanisms should be devised, taking into account the disparities of living standards between urban and rural populations. Increasing differences in life expectancy and other health indicators between the two groups was a cause for concern.

He emphasized the lack of standardized indicators for accessibility, equity, quality and effectiveness of primary health care. Indicators varied from country to country, an issue that should be addressed in WHO's basic documents. He expressed support for WHO's initiative to allocate funds to priority areas as identified by countries. That would strengthen existing structures, reduce duplication and increase efficiency.

Mr VALLEJOS (Peru) said that progress in the twentieth century, in terms of life expectancy and infant mortality, had been significant, but less than the expectations in 1978, when the Declaration of Alma-Ata had been signed. Unequal access to health care in Peru, caused by socioeconomic, educational and ethnic factors, had led to increased mortality and morbidity rates, particularly among high-risk groups such as children, pregnant women and the elderly.

In Peru, as elsewhere, increased life expectancy and reduced infant mortality reflected better access to primary health-care services. Social programmes to improve access to decent housing, sanitation and nutrition would help to maintain progress. Access to treatment for parasitic and water-borne infections, tuberculosis and other diseases was helping to improve the health of the population. The participation of women as the main force for protecting family health had facilitated their access to primary health care, including health education, simple and economical treatment, reproductive health services and prescribed generic medicines.

Highlighting the importance of trained health professionals, he outlined the "family doctor" and "household doctor" strategies being implemented in Peru, which included medical consultations, house-to-house treatment, promoting action to prevent the spread of infections, and referrals that were mainly children and pregnant women. Such strategies aimed to reduce child mortality and morbidity through health promotion and thus relieve pressure on health services.

Dr GIMENÉZ CABALLERO (Paraguay) reaffirmed his Government's commitment to revitalizing primary health care. Implementing the strategy in a universal, integral and equitable manner would reduce social exclusion and facilitate access to health services. Revitalization should be comprehensive, from community health workers to more complex services, building on existing strengths and working towards a coherent whole. He highlighted challenges: balancing promotion and prevention; ensuring universal access to essential medicines; strengthening human resources; improving health information; and increasing participation. Specific technical resources and efforts should be directed towards revitalizing primary health care.

Dr JAYANTHA (alternate to Mr de Silva, Sri Lanka) said that his country's health system, which was based on primary health care, had achieved good results. In the face of the changing

disease burden, however, a revitalized approach was required. Increased incidence of noncommunicable diseases required the promotion of healthy lifestyles and good health practices and those must be incorporated into primary health-care systems. Given the difficulty of finding sufficient resources for health care, he commended the work of his Region in examining how self-care could be promoted and adopted in a rational manner. He urged WHO to pursue action in the four areas highlighted in the report.

Dr BUSS (Brazil) commended the Director-General's commitment to primary health care, and welcomed the consultative process undertaken in that area. Brazil had launched its family health programme in 1994: teams had been established across the country and currently covered nearly 90% of the population, leading to significant reductions in maternal and child morbidity and mortality, and improvements in quality of life. The programme was aimed at the entire population and included health promotion, disease prevention and intersectoral activities, such as action to improve the environment, as well as curative services. The family health teams in the public sector comprised a general practitioner, nursing staff and community health workers, and dentists in many cases, and were capable of resolving 90% of the health problems encountered, with referral of the remainder to other levels of the health system.

His Government was constitutionally obliged to provide services to the entire population and to prioritize primary health care. Developing those services at all levels had met with success Brazil had achieved extensive coverage for measles immunization and the second highest rate of organ transplantation in the world. He supported WHO in its efforts to encourage implementation of primary health-care strategies and to incorporate that element into all its programmes. He emphasized the overall strengthening of health systems, including primary health care, rather than focus on vertical programming. WHO should also emphasize decentralization within the Organization in order to strengthen its regional and country offices.

Mr MIGUIL (Djibouti) said that Djibouti had invested in primary health care and strengthened its health systems, particularly in the area of maternal and child health through increased numbers of trained health personnel; developing health promotion policies; and encouraging community involvement. However, nomadic and displaced people, and refugees, were all placing a great burden on the health system and distorting health indicators. As a small country surrounded by larger countries, in some of which security was uncertain, Djibouti found it difficult to obtain reliable data and to plan and coordinate primary health care activities, including immunization campaigns. He appealed to WHO to provide guidance on enhancing cooperation and collaboration in order to strengthen primary health-care activities.

Dr SADRIZADEH (Islamic Republic of Iran)¹ applauded the Director-General's commitment to the renewal of primary health care. Despite significant changes in the health field since the Declaration of Alma-Ata in 1978, most of those principles and values remained valid, and primary health care was still a priority. Progress in most countries required a reorientation of health systems to ensure that primary health-care services responded better to people's needs and were delivered through facilities embedded in the community. His country had significantly reduced mortality over the past 20 years through its community-based system. He supported the merger of the two draft resolutions on primary health care including health system strengthening and his country wished to be included as a sponsor of the resulting draft resolution.

Ms ARTHUR (France),¹ commending *The world health report 2008*, said that the international community was committed to the goal of universal access to health services. However, some 100 million

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

people were forced into poverty each year by payments for those services, and many more had no access at all. Increased coverage of health insurance and numbers of trained health personnel were essential in order to strengthen health systems in developing countries and support programmes to control communicable and noncommunicable diseases. The State was central to leading that process and to providing funding or co-funding, as concluded at the conference entitled “Social Health Protection in Developing Countries: Who Will Pay?” (Paris, May 2008). However, action could not be left to health ministries alone. In the spirit of the 2005 Paris Declaration on Aid Effectiveness, WHO should take action in mobilizing and coordinating all efforts to improve coverage of health insurance.

Ms BILLINGS (Canada)¹ welcomed the report and confirmed Canada’s renewed commitment to primary health care. Canada looked forward to participating in the drafting group that would merge the two draft resolutions on primary health care and strengthening of health systems. The revised text should be sufficiently flexible to accommodate countries such as hers, where responsibility for primary health care was shared or assumed by subnational authorities. She welcomed the increasing recognition given to strengthening health systems, notably in improved access to health care by disadvantaged population groups in developing countries. Canada would continue support to developing countries in response to their expressed needs.

Ms MATSAU (South Africa),¹ welcoming the renewed commitment, regretted that, despite progress in most countries in implementing primary health care, the ideals set out in the Declaration of Alma-Ata had not been fully realized. There had been many lost opportunities and Member States could have done better.

Two key aspects to strengthening health systems, namely human resources for health and health information systems, should be covered in the revised draft resolution. Some past failures had been due to lack of proper monitoring: only reliable data would indicate how well programmes were performing. There was room to improve equity in, and universality of access to, health services. Specific policies might improve delivery to vulnerable populations groups and bridge gaps in service accessibility. Appropriate governance structures and promotion of community ownership of primary health-care services were also required.

Dr ALVIÁREZ (Bolivarian Republic of Venezuela),¹ expressed support for the revised draft resolution and the strengthening of primary health care through improved community participation. The Constitution of his country recognized health as a fundamental social right. His Government had established primary health-care activities including training of community health workers to provide simplified medical care in remote areas; outpatient clinics with trained staff; and an expanded programme of immunization offering 14 vaccines. Efforts were being made to expand training of health personnel. The number of family practitioners, community doctors and health centres was increasing. Social policies were taking account of determinants of quality of life and covered, for example: disabled people; those with genetic disorders; indigenous peoples; housing; nutrition; education; and control of communicable diseases such as malaria. Those policies, financed by the State, had contributed to a significant fall in infant mortality and to a substantial increase in access to clean drinking water. Regional and global cooperation between countries also played an important role in ensuring successful implementation.

Dr KARAGULOVA (Kazakhstan)¹ drew attention to national and international events in 2007 and 2008 calling for the renewal of primary health care and organized in collaboration with WHO, including the international conference held in Kazakhstan to mark the 30th Anniversary of the

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

Declaration of Alma-Ata. She welcomed the report and thanked the Director-General for her efforts in promoting primary health care on a global, regional and national scale.

She supported the comments made by the members for the Russian Federation and Tunisia and agreed that both of the draft resolutions tabled could be merged to create one practical, usable resolution.

Mgr VITILLO (Holy See), speaking at the invitation of the CHAIRMAN, congratulated the Secretariat for its report, and highlighted the references to equity, solidarity and social justice; and the principles of multisectoral action and community participation, all of which were echoed in the teaching of the Catholic Church.

Organizations based on Church or faith, as well as civil society, had a key role to play in primary health care, frequently reaching communities in rural and isolated areas which had no access to primary health services. Those organizations implemented national health plans, and contributed to strengthening of health systems, but were regrettably excluded from policy-making and direct funding.

The Holy See affirmed the recommendation contained in *The world health report 2008* to enhance efforts to improve health by acting on the wider social, economic, and environmental causes of ill health and health inequalities. In his 2009 World Day of Peace Message, Pope Benedict XVI had promoted similar themes of “global solidarity”, through a “change of lifestyles, of models of production and consumption, and of the established structures of power”.

Dr MUÑOZ (Chile)¹ expressed support for a resolution based on the report to the next Health Assembly. The resolution should clearly mention the vital role of primary health care in social protection for all people. Provision of primary health care should be spread across all sectors of public policy related to social determinants of health, and should be carried out at the community level. He supported the request by representative of Canada to incorporate flexibility so that the resolution could be easily adapted to the situation in each country.

Mr SAMRI (Morocco)¹ thanked the Secretariat for the detailed report and praised the Regional Office for the Eastern Mediterranean for its excellent work in that area. WHO should remain vigilant to the global financial crisis which threatened primary health care, the keystone of all national health systems and central to reducing health inequities.

His country had prioritized primary health care by implementing measures including: obligatory health insurance; access for all people to primary health care; involving civil society; strengthening maternal, infant and child health programmes; regular vaccination campaigns; renewed training of health care workers; and public awareness campaigns, especially in rural areas.

He supported WHO's programme of action and highlighted international solidarity and a fair division of responsibility.

Professor RANTANEN (International Commission on Occupational Health), speaking at the invitation of the CHAIRMAN, welcomed the principles contained in the report and remarked on their link with occupational health. In order to improve overall health care and promote equity, vulnerable and high-risk groups should be targeted.

Workers in developing countries and countries in transition were most at risk from occupational health and safety hazards. More than two million deaths a year were directly caused by occupational health and safety factors, with considerable socioeconomic consequences.

In response to the health requirements of underserved working populations, his organization, with WHO and ILO, had launched Basic Occupational Health Services, an application of primary health-care policy in the field of occupational health. It was being piloted in several countries and areas, including China, Thailand, Viet Nam, the north-west of the Russian Federation, countries in south-east Europe and the east African community area, and it had already been implemented in various forms in other countries such as Brazil, Chile, Finland and the Netherlands.

He recommended the inclusion of basic occupational health services in primary health-care systems, and further pilot projects in other countries. WHO and its partners should assist countries in that regard. Finally, basic occupational health should be taught to primary health-care workers.

Professor GUNN (International Federation of Surgical Colleges), speaking at the invitation of the CHAIRMAN, expressed satisfaction at WHO's efforts to strengthen essential surgery within emergency and primary health care. Although some progress had been made, surgical disease was increasing at an alarming rate, especially in middle-income and lower-income countries, and the inclusion of essential surgery within primary health care remained inadequate.

Around 234 million major surgical procedures were performed each year, equating to double the number of births annually. There were significant inequities in the global coverage of surgical care, with the poorest third of the world's population receiving about 3% of the total. Surgical care was erroneously perceived as a luxury in developing countries.

The Federation was committed to making essential surgery an integral part of primary health care, and requested the Board to consider its inclusion in WHO's overall primary health-care concept and action.

Ms SHASHIKANT (Churches' Action for Health), speaking at the invitation of the CHAIRMAN, and delivering her statement jointly on behalf of the People's Health Movement, proposed an alternative version of the draft resolution.

The meeting rose at 12:30.

FIFTH MEETING

Wednesday, 21 January 2009, at 14:05

Chairman: Mr N.S. DE SILVA (Sri Lanka)

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

Primary health care, including health system strengthening: Item 4.5 of the Agenda
(Document EB124/8) (continued)

Dr SEYER (World Medical Association), speaking at the invitation of the CHAIRMAN, and on behalf of the World Health Professional Alliance, said that the Alliance represented national associations in more than 150 countries and the collective views of more than 25 million health professionals. Welcoming the report, she emphasized the value of well-functioning health-care systems for sustained economic and social development, improving quality of life and fostering world peace. In recent years, the health-care sector had become a major sector in national economies. Health-care systems constituted the pillars of national economies. Building health-care systems around primary care and making that the core of a comprehensive approach was a meaningful and rational strategy. Primary care brought health care close to where people lived and worked. It needed to be sustained by integrated referral systems and regarded as a policy direction for all countries.

The Alliance emphasized the need to broaden the report's strategic directions. Universal care would require comprehensive health-care systems founded on strong primary care structures. That would give all seriously ill patients a chance to receive treatment, would attract health professionals, and underlay sustainable economic development.

Dr COMETTO (Save the Children), speaking at the invitation of the CHAIRMAN, said that the establishment of equitable health systems with high-quality services was at the heart of his organization's strategy, and that WHO was an important ally in pursuing that objective.

At the global level, there was an opportunity to streamline health aid and make it more responsive to the needs of women and children by strengthening health systems with, if necessary, new aid instruments. WHO should use its influence with initiatives such as the International Health Partnership and the High Level Task Force on Innovative International Finance for Health Systems. However, better alignment of external financing and more equitable allocation of domestic resources would be necessary.

Social, economic, cultural and financial barriers prevented populations in lower-income and middle-income countries from gaining access to health care. Reducing financial barriers by removing out-of-pocket payments could be one of the solutions. Payment for health care at the point of use had been shown to restrict access; it caused health expenditure that drove tens of millions of households below the poverty line each year, and adversely affected the wider social determinants of health.

In resolution WHA58.33 the Health Assembly had urged Member States to adopt financing systems based on risk pooling. Limited progress had been made and he urged renewed efforts to implement those recommendations.

Ms YANN (Oxfam), speaking at the invitation of the CHAIRMAN, said that she supported WHO's renewed commitment to primary health care backed by functioning health systems. She emphasized equity: the adoption of policies and practices, including financing and delivering health services, that improved the health of poor and marginalized people. The public provision of free health

services with essential medicines was the surest way to ensure health care for the poor. The quality of private provision varied between “five-star” hospitals and unqualified individuals selling medicines of low quality. Such extremes often failed, in terms of either equity or quality and safety. Therefore, WHO should seek empirical evidence on the nature and efficiency of private providers, and the use of their services by poor people. WHO should also avoid conflating private for-profit organizations with nongovernmental and faith-based organizations. The private sector should complement, but not undermine, public health systems.

Dr ETIENNE (Assistant Director-General) thanked speakers for their commitment to the renewal of primary health care and strengthening of health systems. Discussions at six regional consultations, the thirtieth anniversary celebrations of the Declaration of Alma-Ata and regional committee meetings had guided the formulation of the report and the recommendations for a related resolution. The Secretariat remained fully committed to the primary health-care strategy in achieving improved health outcomes, the Millennium Development Goals, and the highest standards of health. That approach was relevant to all countries and at every stage of the development process.

Speakers had emphasized the strategy’s four policy directions. Some had also mentioned universal coverage, social protection in the form of fee or pool payment schemes, and sustainable health financing. She had taken note of those statements and on the need for service delivery to encompass all levels of care, from the community to more specialized services, and to be responsive to people’s needs and expectations, through comprehensive and integrated delivery.

Responding to a question from the member for the United States on moving health care close to communities, she said that the concept of geographical accessibility should also encompass, *inter alia*, location, culture, suitability, participation and accountability.

There had been calls for “health in all policies” and references to the importance of health in all sectors. Inclusive and participatory approaches to governance and leadership had been emphasized, particularly the need to integrate and empower communities in decision-making.

She recognized that community participation and ownership should be strengthened when implementing the strategy. She had also taken note of the references made to strengthening the six building blocks: health financing, human resources for health, health information, governance, service delivery, and commodities.

The members for the Russian Federation and the Bahamas had commented that the report contained little analysis. That had been due to lack of space. However, a full analysis of the challenges and constraints could be found in both *The world health report 2008* and the report of the Commission on Social Determinants of Health. Remaining gaps in the analysis and evidence would be filled during ongoing implementation of the strategy. The Secretariat would ensure that primary care was brought into the mainstream of the Organization’s work. She confirmed that there would be a linkage between the primary health-care strategy and the social determinants of health. A greater responsiveness to countries’ needs and enhanced technical assistance in country support programmes were also required. The Secretariat would fulfil its leadership role in future implementation of the strategy. She would work with Member States to revise the documentation, and on implementing health systems based on primary health care.

The Board took note of the report.

The CHAIRMAN drew attention to the draft resolution on traditional medicine proposed by China, which had been introduced in the previous meeting.

Dr REN Minghui (China) said that the Declaration of Alma-Ata in 1978 had called for traditional medicines to be included in national health systems. Nowadays, despite all the new technology available, the popularity of traditional medicine was increasing. Traditional medicines were already widely used in Africa, Asia and Latin America. In developed countries, such as Canada,

France and the United States of America, more people were turning to traditional medicine as its efficacy and safety became recognized. The number of countries in which traditional medicines were used had increased from five to 39 between 1990 and 2007; the number of Member States with applicable legislation had increased from 14 to 86 between 1980 and 2003; and the number of Member States with research institutes in the field had increased from 12 to 56 between 1970 and 2007. Norway, Singapore and the United Kingdom of Great Britain and Northern Ireland already had legislation on traditional medicine and other countries sought to introduce traditional medicines into their health systems, but lacked the necessary expertise. The Beijing Declaration on Traditional Medicine had been adopted at the WHO Congress (Beijing, 7–9 November 2008). The draft resolution on traditional medicine reflected the conclusions of the Conference. So far, 11 Member States had expressed their wish to add their names to the list of sponsors. The draft resolution should be adopted so that it could be submitted to the Sixty-second World Health Assembly.

Dr KÖKÉNY (Hungary), speaking on behalf of the Member States of the European Union, thanked the member for China for bringing such an important subject to the Board's attention. He fully recognized the importance of traditional medicine around the world. However, the draft resolution ought to allow Member States to comply flexibly with their own national health systems and priorities. It would be preferable to use the WHO definition of traditional medicine in order to avoid duplication of the Beijing Declaration, particularly in paragraph 1. In addition, he wished to propose the following amendments: that in subparagraph 1(1) "URGES" should be replaced by "INVITES"; in subparagraph 1(2) the word "promote" should be deleted; in subparagraph 1(4) the words "to take action to integrate" should be replaced by "to consider the possibility to integrate"; in subparagraph 1(6) the beginning of the sentence should be changed to "to consider the possibility to establish systems for qualification ..." and the words "in accordance with national capacities, priorities, relevant legislation and circumstances" should be added at the end of the sentence; in subparagraph 1(7) the language from point VI of the Beijing Declaration should be maintained, namely "the communication between the practitioners ... should be strengthened", and the following words "in accordance with national capacities, priorities, relevant legislation and circumstances" inserted thereafter; and subparagraph 1(8) should be deleted. The choice of traditional medicine day should be left to individual Member States. In subparagraph 2(3) the wording should be changed to "implement the Global Strategy", which included recommendations relating to traditional medicine.

Should those amendments be incorporated, the Member States of the European Union would be able to support the draft resolution.

Ms TOELUPE (Samoa), speaking as a cosponsor of the draft resolution, said that Samoa recognized traditional medicine as integral to accessible and affordable primary health care. National legislation had recognized traditional healers and birth attendants as health service providers, making them more accountable and ensuring safer practice. Samoa remained dependent on WHO to provide technical guidance on standards, research and sharing of information.

Dr JAYANTHA (alternate to Mr de Silva, Sri Lanka) said that his Government placed great emphasis on traditional medicine. It had established medical colleges awarding degrees in the subject and established a Ministry of Indigenous Medicine. More than 1500 medical graduates were employed by the Government in the sector, and the country had more than 15 000 practitioners of traditional medicine. He expressed support for the draft resolution and urged WHO to provide technical assistance to relevant countries in order to improve the safety, efficacy and quality of traditional medicine and the competence of its practitioners.

Dr KAMOTO (Malawi), speaking on behalf of the Member States of the African Region, expressed support for the draft resolution, which Malawi wished to cosponsor. Issues relating to traditional medicine affected the poor, the most vulnerable, and those without easy access to modern

health systems. The variation in therapies and practices from country to country could result in traditional medicine being practised in countries without the necessary regulatory framework, and leave them vulnerable to abuse. Fortunately, the recent Beijing Declaration on Traditional Medicine had established some standards in that area.

At the national level, Malawi was supporting and collaborating with traditional healers on tuberculosis, HIV and research into traditional medicine.

Ms HELA (South Africa),¹ speaking as a cosponsor of the draft resolution, suggested that the word “integrate” should be replaced by “include” throughout the text. Traditional medicine was used widely in Africa and was important for delivery of primary health-care services. She emphasized the development of appropriate standards in research into safety and equity; and of reliable instruments to assess traditional medicine’s effectiveness and potential value in the public health services. The institutionalization of traditional medicine within the health system needed to be supported by policy, legislative frameworks and resources.

Dr RAZAFINDRAZAKA (Madagascar)¹ said that traditional medicine was practised in Madagascar, notably in rural areas, and its advantages and disadvantages had been observed. In the current financial crisis, traditional medicine was an alternative that could not be ignored when responding to health problems. He therefore supported the draft resolution, with the exception of subparagraph 1(6) on the role of the State in licensing traditional medicine practitioners. Since reliable medical diagnosis required sound medical training, collaboration between traditional healers and physicians should be emphasized in the draft resolution.

At the request of Dr REN Minghui (China), the CHAIRMAN suggested that further discussion of the subitem should be deferred pending consideration of the proposed amendments.

It was so agreed.

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

Commission on Social Determinants of Health: Item 4.6 of the Agenda (Document EB124/9)

The CHAIRMAN invited the Chairman of the WHO Commission on Social Determinants of Health to introduce the item.

Professor Sir Michael MARMOT (Chairman, Commission on Social Determinants of Health) said that the Commission had been set up in the service of equity and in recognition of the importance of taking action on the causes of illness. Simply expressed, the Commission had concluded that social injustice was killing people on a grand scale. Lack of universal access to health care was one of the important social determinants of health, and the Commission welcomed WHO’s renewed emphasis on primary health care. Nevertheless, primary health care and social determinants of health were mutually dependent. The Commission had established three action areas: daily living conditions; structural drivers, i.e., inequities in power, money and resources; and monitoring, research, evaluation and capacity building. Since the Commission had reported to the Director-General in August 2008, several WHO regions, in particular the Region of the Americas, had shown great interest in the Commission’s findings, and related meetings and follow-up were planned in some countries, including Sri Lanka and the United Kingdom of Great Britain and Northern Ireland.

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

The Commission had worked closely with civil society groups. Involving other agencies and elements of government in the work on social determinants was vital, and WHO had thus encouraged the United Nations Economic and Social Council to consider the work of the Commission.

The CHAIRMAN drew the Board's attention to a draft resolution and its financial and administrative implications for the Secretariat, which read as follows:

The Executive Board,
Having considered the Secretariat's report on the final report of the WHO Commission on Social Determinants of Health,¹

RECOMMENDS to the Sixty-second World Health Assembly the adoption of the following resolution and its financial and administrative implications:

The Sixty-second World Health Assembly,
Having considered the Secretariat's report on the final report of the WHO Commission on Social Determinants of Health;

Noting the 60th anniversary of the establishment of WHO in 1948 and its Constitution which affirms that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

Noting the 30th anniversary of the International Conference on Primary Health Care at Alma-Ata in 1978 which reaffirmed the essential value of equity in health and launched the global strategy of primary health care to achieve health for all;

Recalling the principles of "Health for All", notably the need for intersectoral action (resolution WHA30.43);

Confirming the importance of addressing the wider determinants of health and considering the actions and recommendations set out in the series of international health promotion conferences from the Ottawa Charter on Health Promotion to the Bangkok Charter for Health Promotion in a Globalized World making the promotion of health central to the global development agenda as a core responsibility of all governments (resolution WHA60.24);

Noting the global consensus of the Millennium Declaration to achieve the Millennium Development Goals by 2015 and the concern at the lack of sufficient progress towards many of these goals in some regions at the half-way point;

Noting the publication of *The world health report 2008* on primary health care and its focus on ways to improve health equity by reforming health and other societal systems;

Mindful about the fact that responses to environmental degradation and climate change include health equity issues and noting that the impact of climate change is expected to negatively affect the health of vulnerable and disadvantaged populations (resolution WHA61.19);

Mindful about the facts concerning widening gaps in life expectancy worldwide;

Attaching utmost importance to the elimination of gender-related health inequalities;

Recognizing that millions of children globally are not reaching their full potential and that investing in comprehensive supports for early child development that are

¹ Document EB124/9.

accessible to all children is a fundamental step in achieving health equity across the lifespan;

Acknowledging that improvement of unfavourable social conditions is primarily a social policy issue;

Noting the need to improve coordination among global, national and subnational efforts in tackling social determinants of health through work across sectors, while simultaneously promoting social and economic development, with the understanding that such action requires the collaboration of many partners, including civil society and private sector,

1. EXPRESSES its appreciation for the work done by the Commission on Social Determinants of Health;
2. CALLS UPON the international community, such as United Nations agencies and intergovernmental bodies:
 - (a) to take note of the final report of the Commission on Social Determinants of Health and its recommendations;
 - (b) to take action in collaboration with the WHO Secretariat and Member States on assessing the impacts of policies and programmes on health inequalities and on addressing the social determinants of health;
 - (c) to work closely together with the WHO Secretariat and Member States on measures to improve health for the entire population and reduce inequalities through addressing social factors that influence health;
3. URGES Member States:
 - (a) to develop and implement goals and strategies to improve public health with a focus on health inequalities;
 - (b) to strengthen the role of public health in policy development to reduce health inequalities, including ensuring access to all aspects of public health: health promotion, disease prevention and health care;
 - (c) to strengthen efforts to achieve equitable access to public health interventions, including health promotion, disease prevention and health care for the entire population;
 - (d) to ensure dialogue and cooperation among relevant sectors and be a driving force for this cooperation with the aim of integrating a consideration of health into relevant public policies;
 - (e) to educate health providers on how to take social factors into delivering appropriate care to their patients;
 - (f) to contribute to the improvement of the daily living conditions of major importance for health and social well-being across the lifespan by involving all relevant partners, including civil society;
 - (g) to contribute to the empowerment of individuals and groups, especially those who are marginalized, and take steps to improve the societal conditions that affect their health;
 - (h) to develop or make use of existing methods and evidence, tailored to national contexts in order to address the social determinants and social gradients of health and health inequalities;
 - (i) to make use of, and if necessary, improve health information systems in order to monitor and measure the health of national populations, with data disaggregated according to the major social factors in each context (such as gender, ethnicity, education, employment and socioeconomic status) so that health inequalities can be detected and the impact of policies monitored;

4. REQUESTS the Director-General:
- (a) to work closely with partner agencies in the multilateral system on appropriate measures that address the social determinants of health and to advocate for this topic to be high on the global development and research agendas;
 - (b) to strengthen the capacity within the Organization with the purpose to give sufficient priority to relevant tasks related to addressing the social determinants of health in order to reduce health inequalities;
 - (c) to implement measures, including indicators for the monitoring of social determinants of health, across relevant areas of work and promote addressing social determinants of health to reduce health inequalities as an objective of all areas of the Organization's work, especially priority public health programmes;
 - (d) to ensure that ongoing work on the revitalization of primary health care addressing the social determinants of health is aligned with this, as recommended by *The world health report 2008*;
 - (e) to support Member States in implementing a health-in-all-policies approach to tackling inequalities in health;
 - (f) to support Member States, at their request, in implementing measures with the aim of integrating a focus on social determinants of health across relevant sectors and to design, or if necessary redesign, their health sectors to address this appropriately;
 - (g) to support Member States, at their request, in strengthening existing efforts on measurement and evaluation of the social determinants of health and the causes of health inequalities and to develop and monitor targets on health equity;
 - (h) to support research on effective policies and interventions to improve health by addressing the social determinants of health that also serve to strengthen research capacities and collaborations;
 - (i) to support the regional directors in developing a regional focus on issues related to the social determinants of health and in engaging a broader range of countries in this issue, in accordance with the conditions and challenges of each region;
 - (j) to prepare a global event, with the assistance of Member States, before the Sixty-fifth World Health Assembly in order to highlight the developments, progress and renewed plans for addressing the alarming trends of health inequalities and to increase global awareness on social determinants of health, including health equity;
 - (k) to report on progress in implementing this resolution to the Sixty-fifth World Health Assembly.

1. Resolution Reducing health inequalities through action on the social determinants of health

2. Linkage to programme budget

Strategic objective:

7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches.

Organization-wide expected result:

7.1 Significance of social and economic determinants of health recognized throughout the Organization and incorporated into normative work and technical collaboration with Member States and other partners.
 7.2 Initiative taken by WHO in providing opportunities and means for intersectoral collaboration at national and international levels in order to address social and economic determinants of health and to encourage poverty reduction and sustainable development.
 7.3 Social and economic data relevant to health collected, collated and analysed on a disaggregated basis (by sex, age, ethnicity, income, and health conditions, such as disease or disability).

(Briefly indicate the linkage with expected results, indicators, targets, baseline)

Implementation of the resolution will greatly assist the ability of the Organization to integrate work on the social determinants of health into its programmes and to support Member States in developing national capacity to measure health inequities and implement intersectoral policies on the social determinants of health.

3. Financial implications**(a) Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)**

US\$ 29 850 000 over the years 2009, 2010 and 2011.

(b) Estimated cost for the biennium 2008–2009 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)

US\$ 9 760 000 covering work at headquarters level to extend existing activities, and work in regional offices to build capacity and facilitate regional efforts, in line with the resolution.

(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009?

All activities for the biennium 2008–2009 can be subsumed under the Programme budget 2008–2009.

(d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)

Not applicable.

4. Administrative implications**(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)**

All levels of the Organization.

(b) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant)

3.5 staff members (full-time equivalent) across the six regional offices in order to build regional capacity to work with countries, in line with the resolution.

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

Three years (2009–2011), with a report on progress to be submitted to the Sixty-fifth World Health Assembly in 2012 in line with the resolution.

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union and its 27 Member States, said that the Commission's work was important in understanding how to bring health to all. The Commission's report¹ identified the underlying causes and the actions needed in order to diminish those inequities. He supported the draft resolution and invited all countries to work together in finalizing an effective resolution. He also called for renewed leadership by WHO on health equality.

Dr ZARAMBA (Uganda), speaking on behalf of the Member States of the African Region, expressed support for the draft resolution. Social determinants greatly affected the health status of a nation, and greater knowledge was needed about how they influenced individual and community health. Social determinants differed considerably both between and within countries in the African Region, along with inequalities in health status, well-being and social practices.

¹ See Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health*. Geneva, World Health Organization, 2008.

The evidence gathered by the Commission on Social Determinants of Health would guide Member States and the Secretariat in their efforts to overcome health inequalities. Unless the social determinants of health were addressed, many disease-specific targets, including the health-related Millennium Development Goals, would never be achieved. He appreciated the three main recommendations and the action areas identified in the Commission's report.

More technical and financial support would be needed to assist the Member States of the Region to implement the Commission's recommendations. Lack of reliable data was a challenge. Health inequity must be measurable both within countries and across the world. National governments and international organizations such as WHO and ILO should set up surveillance systems for national and global health equity, monitor social determinants of health and evaluate the impact of policies. National governments must commit themselves, with the support of international partners, to clearly defined policies for multisectoral social protection.

The poor performance of many economies in the African Region presented a further challenge. The assurances and commitments of donor countries, at the high-level consultation on the financial crises and global health held that week, were gratifying. African Member States needed more support in strengthening leadership and governance at all levels and in addressing the findings and recommendations generated by health equity analysis.

Dr JAYANTHA (alternate to Mr de Silva, Sri Lanka), endorsing the draft resolution, said that health inequities were associated with social, economic, cultural and political factors. He welcomed the Commission's final report; its key findings should be taken into consideration by the Member States in the formulation of public policy. Health care in Sri Lanka was based on primary health care and recognized the influence of social determinants of health. Political commitment had been shown by the provision of free health care for all citizens, and by free education at all levels, in order to maximize social justice. As a result, the country had achieved a high literacy rate and commendable health indicators.

Sri Lanka would continue to play a key role in WHO's work on the social determinants of health. In February 2009, his Government would host a high-level consultation for countries of the South-East Asia Region in order to discuss the Commission's recommendations. The meeting should encourage a healthy debate which would benefit other regions as well.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland), said that, at the launch of the Commission's report in London in November 2008, his Prime Minister had stated that it was a matter of social justice to redress the inequality in life expectancy between countries. Furthermore, a major review of health inequalities in England would be undertaken. In September, his Government had contributed to a US\$ 16 000 million deal to restore progress towards meeting the Millennium Development Goals. Global financial problems increased the need for action: they should not be seen as a reason to delay. The draft resolution, of which the United Kingdom was a sponsor, proposed ways of tackling health inequalities collectively.

Dr VOLJČ (Slovenia), speaking as a sponsor of the draft resolution, said that the social determinants of health were closely related to the Millennium Development Goals, WHO's work on communicable and noncommunicable diseases, and the financial crisis. They were more influenced by political, economic and legislative circumstances than by health care itself. In many cases, for example, recent epidemics or the eradication of poliomyelitis, public health workers knew what should be done, but lacked the necessary support. Economic growth by itself did not reduce inequity: social inequities had increased between and within countries and regions even in the recent era of strong economic growth.

In the past, the health sector had targeted the immediate causes of ill-health and relied solely on its own capacities. Health determinants must be approached in collaboration with other sectors. In a less developed region of Slovenia, with the support of the WHO European Centre for Investment for

Health and Development and with local participation, health issues and health standards had been incorporated in the tourism, agriculture, transport, education and social sectors.

Health inequities could not be successfully confronted without a comprehensive “health for all policies” approach. Involving other sectors must be carefully planned, take into account sectoral motives and potential, and receive monitoring support.

Mr HOHMAN (alternative to Dr Wright, United States of America) welcomed the Commission’s report and the draft resolution. His Government was interested in examining the social and economic factors affecting health outcomes. The President had spoken of the need to address economic inequities and health disparities, possibly through support for national commissions or a global conference. The Commission’s report added to the existing data showing how social factors, such as income inequalities or lack of education, could worsen health. However, what most Member States lacked was not information but resources. The report’s recommendation that countries should establish universal social protection programmes was based on data from developed countries, and from the more successful developing countries. That approach might help other countries to build the political will and mobilize the resources needed for the programmes in question.

The Secretariat should provide Member States with evidence on which policy-makers could base decisions and with technical support for their implementation. He endorsed the Commission’s proposals for improving data collection in countries and enhancing WHO’s technical capabilities to assess evidence relating to social and environmental factors that influenced health.

Dr JAKSONS (Latvia) proposed that the draft resolution should be amended to emphasize the need for health ministries to play a stewardship role, as advocated in the Tallinn Charter: Health Systems for Health and Wealth, adopted at the WHO European Ministerial Conference on Health Systems, in June 2008.

Dr GOPEE (Mauritius) said that, like other small island developing States, Mauritius had some vulnerabilities, but it had achieved comparatively good health indicators: major infectious diseases had been largely controlled and nearly 100% vaccination coverage achieved. However, noncommunicable diseases, particularly diabetes, were a major problem.

Democracy had ensured political stability in Mauritius; health care was free from the primary to the tertiary levels; and education was compulsory and also free up to the tertiary level. Social and medical care for the elderly, women’s rights, and child welfare had always been high priorities.

Since independence in 1968, Mauritius had made a strategic move from economic dependence on sugar production to manufacturing and tourism. The resulting development of infrastructure had enhanced the country’s health conditions; generated employment; improved working and living conditions; and ensured nutrition and food security. That experience could inspire other Member States.

Dr BUSS (Brazil) paid tribute to the late Dr Lee Jong-wook, former Director-General of WHO, for having established the Commission on Social Determinants of Health and thanked the Commission for its report.

He expressed support for the draft resolution. Inequities in health between countries, or within countries, were morally unacceptable. He proposed that, in addition to the global event mentioned in subparagraph 4(j) of the draft resolution, the Director-General should be asked to convene a global conference on social determinants of health, in 2010 or 2011, in order to raise awareness and assess the work accomplished following the adoption of the draft resolution currently before the Board, exchange experiences and identify the best strategies for action. Such a conference should be organized in collaboration with Member States and other United Nations agencies.

Brazil’s national commission on social determinants of health had highlighted effective social protection policies, such as the primary health-care policy and the allocation of family allowances to

the poor. Several changes had been proposed to national policies, including the linkage of social protection and economic policies.

Various mechanisms had been established in his Region in order to promote discussion, and disseminate policies and technical practices, including a network for the exchange of experiences and methodologies.

(For resumption of the discussion, see below.)

Discussion of the health situation in the Gaza Strip: Item 4.16 of the Agenda (Document EB124/35) (continued from the third meeting)

The CHAIRMAN drew attention to a revised version of the draft resolution entitled “The grave health situation caused by Israeli military operations in the occupied Palestinian territory, particularly in the occupied Gaza Strip”, incorporating amendments proposed by Members, which read:

The Executive Board,

Guided by the principles and objectives of the Charter of the United Nations, the Constitution of WHO, international law and international humanitarian law and the Universal Declaration of Human Rights;

Affirming that all human rights are interdependent and complementary and that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

Confirming ~~Reiterating~~ the applicability of the Fourth Geneva Convention relative to the Protection of Civilian Persons in Time of War, of 12 August 1949, to the occupied Palestinian territory;

Referring to the reports and statements issued by the World Health Organization, the International Committee of the Red Cross and Red Crescent Societies, ~~and~~ the United Nations Relief and Works Agency, the United Nations Office for the Coordination of Humanitarian Affairs, ~~and~~ the United Nations Children’s Fund and other international and regional organizations, relating to the deteriorating health and humanitarian situation in the occupied Gaza Strip as a result of Israeli military operations;

Recognizing also that the Israeli **blockade siege** imposed on the occupied Gaza Strip and prevention of the passage and delivery of humanitarian supplies of medicines, food and fuel will lead to grave health and humanitarian consequences;

Expressing its deep concern regarding the consequences of Israeli military operations in the occupied Gaza Strip, which have, thus far, resulted in the killing of more than 1300 persons and injured thousands of Palestinian civilians, more than half of whom are women, children, infants and elderly persons;

Expressing its deep concern about the serious deterioration of the health conditions of all Palestinians in the occupied Palestinian territory and in the Gaza Strip in particular;

Asserting the right of patients as well as Palestinian and other medical personnel to access Palestinian health institutions,

1. WELCOMES and emphasizes the respect of the ceasefire from both parties and **calls on Israel for an immediate, durable and fully respected ceasefire leading to full withdrawal of Israeli forces from Gaza Strip, to lift its blockade** ~~calls for the withdrawal of Israeli military forces from the currently occupied Gaza Strip, the lifting of the siege, and to open the opening of all borders crossings~~ to allow access and free movement of humanitarian aid to the occupied Gaza Strip, including the immediate establishment of humanitarian corridors to ensure the delivery of humanitarian medical and food aid and **to facilitate the passage of medical teams and the transfer of the wounded and injured;**

2. CALLS for avoiding of targeting of hospitals, clinics, medical centres, ambulance and emergency crews and food and medicine warehouses;
3. STRESSES avoiding targeting civilians and residential areas in accordance with the Fourth Geneva Convention relative to the Protection of Civilian Persons in Time of War;
4. CALLS **upon** for providing Palestinian people with the protection ~~in order~~ to live **in security** ~~securely~~ on their land, allowing them free movement and ~~work~~, **facilitating** ~~facilitate~~ the tasks of medical teams, ~~and~~ ambulances, and emergency relief efforts, and enabling them to continue to provide health services;
5. CALLS for the urgent provision of necessary support for the Palestinian people ~~by~~ ~~in~~ making available the urgent and immediate needs of ambulances and medical teams, medicines and medical supplies, as well as necessary coordination measures to facilitate the passage of this assistance to the Gaza Strip in support of the health sector and preventing the collapse of health institutions;
6. CALLS for contribution to the reconstruction of the health infrastructure in the Gaza Strip, which has been destroyed by the Israeli military operations;
7. REQUESTS the Director-General to dispatch **an urgent specialized health mission** ~~a special mission~~ to identify the urgent health and humanitarian needs and assess the destruction **of medical facilities** that has occurred in the occupied Palestinian territory, particularly in the Gaza Strip and to submit a report on **current, medium- and long-term needs** on the direct and indirect effects of the Israeli military operations to the Sixty-second World Health Assembly.

The financial and administrative implications of the proposed resolution were:

1. Resolution The grave health situation caused by Israeli military operations in the occupied Palestinian territory, particularly the occupied Gaza Strip	
2. Linkage to programme budget	
Strategic objective:	Organization-wide expected results:
5. To reduce the health consequences of emergencies, disasters, crises and conflicts and minimize their size and economic impact.	5.2 Norms and standards developed, capacity built and technical support provided to Member States for a timely response to disasters associated with natural hazards and to conflict-related crises. 5.3 Norms and standards developed, capacity built and technical support provided to Member States for assessing needs and for planning and implementing interventions during the transition and recovery phases of conflicts and disasters. 5.6 Effective communications issued, partnerships formed and coordination developed with other organizations in the United Nations system, governments, local and international nongovernmental organizations, academic institutions and professional associations at the country, regional and global levels.

<p>(Briefly indicate the linkage with expected results, indicators, targets, baseline)</p> <p>Linked with indicators 5.2.1, 5.3.2, 5.6.1 and 5.6.2.</p>
<p>3. Financial implications</p> <p>(a) Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)</p> <ul style="list-style-type: none"> • US\$ 13.5 million for the acute response period • US\$ 22 million for the recovery and reconstruction phase • US\$ 2 million for the implementation of the health cluster. <p>(b) Estimated cost for the biennium 2008–2009 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)</p> <ul style="list-style-type: none"> • US\$ 18 million for the biennium 2008–2009 <p>Costs will be incurred primarily by the WHO Office in the occupied Palestinian territory, but also by the Regional Office for the Eastern Mediterranean and headquarters.</p> <p>(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009?</p> <ul style="list-style-type: none"> • US\$ 900 000 under existing programmed activities for the biennium 2008–2009. The rest will have to be added into the programme as resources become available from special appeals. <p>(d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)</p> <p>Through a flash appeal for the Gaza Strip; the revised Consolidated Appeal for the occupied Palestinian Territory 2009; the European Commission's Humanitarian Aid department's contribution for strengthening WHO's work in emergencies.</p>
<p>4. Administrative implications</p> <p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)</p> <p>Headquarters, the Regional Office for the Eastern Mediterranean and the WHO Office for the occupied Palestinian territory in Jerusalem.</p> <p>(b) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile)</p> <ul style="list-style-type: none"> • One dedicated health cluster coordinator in the professional category for two years (at US\$ 156 000) • One dedicated deputy health cluster coordinator in the professional category for two years (at US\$ 376 000) • Assessment and response team deployed for three months (at US\$ 200 000) <p>(c) Time frames (indicate broad time frames for implementation)</p> <ul style="list-style-type: none"> • Special mission (two weeks) • Health cluster coordination (two years) • Response operations (three months) • Recovery and reconstruction (two years).

Dr ABDESSELEM (Tunisia) said that the sponsors of the draft resolution agreed that some changes to the wording needed to be made. He thanked the representative of the European Union for his positive stance, which had allowed agreement to be reached, and called for the Board to adopt the new version of the draft resolution by consensus.

Mr BURCI (Legal Counsel) stated that Egypt, Mali, Mauritius, Morocco, Niger, Sao Tome and Principe, Turkey and Uganda wished to join the list of sponsors of the draft resolution.

He drew attention to several amendments not included in the latest version of the draft resolution. In the fourth preambular paragraph, “Red Crescent Societies” should be replaced by “the International Federation of Red Cross and Red Crescent Societies”. In paragraph 1, “on Israel for an immediate, durable and fully respected ceasefire leading to full” should be replaced with “for a complete” and “immediate establishment” should be replaced with the word “reinforcing”. Paragraphs 2 and 3 should be merged to read “Stresses avoiding targeting civilians and residential areas from both sides in accordance with the Fourth Geneva Convention relative to the Protection of Civilian Persons in Time of War and avoiding of targeting of hospitals, clinics, medical centres, ambulance and emergency crews and food and medicine warehouses”, with the numbering of the paragraphs that followed changing as appropriate. In the final line of paragraph 7, the words “on health” should be inserted between the words “effects” and “of”.

Mr STORELLA (alternate to Dr Wright, United States of America) requested a roll-call vote on the draft resolution including the preceding oral amendments.

A vote was taken by roll-call, the names of the Member States being called in the French alphabetical order, starting with El Salvador, as determined by lot.

The result of the vote was as follows:

In favour: Afghanistan, Bangladesh, Brazil, China, Denmark, Djibouti, Hungary, Indonesia, Latvia, Mali, Mauritania, Mauritius, Niger, Oman, Paraguay, Peru, Republic of Korea, Republic of Moldova, Russian Federation, Sao Tome and Principe, Singapore, Slovenia, Sri Lanka, Tunisia, Turkey, Uganda, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland.

Against: United States of America.

Abstaining: Bahamas, Malawi, New Zealand, Samoa.

Absent: El Salvador.

The resolution, as amended, was therefore adopted by 28 votes to 1, with 4 abstentions.¹

Dr DAHL-REGIS (Bahamas), speaking in explanation of vote, said that she had had to abstain as she had not received voting instructions from her Government.

Mr STORELLA (alternate to Dr Wright, United States of America), speaking in explanation of vote, regretted that, despite general agreement about the importance of a response by WHO to the alarming situation in the Gaza Strip, the draft resolution could not be adopted by consensus. His Government had not been able to support the resolution because it believed that the Executive Board, as a global health body, did not have a mandate to make political judgements. He noted that he and others had requested reasonable time to review and amend the text so as to ensure that it was free from one-sided rhetoric. The United States of America supported immediate action to identify the humanitarian and health needs and to ensure that medical assistance and supplies were provided. It would do everything in its power to assist with post-ceasefire needs, and would engage in serious

¹ Resolution EB124.R4.

efforts to promote the stabilization and normalization of life for the people of the Gaza Strip, and to secure the longer-term prospects for peace.

Dr KÖKÉNY (Hungary), speaking on behalf of the Member States of the European Union, said that the European Union would remain firmly committed to supporting the health and humanitarian activities of WHO in aid of the Palestinian population affected by the recent conflict in the Gaza Strip. The five Member States of the European Union represented by members of the Board had voted in favour of sending a specialized health mission to identify the most pressing needs, but regretted that there had not been a greater focus on health and humanitarian matters. The European Union welcomed the recent bilateral ceasefire, which must be durable and fully respected, and hoped that it would lead to a rapid alleviation of the suffering of the civilian population. All parties, especially Israel, must grant immediate, unhindered and safe passage for the delivery of essential services.

Dr ABDESSELEM (Tunisia), speaking on behalf of the sponsors, extended his sincere thanks to the members of the Board for supporting the resolution.

Commission on Social Determinants of Health: Item 4.6 of the agenda (Document EB124/9) (resumed)

Mr MIGUIL (Djibouti), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that a recent regional survey of social determinants of health had identified areas, largely the same as those mentioned in the report, in which action must be taken to overcome health inequities. For 20 years in his Region community-based initiatives had been striving to improve conditions in terms of nutrition, safe drinking water, sanitation, shelter and women's empowerment. Eastern Mediterranean countries were being encouraged to develop those initiatives into tools for action on social determinants of health. He cited examples of how the recommendations of the Commission were being implemented in his Region, notably through a "health in all policies" approach: a strategic plan developed in the Islamic Republic of Iran; urban regeneration in Cairo; and an intersectoral coordination approach in Yemen.

An instrument for monitoring health equity was being designed within the framework of the Eastern Mediterranean Regional Health Systems Observatory. The tool could be adapted to building a database for policy-makers at country level. A regional conference on the social determinants of health in 2009 would provide an opportunity to share experiences.

Ms ROCHE (New Zealand), emphasizing intersectoral action in steps to address the social determinants of health, said that her country's initiatives, which went beyond the health sector, had already helped to reduce ethnic inequalities in health. She welcomed the draft resolution and looked forward to global progress towards the goal of health for all through action on the social determinants of health.

Ms TOELUPE (Samoa) supported the recommendations contained in paragraphs 19, 20 and 21 of the report. Highlighting the influence of other sectors on health, she emphasized the key role of women at grass-roots level in tackling the social determinants of health. Community-based initiatives would help to strengthen primary health care and, thus, entire health systems.

Mr FISKER (Denmark) said that the Secretariat must acknowledge the request from Member States to prioritize, and allocate sufficient resources to, action on the underlying social determinants of health. Member States must assume their own responsibilities for that work, which called for close intersectoral cooperation. He supported the adoption of a substantial resolution on the topic. He proposed three amendments to the draft resolution: first, a new paragraph should be inserted after the sixth preambular paragraph reading: "Welcoming in this regard resolution WHA61.18, which initiated annual monitoring by the World Health Assembly of the achievement of the health-related Millennium

Development Goals”; secondly, another new paragraph should be inserted after the final preambular paragraph, reading: “Mindful of the fact that mental health is an integral part of health”; and thirdly, the word “objective” should be inserted before the word “indicators” in subparagraph 4(c).

Dr ADITAMA (alternate to Dr Supari, Indonesia) emphasized the strong links between poverty, which was the main social determinant of health, and the global economic system, determined by high-income countries, and which had widened the gap between high-income and low-income countries. Members of the Board and the Commission should consider how to promote a fairer system. Capitalism and liberalization had no place in national health systems. They endangered human life by, for example, treating medicines as commercial goods available only to those who could afford them; by encouraging brain drain of health personnel from low-income countries; and by allowing industries in rich countries to exploit natural resources in poor countries, without protecting the local population from the resulting health hazards, and misleadingly claiming to adhere to the concept of corporate social responsibility. The Commission should make strong recommendations on how to achieve health equity through alternative economic solutions.

Dr STARODUBOV (Russian Federation) acknowledged the results of the Commission’s productive and substantial investigations, carried out in the best traditions of social medicine. However, the Secretariat’s report and the Commission’s conclusions did not fully reflect the rich content of the latter’s report. Many of the factors underlying health inequities exceeded WHO’s mandate. He therefore supported the call for United Nations agencies to engage throughout the system in discussion of a strategy for countering health inequities.

He welcomed the Secretariat’s report and strategy for strengthening the potential of the Secretariat and Member States to monitor and address the social determinants of health. The report remained more than ever relevant against the backdrop of financial crisis. WHO could demonstrate its leadership role by involving the international community in the struggle against inequity.

Dr SERPAS MONTOYA (alternate to Dr Larios López, El Salvador) welcomed the report. The Commission’s recommendations covered the essential areas in which countries needed to work in order to address social determinants of health, such as: the development of surveillance systems for social determinants going beyond the health sector; the establishment of indicators and continuous evaluation; and the development of national health policies derived from broad agreement. Countries should gradually build up those indicators and tools. His country had adopted legislation aimed at involving health institutions in common efforts with health policy based on primary health care. He supported the proposed draft resolution.

Dr REN Minghui (China) supported the recommendations made by the Commission in its report, the Chinese version of which, when made available, would be given wide publicity in order to raise awareness of the social determinants of health. As the report pointed out, health equity was a reflection of society, and policy-making to address the issue was not limited to the health sector but rather encompassed all State affairs. His Government had developed slogans and goals for building a basic health system covering both urban and rural areas and providing safe, practical and affordable services. In the light of the Commission’s recommendations, the Secretariat should assist Member States to implement health-for-all policies that addressed social determinants; and in setting up surveillance and evaluation systems, incentives for countries to make real progress towards health equity. His Government supported the main lines of the draft resolution. However, the text failed to reflect all the opinions put forward or the role played by civil society. The wording of subparagraphs 3(a), (b) and (c) in that respect was unclear. In subparagraph 4(j), the word “prepare” (a global event) might perhaps be replaced by “organize”, and the meaning of “global event” should be clarified.

Dr MOHAMED (Oman) said that paragraph 2 of the report contained no mention of individual behaviour as one of the social determinants with serious repercussions on health, and that the omission should be rectified. For example, contracting HIV infection was the result of individual actions. Mention should also be made of human development indicators, child development indicators and women's development indicators, all of which had to be addressed in order to achieve the objectives outlined in paragraphs 19 to 21 of the report. He emphasized that in the context of multisectoral policies, account should be taken of primary health care in order to ensure health equity and social equality.

Dr GIMÉNEZ CABALLERO (Paraguay) congratulated the Commission on its recommendations. The conclusions provided an ethical imperative for reformulating public health policies, an expression of solidarity for concrete action to fill the gaps that had left millions in morally unacceptable conditions. WHO should set up mechanisms for continuous monitoring of the reduction of such gaps, in both the WHO regions and countries. His country was a sponsor of the draft resolution and he endorsed the proposal by Brazil to convene a world conference on social determinants of health.

Dr STARODUBOV (Russian Federation) joined the member for China in calling for the Commission's report to be issued in all official languages. So many positive assessments had only increased his desire to see it in Russian.

Dr SADRIZADEH (Islamic Republic of Iran)¹ said that the social determinants of health accounted for the bulk of health inequities both within and between countries. Global solidarity, high-level political commitment and intersectoral coordination was required. WHO should act as a catalyst in putting the social determinants of health high on the agenda. His Government was committed to reducing health inequities and wished to sponsor the draft resolution. It had encouraged the Asian Parliamentary Assembly to adopt a resolution urging member parliaments to promote policies on health equity and strengthen collaboration among themselves. A subcommittee had been set up to identify the main social determinants of health inequities and provide relevant recommendations.

Dr THAKSAPHON THAMARANGSI (Thailand)¹ said that his Government appreciated the work of the Commission. Closing the gap of health inequalities would require political will worldwide and significant changes in global governance. The aggressive marketing of junk food and soft drinks continued, and the obesity rate among adults in the United States, for example, stood at 34%. The draft resolution would be crucial for applying the Commission's recommendations. However, the call it made for market responsibility was so weak that it was unlikely to be heard by industry unless the world developed better global governance mechanisms and national actions to root out structural inequity and the determinants of poor health. Key terms relating to equity were misused. For example, the phrase "health inequalities", used throughout the text, should be replaced by "health inequities". Some health inequities were attributable to biological variations, others to the external environment and conditions beyond the control of individuals. In the former case it might be impossible to change health determinants, and health inequities were therefore unavoidable. In the latter, uneven distribution was avoidable and therefore unjust, resulting in health inequities.

The draft resolution did not adequately reflect the three main recommendations made by the Commission: improving daily living conditions; tackling inequitable distribution of power, money and resources; and measuring and understanding the problem and assessing the impact of actions. Paragraph 3 should be redrafted to reflect those recommendations. Paragraph 2 should cover the

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

notion of global good governance, market responsibilities in tackling inequitable distribution, ensuring health equity in policies and taking into account the voice of the population, especially the poor. Paragraph 4 should request the Director-General to work with the international community to ensure health equity in policies, systems and programmes, and should refer to the provision of technical support to Member States in monitoring, research and training on social determinants of health. He suggested a major revision of the text. The recommendations made in the Commission's report must be translated into a clear and forceful draft resolution, and the version before the Board was unacceptable. He agreed with other speakers that a working group might be needed to improve the draft resolution. Thailand was ready to take part in such action.

The CHAIRMAN said that any proposals by the representative of Thailand, a Member State not represented by a member of the Board, had to be supported by one of the Board's members in order to be considered.

Professor HAQUE (Bangladesh) supported the proposals made by the representative of Thailand.

Mr CAVALERI (Argentina)¹ welcomed the report and expressed support for the draft resolution. Overcoming health inequities was a high priority of his Government. In cooperation with PAHO, Buenos Aires would host, in August 2009, the first world fair of healthy municipalities, cities and communities. The fair would promote the healthy cities initiative; primary health care; regional and national initiatives to achieve the Millennium Development Goals; and exchange of good practices regarding successful local development. Some 2000 participants were expected, representing a wide range of institutions.

Dr MUÑOZ (Chile)¹ said that, since unequal access to power and goods was a major risk factor for health, the search for greater equity in countries had been transformed from a philosophical discussion into an obligation. Chile had embraced the idea of reducing inequalities. It supported the draft resolution and wished to become a sponsor. The draft resolution should, however, emphasize that advocacy was needed with respect to decision-makers at all levels. The concerns expressed by the Commission must not be seen by ministers of finance and national leaders as confined to health officials: they were integral to the brief of all who sought to improve the population's living conditions. He advocated social protection systems that operated in consonance with social determinants of health, covering all sectors with responsibility for people's living conditions.

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

The meeting rose at 15:30.

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

SIXTH MEETING

Thursday, 22 January 2009, at 09:15

Chairman: Mr N.S. DE SILVA (Sri Lanka)

1. PROGRAMME AND BUDGET MATTERS: Item 5 of the Agenda

Programme budget 2006–2007: performance assessment: Item 5.1 of the Agenda (Documents PBPA/2006–2007 and EB124/19)

Dr DAHL-REGIS (Bahamas), speaking in her capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board and recalling the Committee's deliberations as set out in section 3.1 of document EB124/3, said that the Committee had welcomed the report on performance assessment and expressed appreciation for its utility and comprehensiveness. However, in the light of the relatively low level of implementation in 2006–2007, Committee members had encouraged the Secretariat to improve the Organization's implementation rates. Some members had noted that where expected results had not been fully achieved, it would have been useful to give greater detail on the reasons. Such assessment findings should be made available in good time for governing body discussions on programme budgets.

The Committee had endorsed the proposal to change the time frames for, and format of, monitoring and assessment of the Programme budget 2008–2009, thereby allowing for presentation by the Secretariat of a summary mid-term review to the Committee at its tenth meeting and to the Executive Board at its 125th session in May 2009, as well as production of a summary programme budget performance report in May 2010.

Dr AHMADZAI (Afghanistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, commended the transparent and balanced report, which revealed the progress made in strengthening of health systems, access to medicines, the growing number of persons affected by HIV/AIDS, tuberculosis and malaria, new and emerging diseases, and emergency response.

There was still room for further improvement in performance assessment, particularly with regard to performance indicators, which should be more precise, measureable and relevant.

Observing that the biennium 2006–2007 had seen a record level of expenditure, he pointed out that financial implementation had not kept pace with the budgetary growth of the Organization. The regular budget would have to grow considerably faster in order to align funding and programme delivery, which would improve predictability of resource availability and improve implementation capacity.

Mr AITKEN (Assistant Director-General) agreed that the work on performance assessment needed to be furthered and improved, with particular focus on the indicators.

Ms JAQUEZ (Mexico),¹ speaking on behalf of the Member States in Latin America, referred to the recent Intergovernmental Meeting on Pandemic Influenza Preparedness, the changed date and venue of which had entailed extra cost to the Organization. Expressing gratitude to the Secretariat for keeping the increased costs low, she asked how those costs would be covered. Such a change of date

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

and venue should not set a precedent for future work of any negotiating bodies established by the Organization.

The DIRECTOR-GENERAL recalled that the meeting in question had had to be postponed because of the unavailability of the Chair. The Secretariat and the officers of the Meeting had discussed the only two solutions: the first, to select a new Chair from among the members of the Bureau, which option had been firmly resisted both by the officers and among the Member States on account of the excellence of the chairmanship of Ms Jane Halton of Australia and the need for continuity. The alternative had been to change the date, and consequently the venue, of the meeting, which had entailed additional costs to the Organization of some US\$ 80 000. It had been an unfortunate occurrence, but the Secretariat was in the hands of the officers of the Meeting and Member States.

The CHAIR took it that the Executive Board wished to take note of the performance assessment reports on the programme budget 2006–2007.

It was so agreed.

Medium-term strategic plan 2008–2013 and Proposed programme budget 2010–2011: Item 5.2 of the Agenda (Documents MTSP/2008–2013 (Amended (draft)), PPB/2010–2011 and EB124/20)

Dr DAHL-REGIS (Bahamas), speaking in her capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, recalled that, in its discussion of the draft amended Medium-term strategic plan 2008–2013 and the draft Proposed programme budget 2010–2011, the Committee had expressed appreciation for the clarity of the documents and welcomed the innovation of dividing the draft Proposed programme budget 2010–2011 into three segments: WHO programmes; outbreak and crisis response; and partnerships and collaborative arrangements, since that grouping of items enhanced transparency.

The Committee had welcomed the development of the core voluntary contributions account but expressed concerns at the growing imbalance between assessed and voluntary contributions; the consequent increasing reliance on earmarked voluntary contributions; the inequitable distribution of budget funds to certain strategic objectives; and the uneven distribution of the budget across geographical regions.

Some members of the Committee had expressed concern about the ability of the Organization to raise sufficient income in the current economic climate, and to implement fully the Proposed programme budget 2010–2011; others had called for more budgetary discipline and realism. Some members had requested clarification on the draft Proposed programme budget, including projections of expected exchange rate fluctuations, before the document was submitted to the Sixty-second World Health Assembly.

The Committee had stressed the importance of improving implementation and had recommended a review of the overall level of the Proposed programme budget. Other issues discussed had included: the establishment of a revolving fund in order to allow for more predictable funding of emergency response operations; the need to limit the carry-over from one biennium to the next; and the proposed reallocation of assessed contributions in order to cover the shortfall in resources for strategic objectives 12 and 13. The Committee recommended that the Executive Board should take note of its deliberations set out in paragraph 3.3 of document EB124/3.

The CHAIRMAN, opening the floor for general comments, observed that the Director-General would take such comments into account in any revision of the budget that she might make before its presentation to the Sixty-second World Health Assembly.

Dr MOHAMED (Oman), speaking on behalf of the Member States of the Eastern Mediterranean Region, supported the draft Proposed programme budget 2010–2011 with its enhanced transparency and the amended Medium-term strategic plan 2008–2013, in particular the inclusion of climate change and other important subjects. He welcomed the plans for interventions in the event of epidemics and crises. He noted increased expenditure relative to the previous budget and the need for increased funding.

The lack of flexibility could hamper certain programmes. The regular contributions represented 17% of the budget, with the rest coming from other contributions. Greater flexibility was needed so that resources were not subject to conditions or limited to certain expenditures. In a financial crisis, health and health services were easy targets for cuts. His country was still trying to recover from cuts in the budget for housing and health from previous years. Earmarked voluntary contributions were not generally devoted to the problems of developing countries. The Organization should be given the flexibility to devote its resources to urgent issues and should be present in all countries.

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union and its 27 Member States, said that the European Union had read with interest the draft Proposed programme budget 2010–2011 and the amended draft Medium-term strategic plan 2008–2013 and welcomed the clarifications.

The division of the draft Proposed programme budget into three categories had enhanced clarity and transparency. However, he questioned whether WHO had sufficient implementation capacity to handle the proposed increase, relative to the previous biennium, of more than US\$ 1000 million. The accumulated surplus carry-over of 40% required further explanation.

The issue was related to the earmarking of contributions. High levels of earmarking undermined the ability of the Board to guide the Organization effectively. Important policy decisions of the Health Assembly appeared to have been disconnected from the financing of the Organization. Moreover, partnerships offered opportunities to improve global health but raised problems of earmarking, governance and duplication. The European Union welcomed the Secretariat's proposal and the guidelines but the issue required further discussion, especially on the role of partnerships in the financing of core activities. Although increased voluntary contributions were welcome, support costs should be covered, and extrabudgetary funds directed to WHO's priorities and controlled by the governing bodies. In regard to the regular budget, zero nominal growth, as an approach, should be continued; and the Secretariat should consider how exchange-rate fluctuations might be counterbalanced by savings. Noting that communicable diseases constituted nearly half the budget, he looked forward to a revised proposal with a better balance between resources and the global health burden and Millennium Development Goals, with more precise information on staff costs and their evolution for each strategic objective.

Tobacco control needed close coordination between WHO's Secretariat and the Convention Secretariat in order to avoid duplication and to use resources efficiently.

The European Union looked forward to continued cooperation with WHO on budgetary matters. It welcomed the decision by the Programme, Budget and Administration Committee to set up an independent expert oversight committee and was willing to help to define its terms of reference. Regarding the Global Management System, the European Union urged the Secretariat to overcome the problems. The System was already offering more transparent data and should prove its worth in time.

Professor HAQUE (Bangladesh) commended the draft amended medium-term plan. The achievement of the Millennium Development Goals depended on the coordinated teamwork of WHO at all levels. His Government was committed to those goals and much remained to be done.

Mr FISKER (Denmark) welcomed WHO's acknowledgement that the time had come to consolidate growth and strengthen implementation capacity. Rapidly growing budgets, insufficient implementation capacity and major transfers of funds from one biennium to the next formed an injudicious combination. The changing ratio between regular and voluntary contributions was a

sensitive issue, as few Member States wished to increase their regular contributions. The aim should be not so much to obtain more funds, rather to have funds that were more secure and flexible.

Denmark welcomed the new structure of the budget, which improved transparency. Partnerships accounted for 20% of the total budget, which raised questions of governance and accountability. Perhaps the share of partnerships in the total budget should be limited in order to use the funds already available. The adoption of the action plan for the global strategy for the prevention and control of noncommunicable diseases had been followed by increased resources; that example reflected changing priorities with the shifting burden of disease. Such an approach should be continued so as to reach a balance between communicable and noncommunicable diseases.

Ms ROCHE (New Zealand) commended the report and the Secretariat's work on indicators. However, the amount of carry-over, both in absolute terms and as a proportion of the total budget, was a matter of concern. She supported the views of the European Union on the management of carry-over while ensuring effective expenditure of the proposed increase in the biennial budget. She asked how such factors would influence budget planning for the following biennium. Improved implementation should reduce future amounts of carry-over. In regard to strategic objective 4, she welcomed the Secretariat's offer to review the allocation. Reduced funding for that objective was inconsistent with achievement of the Millennium Development Goals, which should be WHO's top priority. As for strategic objective 6, New Zealand supported the view of the European Union on the need to avoid duplication of work on tobacco control between the WHO's Secretariat and the Convention Secretariat. She was pleased with the improved coordination between the two. The former should be supporting the implementation of the Convention in the countries that were Parties and encouraging others to ratify it. She looked forward to the report on the establishment and operation of an independent audit.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) welcomed the introduction of new indicators for climate change and patient safety. In regard to strategic objective 3 he supported the increased resources for chronic disease, which better reflected the global burden. However, funding remained at 3% of the biennium budget whereas noncommunicable disease accounted for around 60% of all deaths. Regarding strategic objective 4, he shared the previous speaker's concern at the reduced funding and was grateful for the Secretariat's review of the allocation. Despite the financial crisis, it was certainly not the moment to reduce funding for health. Following the points made by the Programme, Budget and Administration Committee about implementation, the Secretariat should reexamine the budget. The problems of the Global Management System were a source of deep concern and had badly constrained the implementation process. However, the Director-General and her team were striving to resolve them.

Ms BLACKWOOD (alternate to Dr Wright, United States of America) welcomed the Proposed programme budget 2010–2011, which reflected a significant increase while consolidating growth and strengthening implementation capacity. She asked for indications of the implementation level for the Programme budget 2008–2009 and, if it were less than targeted, whether the Secretariat would make adjustments to the final budget level for 2010–2011. She supported the creation of an account for core voluntary contributions in order to manage resources effectively, but expressed concern about the reliance on regular funds to subsidize the administrative overheads of programmes funded by voluntary contributions. WHO should pursue a policy of cost recovery for extrabudgetary contributions.

In regard to miscellaneous income, she welcomed the Secretariat's commitment to realistic projections on exchange rates. The United States appreciated WHO's efforts to consolidate the increase in the core budget; it continued to advocate budgetary discipline, efficiency in implementation and programme prioritization.

Dr KAMOTO (Malawi), speaking on behalf of the Member States of the African Region, commended the Committee's report. The Region noted with concern the inadequate funding levels for: strategic objectives 4, relating inter alia to maternal and child health; strategic objective 7 on social and economic determinants of health; and strategic objective 9, related to nutrition and food security and crucial to the attainment of the Millennium Development Goals in Africa. It was gratifying that the Secretariat would review those and adjust the 2010–2011 budget accordingly before its submission to the Sixty-second World Health Assembly.

He commended the Secretariat's efforts to implement the Global Management System, to resolve the problems encountered, and to make contingency plans against future unfavourable developments. He welcomed the transparency of the Programme budget, the checks and balances and the proposal to set up an independent advisory committee, as that would improve accountability at WHO.

Professor AYDIN (Turkey) echoed previous speakers in emphasizing close cooperation between the Convention Secretariat and WHO's Tobacco Free Initiative in order to avoid duplication, given the scarcity of resources for tobacco control.

Mr TOURÉ (Mali), welcoming the Proposed programme budget, stressed Millennium Development Goals 4 and 5 relating to reducing child mortality and improving maternal health; the fight against epidemic diseases that particularly affected Africa; and accelerated efforts to eradicate poliomyelitis. The high risk of transmission of poliovirus in one country in Africa currently threatened those efforts.

Dr JAYANTHA (alternate to Mr de Silva, Sri Lanka) urged the Board to allocate more resources to the changing disease burden in Sri Lanka and many other countries, and mainly characterized by an increase in noncommunicable diseases.

Ms MASTAU (South Africa)¹ welcomed the cooperation between the Convention Secretariat and WHO's Tobacco Free Initiative, in relation to strategic objective 6 and to implementation of the guidelines and protocols of the Conference of the Parties. She asked what percentage of the budget had been allocated to gender support under strategic objective 6. She urged that the share of funding allocated to strategic objectives 7 and 9 should be increased, emphasizing the related health outcomes and the Millennium Development Goals. Expressing deep concern at the reduced resources allocated to strategic objective 4, and the related commitment to maternal health, she asked about the impact of that reduction and the reallocation of those funds.

Mrs NYAGURA (Zimbabwe)¹ echoed the concerns expressed with regard to the budget allocations for strategic objectives 4, 7 and 9, which were crucial to attaining the Millennium Development Goals. She appealed to donor countries to maintain flexibility and predictability of resources and enable the Director-General to respond to health priorities, particularly in the African Region.

Mr BLAIS (Canada)¹ reaffirmed his country's commitment to a policy of zero nominal growth in the budgets of international organizations. The complexity of the Proposed programme budget 2010–2011 encouraged further deliberation on the application of that policy, particularly regarding the balance between assessed and voluntary contributions, and to decisions on reductions. His country would share with others its experience and approach to zero nominal growth.

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

Mr PLATTNER (Switzerland),¹ acknowledging the budgetary difficulties the Organization faced as a result of the imbalance between assessed and voluntary contributions, announced that Switzerland would make its voluntary contributions more flexible for a period of three years. He encouraged the Secretariat to pursue fully flexible voluntary contributions.

Drawing attention to strategic objectives 12 and 13, particularly with regard to the capital master plan, he urged all international organizations to allocate an adequate percentage of their regular budget to infrastructure and equipment; he expressed regret that previous underfunding had been continued in the Proposed budget for 2010–2011, with potentially damaging consequences for both WHO's headquarters in Geneva and its regional offices. He urged the Secretariat to implement measures to comply with the Minimum Operational Security Standards of the United Nations.

Mr ITAYA (Japan)¹ emphasized that the allocation of funds should be examined carefully in the light of the financial crisis and changing health issues worldwide. Japan favoured a policy of zero nominal growth and urged additional measures to minimize the budget and maximize cost-efficiency, without sacrificing prioritized core objectives.

He urged the Organization to focus on its core mission and encourage newer players to share the overall burden. Transparency was critical to donor confidence, as was convincing taxpayers of streamlined operations, avoiding duplication and reduced costs. Knowing the measures taken and results achieved would enable Member States to advocate for a well-funded WHO.

Expressing doubt about the wisdom of applying a fixed currency adjustment mechanism, he asked how the Secretariat would protect itself against unfavourable currency fluctuations; and how would unexpected gains from favourable currency fluctuations be returned responsibly.

He endorsed the comments made by the member for Hungary and other speakers regarding partnership, the Global Management System and programme support costs. The roles and resources of WHO programmes and those of partnerships hosted by WHO needed to be clearly distinguished. Problems with the Global Management System, in which significant resources had been invested, must be resolved. His country was committed to a strong and fully-funded WHO: efficient, transparent and working in the best interests of all Member States.

Mr AITKEN (Assistant Director-General), responding to points made, stressed the need for more flexible and predictable funding. Pledges for a period of more than one or two years would give managers more room for manoeuvre, particularly in the first six months of a biennium. That would also make carry-over from the previous biennium, which currently accounted for around 25% of the budget, more manageable. Managing core voluntary contributions, which accounted for a very small percentage of voluntary contributions overall, was a constant challenge. Although the Secretariat had a clear idea of how they should ideally be allocated, budget aspirations were often not compatible with funding realities.

Concern had been expressed about reduced funding for strategic objective 4. However, a reallocation from strategic objective 4 to strategic objective 10, which dealt with the strengthening of health services, would benefit efforts to reduce morbidity and mortality at key stages of life; integration between the two objectives would thus be improved.

Work was continuing to solve the serious problems experienced with the Global Management System. Nevertheless, those had not been a significant cause of lack of implementation, which was attributable to a combination of factors. In fact, the System had made it possible to provide the expenditures in 2008 with greater timeliness. A forecast for miscellaneous income for 2010–2011 would also be prepared.

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

The capital master plan had not yet been fully funded because Member States as a whole had not yet agreed to do so. Work therefore focused on regular maintenance to ensure that buildings and equipment continued to run rather than on any major new projects. Security was a top priority in high-risk areas but Member States had not yet been persuaded to provide the funding necessary for full implementation of the Minimum Operational Security Standards of the United Nations.

With regard to the problems of currency fluctuations, he explained that some measures had been taken but that there was a limit to what could be done. The impact of fluctuations would be calculated and reported to the Health Assembly, which could then decide how to proceed. In the meantime, the Secretariat was being encouraged to make savings in areas such as travel, publications and meetings.

The DIRECTOR-GENERAL thanked Board members for their comments, which, together with those from the Programme, Budget and Administration Committee, would guide her in revising the Proposed programme budget 2010–2011 before its submission to the forthcoming Health Assembly.

The discussion had been notable for its quality and honesty. She welcomed the call made by Japan and others for committed funding to ensure a strong WHO. She would heed concerns raised about budget discipline, the Organization's growth and ability to implement programmes, governance and the need to avoid duplication within the Secretariat and in WHO's relations with its partners. However, she could not act alone; she would need support from all Member States. For example, it had not proved possible to achieve the desired cost recovery through the levy for programme support costs, which was designed to avoid the use of assessed contributions to subsidize programmes financed by voluntary contributions. Ministries of finance and other donors often tried to negotiate the 13% levy downwards and the average achieved to date was 7%. Health ministries should strongly discourage such action.

She expressed concern that, although levels of voluntary contributions were commendably high, many donations were earmarked to an extent that skewed the core functions of the Organization. If Member States wished to heighten levels of security in WHO offices in high-risk areas, they and the Secretariat would need to examine the updating and funding of the Capital Master Plan.

In respect of cooperation between the Secretariat and the Conference of the Parties to the WHO Framework Convention on Tobacco Control, she was pleased to report progress towards joint planning.

The establishment of the Global Management System had proved a painful exercise to date, and one that had caused her much anxiety. Dr Lee Jong-wook had envisaged the institution of a modern integrated management system, the first in the United Nations system, that would enhance detail and transparency. Feedback from headquarters and the Western Pacific Region, the two areas where the new system had so far been implemented, indicated that progress was being made. However, patience would be needed and it was not possible to say how long it would take for the system to be fully functional across the whole Organization.

As indicated to the Programme, Budget and Administration Committee, she would convene a meeting of donors and other interested parties to consider how best to modernize WHO's funding over the medium to long term to ensure that the Organization had a business model that was fit for the twenty-first century. Again support from Member States would be crucial.

The CHAIRMAN, in the absence of further comments, took it that the Board had concluded its consideration of item 5.

It was so agreed.

2. TECHNICAL AND HEALTH MATTERS: Item 4 of the Agenda (continued)**Commission on the Social Determinants of Health:** Item 4.6 of the Agenda (Document EB124/9) (continued from the fifth meeting)

Ms ALARCÓN (Colombia)¹ welcomed the proposal by the Commission on the Social Determinants of Health that there should be an integrated and uniform approach to efforts to attain the health-related Millennium Development Goals. Pragmatic and effective activities should be formulated, responding to countries' needs and priorities in social development. Colombia's national development plan for 2006–2010 had integrated poverty elimination, social protection, employment, health and education programmes. It aimed to reduce inequalities by emphasizing the most vulnerable population groups and regions, using the family as the entry point for care. Those activities had complemented social security and public health. Positive results were exemplified by the 94% immunization coverage of children in 2007.

Dr MOHAMED (Oman) supported the views expressed at the previous meeting by the representative of the Islamic Republic of Iran. Oman also wished to sponsor of the draft resolution.

Ms BILLINGS (Canada)¹ said that her country had participated in the work of the Commission. She commended the reports of the Commission and the Secretariat. Governments, organizations and academic institutions were increasingly considering initiatives that included the social determinants of health, important for addressing health inequities among vulnerable populations and timely, given the recent economic downturn. Canada was working with other countries to revise the draft resolution, of which it wished to be a sponsor.

Dr SEYER (World Medical Association), speaking at the invitation of the CHAIRMAN and on behalf of the World Medical Association, the International Council of Nurses, the International Pharmaceutical Federation and the World Dental Federation, which together formed the World Health Professions Alliance, welcomed the reports of the Commission and the Secretariat. The Alliance supported the holistic approach to social determinants of health. Health systems should emphasize universal coverage and quality of services. Primary health care must integrate referral systems, including secondary and tertiary care, and not become a second-class service used only by the poorest population groups. Access to health care should be the right of all. She also welcomed the recommendations for increased investment in health personnel. Disaggregated data would enhance understanding of women's contribution to formal and informal health systems.

More attention should have been given to the role of health professionals in addressing the social determinants of health and to the inequalities they faced in their daily work. Their unique experience should be considered in future reports.

The 2008 Joint Health Professions Statement on Task Shifting indicated that health professionals were having to deal with restricted resources. While the Alliance recognized the potential benefits of community health workers, the Statement warned that the new cadres of workers and shifting of tasks resulted in fragmentation and inefficiencies in health services.

Unhealthy and unproductive environments in health care adversely affected the recruitment and retention of health personnel; performance and cost-effectiveness; and patient outcomes. She called on Member States to support the Alliance's campaign to change the health-care workplace and advance the quality of health services.

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

Professor RANTANEN (International Commission on Occupational Health), speaking at the invitation of the CHAIRMAN, expressed satisfaction that the Commission had addressed material health hazards affecting the global workforce, which included biological agents and radio frequency fields. He emphasized further action and prevention management. Cardiovascular morbidity and mortality, metabolic syndrome and mental health were all rising as a result of increased stress related to work. The overall health of workers could improve through the strengthening of occupational health research and services, and the training of service providers.

He encouraged WHO to regard work-related social determinants of health as part of its programme for action. WHO should promote research on models for occupational health services that could respond to the new risks faced by workers worldwide. Resolution WHA60.26 encouraged all countries to implement comprehensive, occupational health services, so that occupational health could become a positive social determinant of health. His organization would collaborate with WHO and its partners in that aim.

Ms SHASHIKANT (Churches' Action for Health), speaking at the invitation of the CHAIRMAN, urged Member States to adopt the recommendations contained in the Commission's report. The Commission should act as a coordinating body in order to monitor implementation of the recommendations. The Secretariat should provide support to Member States for implementation and encourage the use of multilateral trade agreements. An intergovernmental working group should be created in which the views of civil society and social movements were represented. The social determinants of health and equity should be a priority of WHO and the international community.

Dr EVANS (Assistant Director-General) said that health equity was a powerful reflection of social justice. All partners, including civil society, should be actively engaged, empowered and included in addressing the social determinants of health. Evaluation and evidence were vital to measuring the progress achieved, highlighting areas in need, creating ambitious goals and pragmatic targets, and producing indices for health equity. Social determinants were relevant to communicable and noncommunicable diseases, outbreaks and crises, and were therefore essential to health sector actions. The design of health systems, including financing and the deployment and training of health workers, should be informed by social determinants. Social determinants could also help to align comprehensive primary health-care reforms and accelerate the achievement of health-related goals, such as the Millennium Development Goals.

Health should be an integral part of all public policy; using families as entry points, community-based interventions and universal social protection were critical to overcoming health inequities. In that regard, the collaboration of WHO, its sister multilateral organizations and partners, other bodies and society was essential. Results could be achieved through global, not just national, action; that was the case for issues such as trade, the environment and the current financial crisis. He looked forward to participating in the multiple meetings organized to follow up the recommendations in the report.

He thanked Member States for their efforts in that area over the past four years and praised the work of the Commission and its Chairman, Sir Michael Marmot.

The DIRECTOR-GENERAL expressed her deep appreciation of Dr Lee Jong-wook's vision in creating the Commission on Social Determinants of Health. She commended Sir Michael Marmot and the commissioners for their work, and thanked Member States and the global networks of experts and civil society, for their contribution to the work of the Commission. She looked forward to the guidance, support and collaboration of Member States in implementing the recommendations in the report, which emphasized key values of equity, social justice and global solidarity.

The CHAIRMAN said that the item should be kept open pending the conclusions of the informal working group.

It was so agreed.

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

Monitoring of the achievement of the health-related Millennium Development Goals: Item 4.7 of the Agenda (Document EB124/10)

Dr KAMOTO (Malawi), speaking on behalf of the Member States of the African Region, said that some progress had been made but much remained to be done; current trends suggested that many low-income countries in the Region would not attain the Millennium Development Goals.

With regard to Goal 5, six countries in the Region had achieved universal coverage of skilled care at birth. However, there were still high levels of mortality in the Region resulting from complications during pregnancy and childbirth: in some countries the maternal mortality ratio was 500 per 100 000 live births. Additional support from WHO and its partners was needed.

The target for Goal 6 on tuberculosis control had been achieved by the Comoros, Ghana, Mauritius, the Seychelles and Sao Tome and Principe; furthermore, Algeria, Angola, Benin, Cape Verde, Eritrea, Guinea-Bissau and Mali were likely to achieve that target. However, the large numbers of people living with HIV/AIDS in sub-Saharan Africa (comprising 67% of the total worldwide), the spread of drug-resistant strains of *Mycobacterium tuberculosis*, and the growing number of refugees and internally displaced people were all factors that contributed to the increased incidence of tuberculosis. The treatment and containment of HIV/AIDS was improving: by the end of 2007, 42% of those in need were receiving antiretroviral therapy, compared to 17% at the end of 2005.

Malaria morbidity and mortality had been reduced substantially in some countries owing to increased use of insecticide-treated bednets and indoor residual spraying.

With respect to Goal 4, reducing child mortality, some progress had been made in the Region: the number of deaths per 1000 live births had fallen from 187 to 162 between 1990 and 2005.

The Region's slow progress in achieving the health-related Millennium Development Goals was mainly due to its weak health systems, financial problems and a shortage of trained health workers. WHO's renewed commitment to primary health care would enable countries in the Region to build stronger health systems. She appreciated WHO's leadership in promoting implementation of the Paris Declaration on Aid Effectiveness (2005). She welcomed the Director-General's involvement in a high-level task force on innovative international financing, and WHO's work with its partners, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the GAVI Alliance, which were helping to strengthen and finance health systems.

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union and the aligned countries, said that the European Union was committed to annual monitoring of the achievement of the health-related Millennium Development Goals. Results thus far had shown uneven progress among countries and some Goals would not be met, particularly those relating to mothers and children under five. The European Commission, the European Union and its Member States had oriented development cooperation policies towards the objective of eliminating poverty and currently provided 57% of all official development assistance. Member States that had joined the Union before 2002 had committed to reaching the target for such assistance of 0.7% of gross national income by 2015.

The Annual Ministerial Review of the United Nations Economic and Social Council would highlight the health-related Millennium Development Goals. Challenges to achievement of those goals included: strengthening health systems; expanding access to health services; addressing the shortage of skilled health professionals; and building new infrastructure. He also highlighted financial access to health services through social security mechanisms, such as individual insurance schemes, tax-based

funding systems or individual cash-transfer approaches; attending to health in fragile States; and enhancing harmonization among donors and alignment with national policies and plans.

The European Union was promoting, in addition to gender equality, comprehensive sexual and reproductive health programmes; the provision of high-quality antenatal and postnatal care; skilled care during childbirth and family planning services. It had also intensified combat of poverty-related diseases, in particular HIV/AIDS, tuberculosis and malaria, and emphasized prevention, treatment, care and support. It was taking actions, including funding and support, to deal with the shortage of health workers in developing countries. It also supported WHO's immunization activities and its close collaboration with the GAVI Alliance and the Global Fund to Fight AIDS, Malaria and Tuberculosis.

For several decades, the development assistance community had worked with people and governments of developing countries to improve health and living conditions. Progress, though often unrecognized, had been remarkable. Over the previous 30 years, life expectancy had increased by more than 20 years, infant mortality had dropped by half and primary school enrolment had doubled. Poverty could be overcome; however, the battle was far from over. The Millennium Development Goals could still be achieved in most countries if concerted action was increased immediately and sustained until 2015. WHO's leadership role would facilitate the crucial close cooperation needed between governments and nongovernmental partners.

Dr ABABII (Republic of Moldova) said that his Government had been integrating the achievement of the Millennium Development Goals into its economic, development and health policies, and strengthening the health services to new requirements, particularly for vulnerable populations. Progress had been made. Child mortality had fallen by one third, from 16.3 per 1000 in 2001 to 11.2 per 1000. The maternal mortality ratio was 15.8 per 100 000 live births in 2007, compared to about 45 per 100 000 in 2001. Continued improvement in rates of maternal morbidity and mortality would depend on improved access for mothers to high-quality services and primary health care.

In order to achieve Goal 6 (combat HIV/AIDS, malaria and other diseases), his Government had enhanced legislation, strategic planning, organization and monitoring activities. Antiretroviral medicines were currently being provided to some 700 people in Moldova, including prison inmates, and the number was rising. Tuberculosis remained a major problem: morbidity had been rising steadily since 2000, and although the situation had stabilized there were still more than 100 cases per 100 000 population. A national control and treatment programme based on the DOTS strategy had been established, but the country had remained unable to meet the WHO target of detecting at least 70% of cases. Moreover, only 60.8% of patients were treated successfully, well under the WHO target of 85%. Measures had been taken to strengthen screening, prevention and social support, but results had been modest. The emergence of extensively drug-resistant tuberculosis had further increased the risk of transmission of the disease. The situation was exacerbated by high levels of population migration. A mechanism for regional cooperation in treating and monitoring tuberculosis patients was badly needed. New methods for the diagnosis, treatment and prevention of tuberculosis were also needed. Therapies had not changed for many years. WHO should make research into tuberculosis a priority; such research should not be postponed for financial reasons.

Dr REN Minghui (China) said that achievement of the health-related Millennium Development Goals would be made more difficult by the financial crisis and climate change. As the world's most populous country, China's achievement of those goals would have an important global impact.

In China, the target under Goal 4 had been achieved, partly as a result of improved accessibility to public health services: infant mortality had fallen from 50.2 per 1000 live births in 1991 to 15.3 in 2007. Maternal mortality had fallen from 53 per 100 000 live births in 2000 to 36.6 in 2007.

The nationwide elimination of filariasis had been achieved in 2006 and vaccination coverage for children had been extended, with effective control of vaccine-preventable diseases. The spread of HIV had slowed and the prevalence of malaria and tuberculosis stabilized. His Government had recently approved health reforms with a view to achieving the goal of Health for All. China stood

ready to strengthen international cooperation in order to help achieve the Millennium Development Goals, especially in Africa.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland), emphasizing his Government's commitment to the achievement of the Millennium Development Goals, expressed satisfaction at the progress made in reducing child mortality, and acknowledged the need to consolidate and accelerate support for effective strategies. His Government remained concerned that there had been no measurable progress in reducing maternal mortality since 1990. In that regard WHO must prioritize the strengthening of health systems in 2009. Highlighting organizational reform and cooperation with international agencies and global initiatives, he urged WHO to use the International Health Partnership in order to harmonize the health support of national plans. Any draft resolution on the issue should aim to analyse further countries' performance and ascertain the factors that led to success, and those that created barriers to progress towards the Goals.

It was important to secure past gains and to advance towards the Millennium Development Goals. His Government would provide, in addition to its previous commitments to meeting the health-related Goals and its contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria, a further £100 million over the next five years to maintain the campaign to eradicate poliomyelitis. Achieving that objective would make a valuable contribution to the attainment of Goals 1, 4, 6 and 8.

Ms GARBOUJ (alternate to Dr Abdesselem, Tunisia), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that achievement of the Millennium Development Goals by 2015 would be difficult in many parts of the world. Maternal and under-five child mortality remained high in one third of the countries of her Region. Those countries were in the grip of a protracted humanitarian crisis and the underlying cause was poverty.

She called upon WHO and the international community to strengthen the capacities of communities in the Region to break free from poverty; to break down social and economic barriers; to promote equity and health equity in particular; to improve the performance of health services; to promote equitable access to those services; to strengthen human resources; and to address social determinants that affected health outcomes. Action to deal with the underlying causes of poor health and social conditions could, through community empowerment, contribute to the achievement of the health-related Millennium Development Goals. Greater investment was needed, especially in the countries that had made the least progress. States should engage in South-South cooperation, share experiences and strengthen their reporting and monitoring systems.

The meeting rose at 12:35.

SEVENTH MEETING

Thursday, 22 January 2009, at 14:05

Chairman: Sir Liam DONALDSON
(United Kingdom of Great Britain and Northern Ireland)
later: Mr N.S. DE SILVA (Sri Lanka)

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

Monitoring of the achievement of the health-related Millennium Development Goals: Item 4.7 of the Agenda (Document EB124/10) (continued)

Mr VALLEJOS (Peru) said that a committee for the achievement of the Millennium Development Goals had been established by the Peruvian Congress. The committee had drafted laws aimed at strengthening government action and launched a campaign to raise public awareness of the Goals and the deadline of 2015. The national report on the Goals presented in 2008 had revealed high levels of poverty in Peru, a middle-income country. The Congress had included the Goals in the budget and stipulated minimum levels of funding for those activities.

Several United Nations agencies in Peru were promoting specific goals at the community level, including maternal and child health and controlling HIV/AIDS and other infectious diseases. National data indicated tangible achievements: a fall in the number of people living in poverty and extreme poverty in 2007. Furthermore, the most recent UNICEF report noted significant improvements in infant health, maternal mortality, prenatal care and deliveries assisted by skilled attendants. In 2007, his Government had initiated intersectoral efforts in order to improve social services and the quality of life in the 880 poorest districts in Peru.

Professor AZAD (alternate to Professor Haque, Bangladesh) said that his new Government was committed to achieving the health-related Millennium Development Goals. Bangladesh had significantly enhanced control of tuberculosis and malaria and had invested in the combat against HIV/AIDS and in improving child health and survival. For a while, it had appeared that a successful immunization campaign had eradicated poliomyelitis in Bangladesh; however, the disease had proved to be a global problem requiring regional and worldwide cooperation. Family planning was another area in which significant achievements had been made.

Of all the Millennium Development Goals, Goal 5, improving maternal health, was proving the most difficult. Maternal and newborn mortality remained high in Bangladesh, and only about 20% of pregnant women had access to skilled care during pregnancy and birth. Since many African and Asian countries, including Bangladesh, might fail to achieve Goal 5, urgent attention and investment were needed. Bangladesh would work actively in that area and called on WHO to provide timely support.

WHO must continue to elaborate policy and technical guides on health-system development; management of health-care delivery; and innovative health financing, all with primary health care as the driving force. Bangladesh would need guidance on how to finance the health needs of its population and on the best model to adopt. WHO should also play an important role in evidence-based monitoring of progress towards meeting the Goals.

Dr ADITAMA (alternate to Dr Supari, Indonesia) said that Indonesia's health programme to achieve the Millennium Development Goals had been on track but some elements had been slowed by the financial crisis. Half the population still had insufficient access to clean water and basic sanitation;

the number of deaths from HIV/AIDS was increasing, even though the national prevalence remained low. Indonesia also continued to grapple with neglected tropical diseases, such as leprosy and yaws.

More positively, a mosquito control programme aimed to make some parts of Indonesia malaria-free by 2020. A DOTS-Plus programme for multidrug-resistant cases of tuberculosis and a pilot project for the Practical Approach to Lung Health were due to be launched. Tuberculosis prevalence had decreased 42% nationally since 1990. Other approaches being strengthened were community participation, and partnership and intersectoral collaboration as part of primary health care.

Mr HOHMAN (alternate to Dr Wright, United States of America) welcomed the progress made towards achieving some of the targets of the Millennium Development Goals, such as those concerning immunization; prevention of HIV/AIDS; expanding access to safe drinking-water and sanitation; and improving treatments for malaria, tuberculosis, HIV/AIDS and other diseases. Nevertheless, not enough progress had been made in reducing the maternal mortality ratio. It was necessary to improve access to reproductive health services and ensure safer pregnancy. The United States would continue to support programmes addressing those issues. It also supported the expansion of primary health-care services focused on maternal and child health.

Dr DAHL-REGIS (Bahamas) said that, in the Caribbean region, joint efforts had operated successfully, for example in preventing transmission of disease from mother to child; almost all countries in the region had achieved notable success with childhood immunization programmes. However, more research was needed to identify the racial disparities in infant deaths in countries with different levels of development.

Nevertheless, the health conditions in one country in the Caribbean region remained of grave concern. The impact of recent hurricanes, severe food shortages, deteriorating environmental management, poor vector management, unsafe water supplies and poor sanitation all threatened the Caribbean basin. What happened on one island affected all countries in the region. A worrying increase in population movement had been observed. Many of the gains noted in the report might be reversed if such problems were left unaddressed. The world had provided much humanitarian assistance in order to help countries to achieve the Millennium Development Goals, but a new strategic approach was necessary. She therefore supported the suggestion of the member for the United Kingdom regarding the content of an appropriate resolution. However, she emphasized that maternal health should be dealt with separately.

Dr BUSS (Brazil) said that, as shown by the work of the Commission on Social Determinants of Health, all the Millennium Development Goals were in some way related to health. Brazil was making excellent progress in achieving the Goals, but expressed concern about data on progress in many developing countries. Not achieving the Goals would be a failure for the community of nations.

On the basis of conclusions arising from a conference on the Goals held in November 2008, he appealed to the Board to focus more on the neglected Goal 8 (develop a global partnership for development). The Board should identify the countries that were in the worst situation; WHO should make a special appeal to United Nations agencies and civil society institutions, at country level and worldwide, find the resources, and ensure that those developing countries would achieve Goal 8. The Board should issue a strong resolution addressed to the international community, especially at a time of financial crisis, and should intensify coordination on health and development.

Ms MATSAU (South Africa),¹ expressing dismay at the statistics in the report, said that in 15 years there had been no significant reduction in the maternal mortality ratio in the Member States of

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

the African Region. WHO had transferred resources from maternal health proper to strengthening health systems in general, which would contribute to better maternal health outcomes. Clearly, however, progress was too slow and a new approach was needed. She asked whether the Secretariat had observed any pattern in maternal mortality. If three or four common factors could be identified as responsible for a large proportion of maternal mortality, WHO could target them specifically in order to improve maternal health outcomes quickly.

Dr MUÑOZ (Chile)¹ said that many of the health-related Millennium Development Goals could only be achieved by strengthening health services and guaranteeing access for the most vulnerable population groups. Given the slow progress in respect of maternal and infant mortality, it was unrealistic to expect that strengthening health services alone, a slow process of training human resources, could have a major impact on achieving the Goals over the next five years. Every country must prioritize those measures that were most conducive to achievement of the Goals in its own particular context. In the experience of Latin America, building new hospitals would not reduce maternal mortality unless accompanied by effective systems to identify obstetric and gynaecological emergencies and ensure clean, safe delivery.

He shared the sentiments expressed by the member for Brazil. It was essential to diagnose accurately the particular problems experienced by each country and to prioritize effective action. His country would contribute to all efforts coordinated by WHO to share experiences and avoid the mistakes which others had made.

Ms TELLIER (United Nations Population Fund) said that progress towards Millennium Development Goal 5 (improve maternal mortality) was least despite major advances in reproductive health over the past century. It was agreed that factors such as family planning services, good access to emergency obstetric care and skilled care at delivery helped to reduce maternal mortality. Progress towards the targets in terms of the indicators for Goal 5 showed a tragic disparity both among and within countries. For example, a woman's lifetime risk of dying in childbirth ranged from 1:28 000 to 1:7 depending on the country where she lived. The indicators showing the greatest disparity were: adolescent pregnancies; inadequate family planning services; and neonatal mortality. Unequal access to reproductive health services was reflected geographically, culturally and economically. The rural and urban poor were similarly disadvantaged. She welcomed the new Millennium Development Goal target relating to universal access to reproductive health. Progress should be tracked by monitoring socioeconomic indicators, including income quintiles.

Goal 5 was closely related to Goals 3, 4 and 6. Progress in one area would determine progress in the others. Reproductive health was also fundamental to other topics before the Board, including primary-health care and health systems. A primary health-care system needed referrals for emergency obstetric care, reproductive health supplies, skilled staff at delivery and tracking of progress. That required wide-ranging partnerships.

UNFPA was a committed partner of WHO in promoting reproductive health in development and emergency situations. She emphasized strategic objectives 4, covering sexual and reproductive health, and 7, gender, of WHO's Medium-term strategic plan.

Ms ARENDT (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN, said that the impact on health and poverty reduction of early and exclusive breastfeeding, supplemented at a later age by complementary foods, had been widely recognized. Initiation of breastfeeding immediately after birth reduced blood loss in the mother, and exclusive and continued breastfeeding was effective in child-spacing. However, data on breastfeeding were not yet

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

included among the indicators for the Millennium Development Goals. She called on WHO to include breastfeeding data in its statistics and provide more financial and technical support to promote and protect breastfeeding and relevant training for health workers.

Ms LINNECAR (Consumers International), speaking at the invitation of the CHAIRMAN, regretted that the report made no mention of the impact of malnutrition on mortality among children under five, despite the concerns expressed in the *United Nations Millennium Development Goals Report 2008* and the series of articles on maternal and child undernutrition published in *The Lancet*. Undernourished infants and young children could suffer irreversible physical and cognitive damage affecting their future health, economic well-being and welfare.

Breastfeeding reinforced other proven interventions, especially immunization, since it conferred both active and passive immunity and strengthened the infant's developing immune system. Resolution WHA61.15 on the global immunization strategy had recognized the key role of breastfeeding. She called on WHO to include data on early and exclusive breastfeeding in the list of indicators for tracking progress on Goal 4. Resources must be made available to promote optimal breastfeeding practices and decrease undernutrition.

Ms GREENIDGE (International Federation of Pharmaceutical Manufacturers & Associations), speaking at the invitation of the CHAIRMAN, said that the pharmaceutical industry was still playing its part in implementing the Millennium Development Goals, especially Goals 4, 5, 6 and 8. In the current economic climate, all stakeholders must work together and expand partnerships. Her organization's members were major contributors in building capacity in developing countries and those with emerging economies. They had increased research and development projects on the 10 most significant tropical diseases from 32 in 2005 to 58 in 2008, and were working more frequently in specialized product development partnerships such as the Drugs for Neglected Diseases initiative. Her organization was interested in taking part in such collaborative activities as the African Network for Drugs and Diagnostics Innovation. It would launch new activities in 2009 and work towards the Millennium Development Goals in collaboration with other stakeholders.

Ms MAFUBELU (Assistant Director-General), replying to the representative of South Africa, said that there were indeed common factors contributing to maternal mortality in a small number of countries, which accounted for 97% of global mortality. Because of the lack of skilled birth attendants at delivery and the lack of access to emergency obstetric care, including emergency transport, referral systems and supplies of medicines such as oxytocin, countries were unable to respond more effectively to the four principal causes of death in childbirth – postpartum haemorrhage, obstructed labour, eclampsia/pre-eclampsia and sepsis. It was also essential to establish a comprehensive strategy for the prevention of mother-to-child transmission of HIV.

Dr EVANS (Assistant Director-General) agreed that there had been mixed progress in achieving the Millennium Development Goals. Many speakers had stressed the interdependence of the various Goals, for example nutrition as a factor in child survival and a determinant of overall health, as indicated by the Child Epidemiology Reference Group. Others had linked the Goals to other items on the Board's agenda, including health systems, social determinants of health, and climate and environmental change. Monitoring and evaluation had been emphasized: greater investment there would enable countries to better evaluate the reasons for their successes and their failures, and inform the strategic changes at country level needed for sustainable improvement.

Replying to the representative of South Africa, he said that the indicators used to track progress in the implementation of the Goals were defined by the United Nations Department of Economic and Social Affairs, and were not intended to be exhaustive. The Secretariat would certainly suggest breastfeeding rates as a possible indicator when the current indicators were revised; it would meanwhile include breastfeeding in its own publication, *World Health Statistics*.

The DIRECTOR-GENERAL drew attention to the 2009 High-level Segment of the United Nations Economic and Social Council that WHO would be attending at the invitation of the United Nations Department of Economic and Social Affairs. WHO was pleased to work with those partners to address the theme of the Council's Annual Ministerial Review, implementing the internationally agreed goals and commitments in regard to global health; the Millennium Development Goals would be an important part of that discussion.

WHO was working with the relevant partners and United Nations organizations to support national and regional consultations; the health sector could not achieve enough alone but, reaching out to the Economic and Social Council would actively demonstrate that all sectors were working together to promote health in all policies.

The Board took note of the report.

Mr de Silva took the Chair.

Climate change and health: Item 4.8 of the Agenda (Document EB124/11)

The CHAIRMAN drew attention to a draft resolution on climate change and health that had been proposed by the United Kingdom of Great Britain and Northern Ireland and which read:

The Executive Board,
Recalling resolution WHA61.19 on climate change and health;
Noting the proposed workplan on climate change and health,

1. URGES Member States to endorse the proposed workplan on climate change and health;
2. REQUESTS the Director-General:
 - (1) to implement the actions contained in the workplan on climate change and health;
 - (2) to report annually, beginning in 2010, through the Executive Board, to the Health Assembly on progress in implementing resolution WHA61.19 and the workplan.

Dr GOPEE (Mauritius), speaking on behalf of the Member States of the African Region, said that the effects of climate change and global warming in his Region had included floods caused by cyclones and torrential rains in the south-eastern part of Africa, prompting disease outbreaks and exacerbating the poor quality of sanitation infrastructure, and droughts in several countries in the Horn of Africa and the Sahel which had led to further malnutrition. Rapid response to the health-related impact of climate change was needed.

The Libreville Declaration, adopted in 2008 following a conference on health and environment, had recommended: joint action to establish a health and environment strategic alliance; updating of policies; accelerating the achievement of the Millennium Development Goals; and assessment of environmental risks to health.

Noting paragraph 22 of the workplan, he suggested that any assessment should consider the longer-term effects on health, in addition to the more visible, immediate impacts of events caused by climate change. Challenges included the weak coordination between sectors in policy formulation, implementation and evaluation, and the institutional obstacles to project implementation. Centrally coordinated mechanisms should be established in order to ensure multisectoral collaboration and effective responses.

Dr KÖKÉNY (Hungary), speaking on behalf of the Member States of the European Union and its aligned countries, said that the proposed workplan would expand the work of WHO in adapting health systems to the impacts of climate change. Climate change was the urgent, defining challenge of

the present generation; it was already affecting people's health and a burden on health systems. Nevertheless, awareness of its consequences on health was widespread.

The Board needed to support and endorse the workplan since many health ministries looked to WHO for assistance in establishing adaptation and mitigation measures. He supported the workplan as it would stimulate cross-sectoral activity, identify knowledge gaps and facilitate research.

The United Nations system must further the collective commitment to tackling climate change. WHO should send a powerful message to the 15th Conference of the Parties to the United Nations Framework Convention on Climate Change, to be held in Copenhagen in December 2009, that urgent action was needed to tackle the causes and health consequences of climate change. He commended the work of the WHO Regional Office for Europe in that respect and urged the Director-General to sustain her leading role and remind the world that the poorest communities were those first affected by climate change.

Professor HARPER (alternate to Sir Liam Donaldson, United Kingdom of Great Britain and Northern Ireland) said that early progress had been made on the global health risk posed by climate change, and expressed gratitude to the Director-General for her commitment and to Member States for their relevant expertise.

Noting the workplan, he outlined the contents of the draft resolution and proposed a textual change: in paragraph 1, the words "URGES Member States to endorse" should be replaced by "ENDORSES" to make it clear, in the context of an Executive Board resolution, that the Board itself endorsed the workplan.

Dr REN Minghui (China) said that health systems faced a new task in tackling climate-related effects on health and stressed the need to adopt measures. The workplan reflected current needs and China supported its submission to the Health Assembly for consideration.

His Government was acting in accordance with the principle in the United Nations Framework Convention on Climate Change of common but differentiated responsibility. It had launched a national plan of action on environment and health for 2007–2015; conducted research into the effects of climate change on health; and strengthened capacity in environment and health management.

Health systems in Member States should be strengthened in order to deal with climate-related health risks; the Secretariat should help Member States to conduct research and gather relevant evidence. Further efforts should be made and training conducted in order to raise public awareness; and an international mechanism for sharing relevant data was also needed.

He supported the proposed draft resolution.

Ms TOELUPE (Samoa) said that, at the fifty-ninth session of the Regional Committee for the Western Pacific (Manila, 22–26 September 2008), the small island States of the South Pacific had appealed for help regarding climate change, as many were vulnerable to future displacement following loss of country, identity and culture.

The focus on climate and health in Samoa provided by the environment sector had exemplified good cross-sectoral partnership at national level. In conducting the actions proposed in the workplan, WHO should emphasize collaborative and complementary approaches since many vulnerable countries lacked the resources to deal with climate and health issues separately. Thus vertical programming should be avoided.

Samoa welcomed further initiatives regarding climate change based on: public health-care strategies; health promotion initiatives; disease prevention and control programmes; food security; and consideration of infrastructure. Such initiatives bolstered disaster and emergency preparedness. Small island States urgently needed greater research capacity in monitoring and evaluation of adaptation and mitigation plans. WHO should increase its activity in global forums on climate change and health in order to strengthen collaboration at all levels. She welcomed the report and her Government was ready to participate in regional initiatives on climate change and health.

Dr MOHAMED (Oman), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that particular attention had been given to climate change within the Region. The lack of rainfall and water shortages had caused problems for agriculture and affected health in many urban centres.

The Regional Office had organized seminars on the impact of climate change on health. The difficulties faced by health ministers in preparing plans and responding to climate change had been listed: the strengthening of health plans, rather than just preparing emergency and disaster programmes, had been emphasized. It had been recommended that countries should establish national committees in order to coordinate work on climate change.

Noting that the workplan emphasized strategic objective 8 of the Medium-term strategic plan 2008–2013, but also stressed the need to implement the other objectives, he urged Member States to collaborate further in order to implement the proposed workplan and study the impact of climate change. He supported the workplan and the need to expedite its implementation. The activities proposed should also be included in the Medium-term strategic plan 2008–2013; greater emphasis should be placed on the objective of collecting scientific data, as no specific reference had been made to assisting developing countries in that respect.

Dr LEE Hoon-sang (alternate to Professor Sohn Myong-sei, Republic of Korea), emphasizing surveillance systems, suggested that action 3.6 of the workplan should also encourage Member States to share surveillance information, especially on changes in vector density and distribution due to climate change. The Secretariat should provide guidance for developing systems of vector surveillance and information sharing in each Member State, so as to enhance their preparedness and response to any emergence of vector-borne diseases.

Ms ROCHE (New Zealand), welcoming the attention paid to adaptation and mitigation in the workplan, said that potential co-benefits to health should be included in cost-benefit analyses of mitigation initiatives. She suggested that WHO's work on climate change should cover the health sector's contribution to mitigation efforts. The Secretariat's global role in advocating action on health and climate change would be further underpinned by producing a sustainable behaviour model; developing and implementing a plan to reduce its own carbon footprint; and advising Member States on how to enable their national health ministries to do likewise.

Mr HOHMAN (alternate to Dr Wright, United States of America), observing that climate change was the significant challenge of the day, said that evidence of its impact on human health was persuasive and he encouraged Member States and the Secretariat to take appropriate action. The United States consequently supported many programmes that protected human health from risk factors sensitive to climate by improving local health institutions; strengthening disease surveillance through global systems; advancing climate science; and integrating climate considerations into sustainable development projects. The core functions of the Secretariat included providing Member States with valuable knowledge and technical support; monitoring global health situations; and articulating ethical and policy options based on evidence. Therefore, the workplan must emphasize the collection and dissemination of reliable data on which Member States could base their policy decisions and, with technical support from WHO, implement those decisions. The United States generally supported the workplan. The Secretariat should use the relevant assessments by the Intergovernmental Panel on Climate Change to guide implementation of the workplan. Referring to paragraph 29 of the document, he asked what kinds of support were planned in order to help health systems to reduce their own greenhouse gas emissions, and how that activity related to the four objectives.

Dr ADITAMA (alternate to Dr Supari, Indonesia) said that Indonesia was particularly vulnerable to the effects of climate change owing to its geography, the large populations living in coastal areas and cities, and its economic reliance on fossil fuels. He reaffirmed his Government's

commitment to the Bali Road Map adopted at the United Nations Climate Change Conference (Bali, Indonesia, 13–14 December 2007), which called for a cross-sectoral approach to dealing with climate change. Hence adaptation programmes sought to improve, inter alia, disease surveillance, drinking-water safety, response to emergencies, vector management, and environmental health protection. Indonesia supported the Secretariat in its efforts to implement the regional framework for action to protect human health from the effects of climate change and resolution WHA61.19. It would also assist the Secretariat in preparing a draft resolution for the Sixty-second World Health Assembly, in response to paragraph 11 of the Bali Declaration on Waste Management for Human Health and Livelihood.

Professor AZAD (alternate to Professor Haque, Bangladesh), recalling the devastating effects of the natural disasters suffered by Bangladesh and other countries in the South-East Asia Region in recent times, said that professionals and organizations in the most vulnerable countries would benefit greatly from implementing the workplan through awareness-raising and capacity-building. He therefore proposed that the following text should be added to paragraph 32: “Organizations, researchers and appropriate professionals from the countries which are most in danger of climate change will be included in most efforts and actions. Those countries will also be considered as good candidates for a research base, as climate change will hit them earliest.”

Dr SERPAS MONTOYA (alternate to Dr Larios López, El Salvador) drew attention to his Government’s plan of action to protect the population from the health effects of climate change through a range of adaptation policies on national surveillance, drinking-water supply, vector-borne disease control, food safety and security, and emergency preparedness and response. His Government prioritized coordinated action with other sectors and with the general public. He welcomed the report and expressed support for the proposed draft resolution.

Dr DAHL-REGIS (Bahamas), expressing her appreciation for the shared surveillance systems provided by the United States of America, which had helped save many lives during the recent catastrophic hurricanes in her region, proposed that the phrase “all countries, in particular low- and middle-income States and small island States” in paragraph 4 of document EB124/11 be inserted in paragraphs 26 (“The Secretariat will collaborate with all countries, in particular ...”) and 29 (“The Secretariat will work with all countries, in particular ...”).

Dr JAYANTHA (alternate to Mr de Silva, Sri Lanka) said that his country needed more technical support to develop advocacy and awareness-raising campaigns based on: information about the likely impacts of climate change on Sri Lanka and the wider region; education packages for women, the elderly and other vulnerable groups; and training for professionals in both the health sector and other fields. He expressed support for the workplan and implementation of the recommended actions.

Dr BUSS (Brazil) said that climate change was a matter of great importance to Brazil. Its impact on human and environmental health had been taken into account in a joint project with the other seven countries of the Amazon Cooperation Treaty Organization. His Government had taken measures to prevent any serious damage from the current construction of two hydroelectric energy plants in the vicinity of the Amazon forest, which was expected to attract some 70 000 people to the area over the coming 10 to 15 years. With respect to greenhouse gas emissions, some of the industrialized countries most responsible had yet to commit themselves to the Kyoto Protocol, and he urged the Board to call on them to do so. Expressing his support for the workplan, he recommended that education campaigns should advocate more practical means of disaster risk reduction such as changing lifestyles and controlling energy consumption.

Mr CALVETE OLIVA (Spain)¹ said that Spain had already begun to feel the health effects of climate change, as reflected in increasing morbidity and mortality. Its response included an adaptation plan to climate change and a project to establish a climate change and health observatory for analysing and evaluating those effects. It had participated in European and international high-level meetings aimed at identifying actions to tackle the threats and to protect public health; and in October 2008, it had hosted a WHO conference, attended by researchers, representatives of donor bodies and other United Nations organizations, which had culminated in a global research agenda on climate change and health. The health sector must coordinate strategies with the other stakeholders in climate change mitigation and adaptation. He expressed support for the workplan and his Government would contribute to the climate change and health agenda under objective 8 of the Medium-term strategic plan for 2008–2013.

Ms TOLSTOÏ (France)¹ said that scientists and the international community had generally recognized the impact of climate change and its adverse effects on health. Major health problems could be exacerbated through climate change, particularly in developing countries. France welcomed WHO's organization, in coordination with UNDP, of the First Inter-Ministerial Conference on Health and Environment in Africa (Libreville, 26–29 August 2008).

She emphasized coordinated action through objective 2 of the WHO workplan, aimed at partnerships with other United Nations organizations and sectors. Global and intersectoral policies on health, energy, urbanization and transport must be elaborated in order to anticipate and limit the effects on health of: drought, floods, and storms; malnutrition; migration; waterborne diseases and changes in the modes of transmission of vector-borne diseases. She emphasized advocacy and raising awareness of those effects, and research to confirm the linkages between climate change and health, which must also be elaborated in national policies. Cholera epidemics could be mitigated and even avoided through advance primary prevention, particularly sanitation measures. The health of populations would benefit and the cost of crisis response would be reduced. Action by all sectors that aimed to reduce environmental hazards could reduce morbidity, and benefit quality of life and greater well-being.

Ms JAQUEZ (Mexico)¹ said that the workplan would help the international community in mitigating the impact on health of one of the greatest challenges ever faced by humanity. The workplan was compatible with her Government's actions to mitigate the effects of climate change on the health of the population, particularly its most vulnerable sectors.

Mr CHAUDHRY (India)¹ welcomed the workplan for scaling up WHO's technical support to Member States in responding to the implications of climate change for health and health systems. Nonetheless, motivating behavioural change and building societal support for mitigation were best left to the United Nations Framework Convention on Climate Change. The greatest challenge to good health and equitable access to quality health care in developing countries was poverty. Malnourishment, anaemia and various diseases were caused by poverty and poverty was his Government's overarching priority.

The emphasis on bio-fuels had resulted in the conversion to fuel crops of huge land areas formerly used for food crops, thereby exacerbating the global food shortage, which adversely affected health, particularly in low-income countries. The workplan should emphasize that WHO, in undertaking mitigation measures and entering into partnerships with other United Nations organizations, and in sectors other than the health sector, must avoid any action that would reduce the global food supply or impede efforts to eradicate poverty in developing countries.

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

Ms ALARCÓN LOPEZ (Colombia),¹ having cited the summaries for policy-makers in the contributions of Working Groups II and III to the fourth assessment report of the Intergovernmental Panel on Climate Change,² said that adaptation, risk management and risk prevention policies, as well as public health measures, must be developed and promoted. Although the report of Working Group III referred to health benefits from reduced air pollution as a result of actions to reduce greenhouse gas emissions, she believed that mitigation should be linked to sustainable development efforts.

Economic and social development and poverty eradication were priorities for developing countries. The response to climate change called for all countries to cooperate on the basis of their common responsibilities, their respective capacities and their social and economic conditions. Improved awareness would help professionals in the health sector to provide leadership in supporting strategies for mitigation and adaptation.

Dr ALVIÁREZ (Bolivarian Republic of Venezuela)¹ supported the comments made by the member for Brazil, notably regarding prevention. His country had signed the Kyoto Protocol; it was recycling gas emissions from petroleum production; advocating the saving of energy; and establishing ecological villages using solar energy. Paragraph 8 of the report should have emphasized that the reduction of greenhouse gases was one of the actions that must be taken by WHO. He advocated global campaigns in order to change behaviours related to consumerism. Awareness-raising activities in communities, and in the educational system in general, were more important than adaptation to future disasters. Those activities should be specified in the report. An appeal should be made to the industrialized countries to sign the Kyoto Protocol in the interests of saving humanity.

Dr BABB-SCHAEFER (Barbados)¹ acknowledged that the report, which she welcomed, recognized the particular vulnerability of small island States to the effects of climate change. Barbados supported the proposed draft resolution, which would enable the Director-General to implement the actions contained in the workplan on climate change and health. She also endorsed the amendments proposed by the Bahamas.

Mr ROSALEN (Bolivia)¹ said that his President had emphasized problem of climate change in October 2008 through his proposed “10 commandments” to save the planet. Bolivia welcomed the report and the necessary work to define policies on the relationship between climate change and health and its consequences. The awareness-raising campaign to which the report referred should also be addressed to decision-makers in those industrialized countries that were causing harm to the planet.

Mr SAMRI (Morocco)¹ said that Morocco had been particularly hard hit by the impact of climate change on health. It was affected by desertification and water shortages. His Government was engaged in urgent mitigation efforts, but concerted global action was needed. WHO should establish partnerships with other specialized agencies such as UNEP and become more deeply involved in work at grass-roots level.

Dr HEYMANN (Assistant Director-General) thanked members of the Board for their guidance on additional ways that the Secretariat could support Member States and for the support that had permitted the development of the workplan before the Board and of the research agenda. Advocacy

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

² Parry ML et al. *Climate change 2007: inputs, adaptation and vulnerability. Continuation of Working Group II to the Fourth Assessment Report of the Intergovernmental Panel on Climate Change*: Cambridge, England, Cambridge University Press, 2007, and Metz B et al. *Climate change 2007: mitigation. Contribution of Working Group III to the Fourth Assessment Report of the Intergovernmental Panel on Climate Change*: Cambridge, England, Cambridge University Press, 2007.

had been well under way since World Health Day in 2008, when the Director-General had called attention to the need to protect health from climate change, and health remained a major part of climate change discussions. The partnerships created within the United Nations and with other sectors had enhanced WHO's advocacy efforts.

The research agenda, intended to increase evidence on which to base estimates and strategies to better protect health, had been reviewed at the Global Ministerial Forum on Research for Health, held in Bamako in 2008. WHO continued to work with countries to incorporate in health systems those activities, such as vector surveillance and control, that would strengthen Member States' ability to guard against climate-sensitive health effects. The WHO initiative to reduce its own carbon footprint was in the final stages of review and approval. The Secretariat would also help Member States as they developed their own plans to reduce carbon footprints within the health sector. He proposed that the final sentence of paragraph 29 of the report should be revised to read: "In addition, support will be provided to countries that wish to reduce their own carbon footprint from the health sector."

Mr SOLOMON (Office of the Legal Counsel), replying to the procedural question whether it was appropriate for the Board to endorse the workplan rather than merely note it, as the proposed amendment to the draft resolution would have it, confirmed that it was within the Board's power to do so. First, the governing resolution, resolution WHA61.19, provided for the workplan to be presented to the Board without reference to the Health Assembly. Second, and more importantly, the workplan primarily involved activities of the Secretariat rather than those carried out at the intergovernmental level. Therefore, for the Board to endorse the workplan was consistent with its executive functions and constitutional authority.

The DIRECTOR-GENERAL thanked the Board for its guidance. With regard to the need for better coordination and policy coherence within the United Nations, the Secretary-General himself placed great importance on the issues of climate change and the food crisis. Within the United Nations System Chief Executives Board for Coordination, which he chaired, he had made clear to all heads of agencies the need for better coordination within the United Nations family. While the lead roles on climate change and the food crisis were naturally being taken by UNEP and FAO, respectively, WHO also contributed to the work, particularly on monitoring the impact of acute and chronic malnutrition.

With regard to call by the member for Hungary for her to continue strong advocacy, she certainly would, especially because, as many speakers had noted, the relationship between climate change and health was still not generally well understood.

The member for New Zealand had asked what WHO had done so far to reduce its carbon footprint. She recalled that the late Dr Lee had begun the process of replacing all petrol-engine official cars with hybrid vehicles. Other measures included reducing the temperature in the headquarters building, and reducing print publications by increasing the online availability of documents. Although it was difficult to reduce the number of country visits, she would make an effort to ensure that they were strategically planned.

The resolution, as amended, was adopted.¹

WHO's role and responsibilities in health research: Item 4.9 of the Agenda (Documents EB124/12, EB124/12 Add.1 and EB124/12 Add.2)

Dr BIN SHAKAR (United Arab Emirates), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that, as a result of a series of national and international

¹ Resolution EB124.R5.

consultations, five main objectives had been set for WHO's role and responsibilities in health research. The consultations had been broad-based, with numerous researchers from countries in the Region. Emphasis had been placed on developing national strategies for health research, and on involving as many stakeholders as possible. With support from WHO and other partners, several countries in the Region, including his own, were finalizing national strategies for health research. The United Arab Emirates had established a research centre which worked closely with all the relevant ministries and institutions and was being increasingly consulted. A prize was offered for health research and a database was being compiled. Exchanging information on the results of research were widely recognized. Once national strategies were in place, countries should be able to strengthen their health infrastructure and offer better services to their people.

Mr HOHMAN (alternate to Dr Wright, United States of America) welcomed WHO's renewed commitment to research, since it built on the Organization's core function of "shaping the research agenda, and stimulating the generation, dissemination and application of valuable knowledge". He expressed support for the plan outlined in the draft strategy to strengthen the research culture across the Secretariat by bolstering existing mechanisms; enhancing the research competencies of relevant staff; and improving the coordination of affiliated research.

However, the expansion of research conducted by WHO itself could duplicate efforts and dilute resources, as the Secretariat simultaneously assisted Member States in expanding their own research capacities. Moreover, the Secretariat's strength lay in translating research findings into technical guidance for Member States rather than in conducting pure research itself.

He also questioned the strategy's portrayal of copyright and intellectual property issues in paragraph 63 of the annex to document EB124/12. Such mechanisms existed to assist researchers in gaining access to materials. For example, the United States National Institutes of Health ensured public access to the published results of its funded research by requiring scientists to submit final, peer-reviewed manuscripts to a central digital archive. He was also concerned that the draft resolution foresaw a role for Member States in implementing the strategy, which had been designed for the management and organization of research activities within WHO. Although he had several amendments to propose, the Board should adopt a draft resolution similar to the one just adopted under the previous agenda item. Such a resolution would, however, still have to be submitted to the Health Assembly since it had requested the proposed research strategy in resolution WHA60.15.

Dr REN Minghui (China) said that WHO should assume still more responsibility in improving health research, and the related capabilities of developing countries. Although his Government welcomed the report, it emphasized that WHO should improve the coordination of its research activities and promote the application of research findings. WHO might consider: establishing and supporting collaborating centres in developing countries; increased training for research managers; providing technical support for Member States and enhancing their capacities in the application of decision-making for health. A percentage of the budget could be earmarked for research activities in key development areas.

Dr MAIGA (alternate to Mr Touré, Mali), speaking on behalf of the Member States of the African Region, said that health research particularly concerned the African countries. There was a widening gap between new technologies and their application for the purpose of improving health. The Global Ministerial Forum on Research for Health (Bamako, November 2008), convened in response to resolution WHA60.15, had led to the Bamako Call to Action on the further development of health research. Consultations had led to finalizing the WHO strategy on health research.

The importance attached to health research in the African Region had been demonstrated by the Abuja Declaration of March 2006; the Accra Declaration on Health Research of June 2006; the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa, of April 2008; and the Algiers Declaration on Health Research in the African Region, of June 2008. All those initiatives

were commitments to strengthen health research, information, management, and investment. Through enhanced knowledge and increased health equity, the African Region could accelerate progress towards meeting the Millennium Development Goals.

In the light of the Algiers Declaration and the Bamako Call to Action, the next challenge would be to mobilize funding, for example, by allocating 2% of national health budgets and at least 5% of official development assistance to research. Sustainable financing would safeguard progress, particularly at a time of financial crisis. Measures would be needed to ensure that research findings were communicated and applied.

In March 2009, Mali would have access to the WHO Evidence-Informed Policy Network. Further needs included capacity-building, creation of research networks, and establishment of centres of excellence.

She called on the Board to adopt the draft WHO strategy on research for health. Finally, a World Day of Research for Health was needed, as proposed in the Bamako Call to Action.

Professor AZAD (alternate to Professor Haque, Bangladesh) supported the draft strategy. He proposed the addition, in paragraph 49 of the annex, of the words “and encouraging multi-centre studies” after “global networks”. In subparagraph 51(f) the words “and multi-centre studies” should be inserted after “global networks”. Paragraphs 65 and 66 should have mentioned, as factors limiting access to research, insufficiencies and lack of standards in health informatics and related problems of affordability and language.

Dr STARODUBOV (Russian Federation) welcomed the draft WHO strategy on research for health. WHO was recognized throughout the world as the most authoritative organization in the field; an arbiter in matters relating to health research; important in disseminating research findings and developing an evidentiary basis for health protection. The Secretariat had a role in encouraging the governments of Member States to allocate appropriate funding to research. The adoption of the draft strategy would enhance research at country level, which in turn would encourage governments to adopt national strategies for health research.

He supported the draft resolution but proposed that an amendment should be made to subparagraph 4(6) concerning the strengthening of the role of the WHO collaborating centres for interaction with countries in the field of health research.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) said that research for health and the knowledge derived from it were global public goods. Acting on the best available knowledge would accelerate attainment of the health-related Millennium Development Goals, deliver safe, and equitable health systems, and improve health security for all peoples. He had been surprised at the thought of WHO conducting research, as mentioned by the member for the United States. However, Article 2(n) of the WHO’s Constitution stated that the role of WHO was to promote and conduct research in the field of health. Perhaps that was an outmoded concept and “promote and support research” might be more appropriate.

The strategy should be coordinated with implementation of the Global strategy and plan of action on public health, innovation and intellectual property. He supported the Bamako Call to Action, which urged WHO to streamline the structure and governance of its research activities. The Director-General might wish to consider convening such discussions before the Health Assembly and also amending the resolution to call upon other parties concerned to participate in such discussions. He would submit proposed amendments to the draft resolution to the Secretariat.

Mr FISHER (Denmark) welcomed the vision and guiding principles of the draft strategy. There was an increasing need to develop evidence and research capacity. WHO was not primarily a research institution, but a normative organization providing guidelines and recommendations for health authorities around the world. It needed to keep abreast of developments in knowledge and research.

WHO must interact with the global research community and the private sector. Global health research was fragmented, which made it difficult for countries to create comprehensive approaches to research and ensure sufficient capacity. The Global Ministerial Forum in Bamako had called for better alignment and harmonization of research funding. Research priorities should be informed by current trends in the global burden of disease and by the determinants of health. Priority should be given to the implementation of research that enhanced health and health equity.

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

The meeting rose at 17:30.

EIGHTH MEETING

Friday, 23 January 2009, at 09:10

Chairman: Mr N.S. DE SILVA (Sri Lanka)

1. ORGANIZATION OF WORK

The CHAIRMAN said that he had received a request to take up item 4.11 on counterfeit medical products immediately after consideration of item 4.9.

In reply to Mr HOHMAN (alternate to Dr Wright, United States of America), who said that he had no objection in principle but wanted to know the reasons for the suggested change, the CHAIRMAN explained that, if the item were taken up at an early stage, it might be possible to arrange informal consultations in order to avoid protracted discussion.

Mr FISHER (Denmark) suggested that, as there existed substantial differences of opinion on the subject, an informal working group should be set up before the Board embarked on a substantive discussion.

Mr HOHMAN (alternate to Dr Wright, United States of America) said that if the item were opened in order to allow an informal group to be set up, without any formal discussion, he would have no objection.

Dr REN Minghui (China) said that there was no reason to advance consideration of item 4.11; it was a complex topic on which members of the Board held differing views. He could agree to the suggestion to set up an informal group if a volunteer could be found to lead its deliberations.

The DIRECTOR-GENERAL said that the proposal to advance consideration of item 4.11 had aimed to facilitate the establishment of an informal group in order to narrow differences of opinion. She sought a volunteer to lead the group's discussions.

Dr BUSS (Brazil), supported by Dr LUKITO (alternate to Dr Supari, Indonesia) and Dr BIN SHAKAR (United Arab Emirates), favoured advancing consideration of item 4.11 for preliminary discussion before the setting up of an informal working group, if necessary.

The CHAIRMAN, noting the absence of consensus, said that the agenda item would be taken up in the order originally planned.

It was so agreed.

2. TECHNICAL AND HEALTH MATTERS: Item 4 of the Agenda (continued)**WHO's role and responsibilities in health research:** Item 4.9 of the Agenda (Documents EB124/12, EB124/12 Add.1 and EB124/12 Add. 2) (continued from the seventh meeting)

Dr BUSS (Brazil), welcoming the quality of the reports, expressed support for the draft strategy on research for health. Drawing attention to the relationship between health research and the theme of innovation and intellectual property, he said that the draft strategy would avoid duplication of efforts if it were linked with resolution WHA61.21 on the global strategy on public health, innovation and intellectual property. He also drew attention to key points in the Bamako Call to Action on research for health which, in line with the Paris Declaration on Aid Effectiveness, and urged efforts to respond to that call.

Dr GOPEE (Mauritius) said that the recommendation in the Bamako Call to Action that national governments should allocate at least 2% of budgets of ministries of health to research was a major constraint to low- and middle-income countries, including Mauritius. The current financial crisis might result in reduced allocations. He appealed to the Director-General to defend the allocation at the Sixty-second World Health Assembly and in other forums.

Mr HOHMAN (alternate to Dr Wright, United States of America), clarifying the intervention he had made the previous day on the extent to which WHO should engage in research, acknowledged that WHO had a strong role in research through IARC, the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases and the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction. There existed many legitimate ways in which the Organization conducted research, but the emphasis should be placed on translating research findings into information in order to help Member States to reach informed policy decisions.

Dr LUKITO (alternate to Dr Supari, Indonesia) welcomed the report and the draft strategy (document EB124/12). In paragraph 12 of the report, he proposed to qualify the definition of research by adding the words "through an evidence-based approach" and "and responsible" so that the paragraph would read: "research is defined as the development of knowledge through an evidence-based approach with the aim of understanding health challenges and mounting an improved and responsible response to them". The additional wording would reflect the multifaceted nature of research, which comprised ethics, management, the interpretation of research outcomes and their translation into health policies. After hearing the observations made by the member for the United States, he asked to what extent and how WHO was already engaged in the translation of research into policy development. It was important for the Board to be kept informed about such activities.

Turning to the draft resolution contained in document EB124/12, he proposed adding two new preambular paragraphs after the paragraph beginning "Realizing ...":

Affirming the roles and responsibilities of WHO, as a leading global health organization, in health research;

Recognizing the need to strengthen the capacity of public sectors in health research;

He further proposed the addition, in subparagraph 3(4), of the words "and other determinants of health" after the words "infrastructure development".

Finally, he sought clarification on the sums mentioned in connection with funding in paragraphs 78 and 79 of the draft strategy on research contained in the annex to document EB124/12.

Dr GIMENÉZ CABALLERO (Paraguay), welcoming the report, expressed support for the draft strategy and the call to observe the Bamako Declaration. Both action and research were required in the field of public health and WHO's role in research, as outlined in the documents, was justified. It was WHO's function to help to develop health policies based on the conclusions of public health research.

In the context of the new strategy, research on primary health care and on the social determinants of health should be emphasized. Publications had tended to focus on biomedical subjects whereas the countries in the Region of the Americas also needed relevant and reliable research on health management and systems, on which they could base decisions; WHO should strengthen research in those areas. Research should be promoted through regional networks, by setting up databases and regional research teams: problems of methodology and financing could then be shared and result in the elaboration of new policies.

Dr ASLANYAN (Canada)¹ welcomed the draft WHO strategy on research for health, and expressed support for the draft resolution. He endorsed the Bamako Call to Action. The draft strategy would influence how research was performed in Member States, and the Secretariat would need to respond to countries' requests for support in strengthening national capacity for conducting, managing and using health research.

In order to implement the strategy, WHO should strengthen its internal research structures and special programmes and initiatives, and make linkages to the Global Plan of Action approved by the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property. He emphasized partnerships, including public-private research partnerships and those with specialized organizations such as the Global Forum on Health Research and the Council on Health Research for Development.

Dr CHAUHAN (India),¹ expressing appreciation for WHO's efforts to support, promote and conduct health research, said that the five interrelated goals identified in the draft strategy would be useful in building capacity. WHO's role in health research should be strengthened in the face of widening disparities between nations on access to technology and research in the field of medicine and health care. In addition to WHO's research work, much research, both classic and normative, was done by other agencies, either independently or in association with WHO, and he asked whether the draft strategy would influence or guide the policies of such bodies.

He drew attention to the need for coordination with health authorities in pursuing national health priorities and for capacity-building to carry out operational research in countries where no such structures existed. A large number of innovations failed to reach the point of evaluation for introduction into health systems, and WHO should develop a mechanism to assist in that regard. More public-private partnerships should be established and information on successful models should be shared, for adoption elsewhere. Health economics, policy and social sciences should be integrated in a more comprehensive manner.

Dr MUÑOZ (Chile),¹ welcoming WHO's coordinating efforts to direct research towards global health priorities, emphasized research to develop medicines and interventions to treat the diseases that disproportionately affected developing countries.

Findings on interventions that responded to country priorities, particularly the health-related Millennium Development Goals, could be disseminated, and he welcomed the draft strategy's focus on priority health needs. Strengthening national capacities to analyse the ethical aspects of research with human beings should also be a priority.

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

Mr RAJALA (European Commission) said that WHO should demonstrate the application of the draft strategy throughout its operational mandate, and link it to the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property and other relevant initiatives.

Collaboration with WHO was important to the European Commission, helping it to determine its strategic areas for research and to develop its strategic vision. Current European Union research focused on public health, and on health systems at the global level within the context of the Millennium Development Goals; WHO's participation in project consortiums was also welcomed.

With European Union funding, WHO would support research and development on tropical and neglected diseases related to poverty, and research aimed to improve: access to medicines in developing countries; technology transfer of pharmaceuticals; and local production. Those activities would facilitate consultation and set priorities for other research and demonstrate how the two institutions could best collaborate on issues of mutual interest.

Dr BUSS (Brazil), in response to the comments made by the member for Indonesia, drew attention to the Evidence-Informed Policy Network, a WHO initiative that encouraged policy-makers in low- and middle-income countries to use evidence generated by research.

Dr ALVIÁREZ (Bolivarian Republic of Venezuela)¹ welcomed the draft strategy and emphasized the economic and social importance of science and technology in improving conditions in developing countries. The draft strategy should enhance the Secretariat's capacity to encourage Member States and other bodies to work in a coordinated way in order both to produce data and research tools, and to guarantee technology and knowledge transfers that would improve peoples' health and quality of life. The principle of equity should guide ethically conducted research that benefited poor and dependent populations.

The proposed goal on standards should include establishing agreements on good practices, scientific benchmarks, bioethical guidelines and accountability mechanisms; and should take into account social, economic and technological circumstances, so as to respond to national realities. Concerning the goal on translation, the application of knowledge and new technologies was a lengthy social process and must be introduced in a manner that ensured sustainability and cultural acceptance.

With regard to the research community, joint networks were vital in decision-making and should be included in the process, not merely consulted. Research stimulated the development of vaccines, medicines and diagnostics where market forces alone were insufficient. The preparation of the draft strategy should reorient WHO's actions and promote social development in all Member States.

Mr MATLIN (Global Forum for Health Research), speaking at the invitation of the CHAIRMAN, welcomed the draft strategy. His organization had been pleased to participate in the consultation. He expressed appreciation for: the use of the phrase "research for health" in the draft strategy rather than "health research", which acknowledged that health determinants were not only biological; the strategy's emphasis on WHO's normative and stewardship role; and the need for WHO to be a model of good practice in the acquisition and use of research evidence.

Implementing the draft strategy would require partnerships that crossed disciplinary and sectoral boundaries, and innovative approaches to structures and financing. The complex composition of entities concerned with research for health, which led to high transaction costs and inefficiencies, needed a streamlined and coordinated approach, and he looked forward to working with WHO and others to overcome the challenges involved.

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

Dr LHOTSKA (Consumers International), speaking at the invitation of the CHAIRMAN, welcomed the draft strategy, but pointed out that safeguarding health policy-setting from undue commercial influence had not been included in the guiding principles. The research base used in formulating public health policy should always be evaluated by an independent body and should contain the largest possible proportion of independently-funded research, notably with regard to policies affecting the health of infants, young children and most vulnerable adults. In order to ensure that public health policies were made entirely in the public interest, WHO should include the principle of independence in the draft strategy. It should strengthen its policy on interactions with the private sector to include mechanisms for minimizing conflicts of interest.

Dr EVANS (Assistant Director-General), responding to comments made, said that, with respect to the importance of translating research findings, most of WHO's research activities centered around secondary systematic synthesis of information to inform the development of guidelines and policy. The prominence of the organizational goal within the draft strategy would encourage WHO to strengthen its research culture in line with good practice. The Evidence-informed Policy Network, to which the member for Brazil had drawn attention, was part of the Secretariat's efforts to work with countries to ensure that research findings and evidence were translated into the policy process.

Turning to paragraph 63 of the annex to the report, he acknowledged that the concepts of copyright and intellectual property did not necessarily constitute barriers to the access of research results, although complementary policies were often required in order to enhance access. However, the text of the paragraph could be revised for the purposes of clarity. The text of the report could also be amended to take account of the comments made by the member for Bangladesh with regard to multi-centre studies.

He acknowledged the calls for WHO's leadership with regard to the Paris Declaration on Aid Effectiveness and the current organization of research globally, in respect of which the Organization would take action in conjunction with its partners, and for clear linkages with the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property.

In response to the member for Indonesia, he clarified that the figures given in paragraphs 78 and 79 of the annex to the report were for expenditure not budget figures, as WHO had no single budget line for research. The figures were based on analysis of the biennium 2006–2007. The introduction of the Global Management System would enable more continuous and up-to-date analysis of WHO's research expenditure.

All five goals, including the organizational goal, had implications for the functioning of the Secretariat, and the draft strategy therefore represented a significant agenda for improvement.

He acknowledged the comments made by the representative of the European Commission and the fruitful collaboration between the two institutions.

Professor WHITWORTH (Chairman of the WHO Advisory Committee on Health Research, ACHR) said that the Committee had worked closely with the External Reference Group, WHO headquarters and the regional offices in the development of the WHO strategy on research for health, and appreciated the wide consultation process. At its previous meeting in October 2008, ACHR had fully endorsed the draft strategy and had considered that it would be fundamental to WHO's remit, its role in the provision of best evidence and its capacity to support Member States in improving health for all and achieving the health-related Millennium Development Goals.

The strategy provided an opportunity: to consolidate and harmonize research and evidence across the whole Organization, as requested by the member for China; to strengthen technical support to countries; and to re-establish WHO leadership in global health research, as emphasized by the member for Bangladesh. It synthesized the advice and direction given, and priorities set, by ACHR in recent years and incorporated the Committee's key initiatives, including: reviews of ethics and guidelines; good scientific conduct; the clinical trials registry; and knowledge translation activities such as the Evidence-informed Policy Network, in line with the comments made by the members for

Indonesia, Paraguay and the United States. In response to regional and country suggestions, the strategy was flexible and adaptable to the needs and priorities of the diverse WHO regions, as requested by a number of Board members.

ACHR would celebrate its fiftieth anniversary in 2009 and remained committed to continuing its support for WHO either in its present capacity or with a revised mandate. The key to successful implementation of the strategy was efficient structure for its governance and an inclusive participatory approach that would link WHO's diverse but related research activities, including: the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property, as requested by the member for Brazil; the Task Force on Health Systems Research; and the Bamako Call to Action, as highlighted by the member for Mali. She urged Member States and other partners to endorse the draft WHO strategy on research for health and to support its implementation.

The DIRECTOR-GENERAL said that she would convene a meeting, if possible before the Sixty-second World Health Assembly in May 2009, in order to consider how the complex global organization of research for health might be streamlined within and outside WHO. She reiterated the assurance she had given many times in the past that, while she would pursue an inclusive approach, working with Member States, industry and other partners to seek effective solutions, she would fiercely guard WHO's independence to ensure that its integrity could not be compromised.

The CHAIRMAN invited further comments on the draft resolution set out in paragraph 33 of document EB124/12 and the financial and administrative implications of the draft resolution listed in document EB124/12 Add.1.

Mr HOHMAN (alternate to Dr Wright, United States of America) said that he had a number of amendments to propose and believed that that was also the case for other Board members.

The CHAIRMAN invited members to submit their proposals in writing, and the Secretariat would amend the draft resolution accordingly and circulate a revised text for consideration at a later meeting.

It was so agreed.

(For continuation of the discussion, see summary record of the tenth meeting.)

Commission on Social Determinants of Health: Item 4.6 of the Agenda (Document EB124/9) (continued from the sixth meeting, section 2)

The CHAIRMAN invited comments on the revised draft resolution on reducing health inequities through action on the social determinants of health, proposed by Brazil, Canada, Denmark, Hungary, Latvia, Norway, Paraguay, Slovenia, Sri Lanka and the United Kingdom of Great Britain and Northern Ireland, which read:

The Executive Board,
Having considered the Secretariat's report on the final report of the WHO Commission on Social Determinants of Health,¹

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

The Sixty-second World Health Assembly,
Having considered the Secretariat's report on the final report of the WHO Commission on Social Determinants of Health;

Noting the 60th anniversary of the establishment of WHO in 1948 and its Constitution which affirms that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

Noting the 30th anniversary of the International Conference on Primary Health Care at Alma-Ata in 1978, which reaffirmed the essential value of equity in health and launched the global strategy of primary health care to achieve health for all;

Recalling the principles of "Health for All", notably the need for intersectoral action (resolution WHA30.43);

Confirming the importance of addressing the wider determinants of health and considering the actions and recommendations set out in the series of international health promotion conferences, from the Ottawa Charter on Health Promotion to the Bangkok Charter for Health Promotion in a Globalized World making the promotion of health central to the global development agenda as a core responsibility of all governments (resolution WHA60.24);

Noting the global consensus of the **United Nations** Millennium Declaration to achieve the Millennium Development Goals by 2015 and the concern at the lack of sufficient progress towards many of these goals in some regions at the half-way point;

Noting the publication of *The world health report 2008* on primary health care and its focus on ways to improve health equity by reforming health and other societal systems;

Mindful about the fact that responses to environmental degradation and climate change include health equity issues and noting that the impact of climate change is expected to negatively affect the health of vulnerable and disadvantaged populations (resolution WHA61.19);

Mindful about the facts concerning widening gaps in life expectancy worldwide;

Attaching utmost importance to the elimination of gender-related health **inequities** ~~inequalities~~;

Recognizing that millions of children globally are not reaching their full potential and that investing in comprehensive supports for early child development that are accessible to all children is a fundamental step in achieving health equity across the lifespan;

Acknowledging that improvement of unfavourable social conditions is primarily a social policy issue;

Noting the need to improve coordination among global, national and subnational efforts in tackling social determinants of health through work across sectors, while simultaneously promoting social and economic development, with the understanding that

¹ Document EB124/9.

such action requires the collaboration of many partners, including civil society and private sector,

1. EXPRESSES its appreciation for the work done by the Commission on Social Determinants of Health;
2. CALLS UPON the international community, ~~such as~~ **including** United Nations agencies, intergovernmental bodies, **civil society and the private sector**:
 - (a) to take note of the final report of the Commission on Social Determinants of Health and its recommendations;
 - (b) to take action in collaboration with ~~the WHO's Secretariat and~~ Member States **and the WHO Secretariat** on assessing the impacts of policies and programmes on health ~~inequalities~~ **inequities** and on addressing the social determinants of health;
 - (c) to work closely ~~together with the WHO's Secretariat and~~ Member States **and the WHO Secretariat** on measures **to enhance health equity in all policies in order** to improve health for the entire population and reduce ~~inequalities through addressing social factors that influence health~~ **inequities**;
3. URGES Member States:
 - (a) to develop and implement goals and strategies to improve public health with a focus on health ~~inequalities~~ **inequities**;
 - ~~(b) to strengthen the role of public health in policy development to reduce health inequalities, including ensuring access to all aspects of public health: health promotion, disease prevention and health care;~~
 - ~~(c) to strengthen efforts to achieve equitable access to public health interventions, including health promotion, disease prevention and health care for the entire population;~~
 - (b) to take into account health equity in all national policies that address social determinants of health and to ensure equitable access to health promotion, disease prevention and health care;**
 - ~~(d) (c) to ensure dialogue and cooperation among relevant sectors and be a driving force for this cooperation with the aim of integrating a consideration of health into relevant public policies;~~
 - ~~(e) to educate health providers on how to take social factors into delivering appropriate care to their patients;~~
 - (d) to increase awareness among public and private health providers on how to take account of social determinants when delivering care to their patients;**
 - ~~(f) (e) to contribute to the improvement of the daily living conditions of major importance for~~ **contributing to** health and social well-being across the lifespan by involving all relevant partners, including civil society **and the private sector**;
 - ~~(g) (f) to contribute to the empowerment of individuals and groups, especially those who are marginalized, and take steps to improve the societal conditions that affect their health;~~
 - ~~(h) (g) to develop~~ **generate new**, or make use of existing, methods and evidence, tailored to national contexts in order to address the social determinants and social gradients of health and health ~~inequalities~~ **inequities**;
 - ~~(i) (h) to develop~~, make use of, and if necessary, improve health information systems in order to monitor and measure the health of national populations, with data disaggregated according to the major social ~~factors~~ **determinants** in each

context (such as **age**, gender, ethnicity, education, employment and socioeconomic status) so that health ~~inequalities~~**inequities** can be detected and the impact of policies monitored **in order to devise appropriate policy interventions to minimize health inequities**;

4. REQUESTS the Director-General:
 - (a) to work closely with partner agencies in the multilateral system on appropriate measures that address the social determinants of health **and promote policy coherence to minimize health inequities**; and to advocate for this topic to be high on the global development and research agendas;
 - (b) to strengthen the capacity within the Organization with the purpose to give sufficient priority to relevant tasks related to addressing the social determinants of health in order to reduce health ~~inequalities~~**inequities**;
 - (c) to implement measures, including **objective** indicators for the monitoring of social determinants of health, across relevant areas of work and promote addressing social determinants of health to reduce health ~~inequalities~~**inequities** as an objective of all areas of the Organization's work, especially priority public health programmes;
 - (d) to ensure that ongoing work on the revitalization of primary health care addressing the social determinants of health is aligned with this, as recommended by *The world health report 2008*;
 - (e) to support Member States in implementing a health-in-all-policies approach to tackling ~~inequalities~~**inequities** in health;
 - (f) to support Member States, **upon at their** request, in implementing measures with the aim of integrating a focus on social determinants of health across relevant sectors and to design, or if necessary redesign, their health sectors to address this appropriately;
 - (g) to support Member States, **upon at their** request, in strengthening existing efforts on measurement and evaluation of the social determinants of health and the causes of health ~~inequalities~~**inequities** and to develop and monitor targets on health equity;
 - (h) to support research on effective policies and interventions to improve health by addressing the social determinants of health that also serve to strengthen research capacities and collaborations;
 - (i) to support the regional directors in developing a regional focus on issues related to the social determinants of health and in engaging a broader range of countries in this issue, in accordance with the conditions and challenges of each region;
 - (j) to ~~prepare~~ **convene** a global event, with the assistance of Member States, before the Sixty-fifth World Health Assembly in order to highlight the developments, progress and renewed plans for addressing the alarming trends of health ~~inequalities~~**inequities** and to increase global awareness on social determinants of health, including health equity;
 - (k) to report on progress in implementing this resolution to the Sixty-fifth World Health Assembly **through the Executive Board**.

The financial and administrative implications of the draft resolution were:

1. Resolution Reducing health inequalities through action on the social determinants of health	
2. Linkage to programme budget	
Strategic objective:	Organization-wide expected results:
7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches.	7.1 Significance of social and economic determinants of health recognized throughout the Organization and incorporated into normative work and technical collaboration with Member States and other partners. 7.2 Initiative taken by WHO in providing opportunities and means for intersectoral collaboration at national and international levels in order to address social and economic determinants of health and to encourage poverty reduction and sustainable development. 7.3 Social and economic data relevant to health collected, collated and analysed on a disaggregated basis (by sex, age, ethnicity, income, and health conditions, such as disease or disability).
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
Implementation of the resolution will greatly assist the ability of the Organization to integrate work on the social determinants of health into its programmes and to support Member States in developing national capacity to measure health inequities and implement intersectoral policies on the social determinants of health.	
3. Financial implications	
(a) Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)	
US\$ 29 850 000 over the years 2009, 2010 and 2011.	
(b) Estimated cost for the biennium 2008–2009 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)	
US\$ 9 760 000 covering work at headquarters level to extend existing activities, and work in regional offices to build capacity and facilitate regional efforts, in line with the resolution.	
(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009?	
All activities for the biennium 2008–2009 can be subsumed under the Programme budget 2008–2009.	
(d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)	
Not applicable.	
4. Administrative implications	
(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)	
All levels of the Organization.	

(b) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant)

3.5 staff members (full-time equivalent) across the six regional offices in order to build regional capacity to work with countries, in line with the resolution.

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

Three years (2009–2011), with a report on progress to be submitted to the Sixty-fifth World Health Assembly in 2012 in line with the resolution.

Mrs GOY (Luxembourg),¹ expressing support for the initiative to reduce health inequities through action on the social determinants of health, said that the Board's discussion of item 4.7, Monitoring of the achievement of the Millennium Development Goals, had illustrated the importance of such action both in the realization of the Goals by 2015 and in activities to follow up resolution WHA61.18. She proposed the insertion of a reference to that resolution; the Board might therefore consider inserting a new seventh preambular paragraph to read: "Welcoming in this regard resolution WHA61.18, which initiated annual monitoring by the World Health Assembly of achievement of the health-related Millennium Development Goals". She confirmed the interest that had been expressed in swift action to implement resolution WHA61.18. She emphasized the interdependence of the two subjects and the interests of greater consistency.

Dr VOLJČ (Slovenia) seconded the proposed amendment.

Professor ALI (alternate to Professor Haque, Bangladesh) also supported the proposal.

The resolution, as amended, was adopted.²

International recruitment of health personnel: draft global code of practice: Item 4.10 of the Agenda (Document EB124/13, EB124/13 Add.1 and EB124/INF.DOC./2)

The CHAIRMAN drew attention to the draft resolution set out in document EB124/13 and to its financial and administrative implications, which were listed in document EB124/13 Add.1. The draft code of practice, developed in pursuance of resolution WHA57.19, was annexed to the draft resolution.

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union and its 27 Member States, welcomed the WHO code of practice on the international recruitment of personnel. The international mobility of health-care workers was leading to loss of human resources in lower-income countries yet failing to meet workforce needs in higher-income countries. The European Union was seeking an equitable balance of interests among health personnel and source and destination countries. WHO's Member States had a responsibility to develop workforce strategies, although collective action would be needed to minimize the adverse effects on health systems in countries of origin. The proposed draft should be voluntary, since freedom of movement must be respected. One aim should be to balance the rights, expectations and obligations of health workers, without impinging on their right to migrate to countries that wished to admit and employ them. He emphasized the principles of transparency, ethics,

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

² Resolution EB124.R6.

fairness and mutuality of benefits. Monitoring, data gathering and information exchange were important elements of the draft code.

The European Union believed that significant results could be achieved if proper action was taken at Union level and would actively pursue the European Programme for Action to Tackle the Critical Shortage of Health Workers in Developing Countries (2007–2013). The draft code of practice before the Board could provide a basis for further regional and bilateral agreements.

Dr JAYANTHA (alternate to Mr de Silva, Sri Lanka), welcoming the documents provided, expressed appreciation for the support provided by the Regional Office for South-East Asia for the training of paramedical staff from Bhutan and Maldives. Sri Lanka encouraged some health personnel to gain experience and professional development abroad but had suffered from the migration of medical professionals. Sri Lanka provided free education to health personnel, including doctors and consultants to postgraduate level and supported specialist training in developed countries. However, some trainees failed to return home despite a legal obligation to do so, meaning that the Government's investment was benefiting only the recipient countries. Shortage of trained medical professionals could jeopardize Sri Lanka's attainment of the health-related Millennium Development Goals.

Article 5 of the draft code of practice on mutuality of benefits must be enforceable; it should be strengthened in order to ensure greater compliance, perhaps providing for compensatory mechanisms that would enable developing countries to invest in training of new students.

Dr OULD JIDDOU (Mauritania), speaking on behalf of the 46 Member States of the African Region, said that increased migration of health professionals from developing countries had weakened fragile health systems and was jeopardizing the attainment of the health-related Millennium Development Goals. Resolutions WHA57.19 and WHA58.17 had requested the Director-General, *inter alia*, to formulate mitigation strategies; policies to improve retention; and to develop, through wide consultation, a code of practice for international recruitment. The only existing code in that area to date was the 2003 Commonwealth Code of Practice for the International Recruitment of Health Workers. The draft code before the Board would have universal coverage.

The African Health Workforce Observatory aimed to support the dissemination of information to guide decision-making and WHO had supported the formulation of guidelines on retention of health personnel. Case studies to document the situation in remote areas had been conducted in Mali in April 2008 and Senegal in July 2009. In 2008 the Regional Office for Africa had participated in the technical working group led by WHO established to develop the draft code.

The First Global Forum on Human Resources for Health had been organized jointly by WHO and the Global Health Workforce Alliance. Member States had been invited to comment electronically on proposed measures of the draft code, which set out principles and guidelines for international recruitment. Challenges included the lack of financial resources for training and retention activities and implementation of the proposed code of practice at national and regional levels.

Dr AHMADZAI (Afghanistan), speaking on behalf of the Member States in the Eastern Mediterranean Region, supported the draft global code of practice and the aims of equitable distribution of health personnel. Low-income countries were suffering from the effects of health-worker migration and many countries lacked formal systems of migration management or retention policies. Furthermore, the absence of data hindered evaluation of the ethical, legal and financial implications of the problem.

He highlighted the need to generate evidence on migration and its national, regional and global policy implications. Further analysis should include pull and push factors, incentive schemes and career opportunities centered on performance. Innovative solutions to health-worker migration, including multilateral agreements, could be facilitated through collaboration between the Secretariat, Member States and partners.

Professor ALI (alternate to Professor Haque, Bangladesh) said that, if handled correctly, health-worker migration could be mutually beneficial. However, the global financial crisis was, in some cases, resulting in migrant health personnel losing their jobs and returning to their country of origin, thereby contributing to employment problems in the source country.

Although health workers in many developing countries received similar training to that provided in more affluent countries, they could be discouraged from working in developed countries if their training emphasized local needs. Economic factors were at the heart of migration of health personnel. Financing was therefore needed in developing countries in order to provide employment opportunities and training facilities, both of which would help to control the migration of health workers.

Dr ABABII (Republic of Moldova) said that the migration of health personnel to countries offering better economic prospects was posing a serious threat to his country's health system. Rural areas were particularly affected. Data on the numbers involved were unavailable, such was the speed at which health workers were migrating. He questioned the benefit to the State of providing training to medical personnel if their knowledge and experience were being used in other countries.

His Government had legislated to give health personnel who had sat competitive examinations better career prospects and benefits if they did not migrate. However, those measures had proved insufficient. A global policy was needed that could both tackle the macroeconomic problems which lay at the root of health-worker migration and mitigate the negative effects of international recruitment. He stressed the need for: targeted technical assistance; further medical equipment and technology; improved access to trained personnel; assistance in the continued training of health personnel; and help on issues such as the granting of licences. The remit of WHO and its regional offices should be extended to cover human resource management and training of health personnel.

He supported the draft global code of practice, but encouraged strengthened recommendations on cooperation, with compensation for countries of origin.

Dr ZARAMBA (Uganda) said that the negative repercussions of health-worker migration had been particularly hard on developing countries. He noted with satisfaction that the draft global code of practice stressed the involvement of all countries in dealing with that crisis.

The draft code should emphasize the individual's right to free movement but within the context of the right to health of populations in the source country, whose taxes were used in the training of health personnel, but who did not receive the corresponding benefit. The draft code should also underline the need for recipient countries to be sensitive to the concerns of source countries.

He thanked the Secretariat for gathering electronically the data contained in the draft code, but questioned its comprehensiveness. In that regard, he suggested the establishment of a stakeholders' working group and a drafting group in which the views of the Secretariat, source countries and recipient countries could be represented, in order to prepare a revised draft of the global code of practice for submission to the Sixty-second World Health Assembly.

Mr CAMPOS (alternate to Dr Buss, Brazil) said that the Brazilian ministries of health, education and labour had been tackling the issue of health workforce development in collaboration with WHO, its Regional Office for the Americas and the Global Health Workforce Alliance. In that regard, the two principal challenges involved creating appropriate working conditions for the three million health workers in Brazil, and linking health services with educational institutions. The impact of health-worker migration on the poorest countries was potentially devastating. He agreed with the comments made by the members for Sri Lanka and Uganda that it was ethically unacceptable for the taxes of very poor populations to benefit the richest countries.

He supported the establishment of a code of practice that would redress health inequity, and guide countries and institutions. The introduction of compensatory mechanisms, although difficult to implement, could alleviate health inequities among countries.

He proposed amending the title of Article 7 of the draft code to “Strengthening information and research” and requested support for the creation of health observatories on national and regional levels. Extensive data were essential to a sustainable decision-making process.

Dr REN Minghui (China) supported the creation of a draft code of practice to standardize the international recruitment of health personnel. However, greater emphasis should be given to the responsibilities and obligations of destination countries. Global cooperation would be necessary. Destination countries should offer additional assistance to source countries through specialized training, technical support, and transfer of know-how; and by implementing measures to facilitate the long-term or periodic repatriation of migrant health workers.

Dr MOHAMED (Oman) said that further funding was needed globally to train health workers. Oman was already contributing substantially funds to the training of health workers. Migrant health workers were recruited to work in his country’s modern hospitals and, following rotation periods of seven years, returned to their country of origin with valuable training and new skills which could be used to strengthen their own health systems.

He agreed with previous speakers regarding compensation for developing countries which had lost human resources. He supported the introduction of bilateral and regional agreements for the international recruitment of health personnel, developed in partnership with WHO.

Mr MIGUIL (Djibouti) said that the draft global code of practice should be strengthened through consultation. Wealthy countries should generate enough human resources to ensure that their health systems functioned well; refrain from the active recruitment of health professionals trained in developing countries; and assist the poorest countries in creating an environment conducive to the retention of health personnel. However, countries of origin should take responsibility for improving their health systems, and thus retain health professionals for longer.

In Djibouti, salaries for doctors and paramedicals had doubled since 2006, and a specialist physician currently received twice the salary of a minister. Although a faculty of medicine had been established in Djibouti, many students were still trained abroad. A recruitment policy encouraged medical students to return to the country after completion of their fifth year of study, and many students were returning. However, such actions had dramatically increased health spending over five years and that could not continue indefinitely; countries like his could not compete with the salaries offered by developed countries.

The draft code should give greater attention to the management of international migration, which must not be in one direction only. Real solutions must be found to reduce the detrimental effects on the countries of origin. The time had come for concrete measures rather than statements of good intent. If the Millennium Development Goals were to be attained by 2015, bilateral agreements would have to be developed under the auspices of WHO. Countries of origin should be compensated for the training of health personnel. The draft code should also focus on the means of strengthening training institutions in the countries of origin.

Ms SCHLACHTER (alternate to Dr Wright, United States of America) said that the draft global code of practice offered many strengthened policy responses to the migration of health personnel. Shortages of health personnel were a serious concern, particularly in the developing world. Factors such as poor economic conditions in the home country, low job status, lack of professional recognition and opportunities, and poor working conditions were the root causes of migration. Those needed to be addressed, and the United States was ready to assist. The President’s Emergency Plan for AIDS Relief had assisted 2.6 million training opportunities for health-care personnel, and would train 140 000 health-care providers over the next five years.

The United States would be unable to support the adoption of the draft global code of practice unless it was clear that the code was voluntary, and she suggested that the title should be amended

accordingly. Member States should use the draft code as guidelines. As it currently stood, the text could impose behaviours, legal and administrative frameworks, and research and reporting processes upon Member States and stakeholders. Those were intrusive measures and went far beyond existing legislation and policies in many countries. It also contained very ambitious goals regarding the coordination of national policies and international recruitment of health workers. Those were not necessarily realistic, particularly for countries, such as hers, that did not have nationalized health-care systems. The concept of mutuality of benefits set out in Article 5 could be interpreted as creating a sense of obligation on destination countries to link the migration of health workers to development aid for specific source countries. The concept of linked compensation was unacceptable and infringed the rights of sovereign nations to decide, through bilateral consultations, when and where to provide assistance to individual developing countries. The draft code should also reflect the roles and responsibilities of countries of origin and of migrants themselves. The need to respect the human rights of migrant workers should also be recognized. Her Government was concerned that the draft encouraged recruiters to exclude entire populations of health-care workers from the international recruitment process because they worked in a country with a vulnerable health-care system. The burden for the viability of a country's health-care programme should be placed on the government, not on individual health-care workers.

Additional consultation between Member States was critical, and she suggested that a working group should be established to give Member States the opportunity to discuss and revise the text of the draft code before the Sixty-second World Health Assembly.

Dr GIMENÉZ CABALLERO (Paraguay), having expressed support for the draft resolution, said that, although most health personnel migrated for economic reasons, other factors, including poor working conditions, were also relevant. He emphasized the strengthening of health systems. Many nurses in Paraguay migrated to Europe, and doctors to the United States and Europe. The shortage of health-care workers in his country would become more acute because of the inequitable distribution of human resources. His Government's strategy would involve the education sector, universities and also trade unions.

The draft resolution should encourage recipient countries and countries of origin to invest in their institutions and gradually reduce the shortage of human resources.

Article 5 of the draft code should be strengthened by covering social security benefits for migrant health personnel.

Dr KÖKÉNY (Hungary) emphasized the need for a clear code of practice regarding the international recruitment of health personnel. The issue was sensitive and there should be further consultation with Member States and stakeholders before a draft code was submitted to the Sixty-second World Health Assembly. The text should be made more explicit, shorter and simpler, balancing various interests while at the same time protecting the health systems of poor countries. The principles of self-sufficiency and moderation in cross-border recruitment should be explored. At all events, unethical recruitment practices should be avoided and the impact of migration on health systems better presented. In the current financial crisis, the Director-General should call on Member States to assist developing countries and countries with economies in transition in providing all health professionals with incentives to continue their careers in their home countries.

Dr JAKSONS (Latvia) said that guidance concerning multilateral arrangements and mutual benefits required further elaboration, and greater clarity in the text was needed. Given the important and diverse views expressed on some aspects of the code, he suggested that a one-day consultation should be organized before the Sixty-second World Health Assembly.

Dr KAMOTO (Malawi) endorsed the views expressed by the members for the Republic of Moldova, Sri Lanka and other Member States on mutuality of benefits (Article 5) and called for the

text to be reviewed with the aim of providing further support to developing countries. At present, some 60% of the doctors trained in Malawi remained outside the country, owing to incentives offered by developed countries. She urged the developed countries to help countries like her own to devise better arrangements, since poor countries also required specialized personnel. She observed that the United Kingdom's Department for International Development and the Global Fund to Fight AIDS, Tuberculosis and Malaria were currently helping Malawi by giving incentives, including a salary top-up, to all health personnel working in the country. She suggested that developed countries should follow the example set by Australia, which did not permit doctors from Africa to remain in the country upon completion of their training.

Dr ADITAMA (alternate to Dr Supari, Indonesia) said that the free flow of health personnel was contributing to public health problems in the developing world. Recipient countries should have a clear obligation to countries of origin that suffered from the migration of health personnel.

Dr DAHL-REGIS (Bahamas) said that, although the draft code of practice proposed built on the Commonwealth Code of Practice for the International Recruitment of Health Workers, it did not go far enough. Low-income countries and small-island States were disproportionately affected, and therefore the focus and language of the text should be strengthened. She supported the recommendation for further consideration to be given to the code with a balanced representation of all stakeholders.

Ms ROCHE (New Zealand) expressed support for the idea of further consultations. However, participants from Member States who would be unable to travel to Geneva for a one-day meeting should not to be disadvantaged.

Ms TOLSTOÏ (France)¹ expressed appreciation for the work undertaken to produce the draft code of practice and the related electronic consultation. The migration of qualified health personnel from countries with fragile health systems weakened those systems even further. Such countries were already coping with major burdens of morbidity with limited human resources. For example, Africa, which bore 25% of the global disease burden, had only 3% of the world's health personnel. It was thus urgent to limit those terrible effects on health systems, while also respecting the right of health personnel to move in search of greater opportunities. In that context, the code should speak more explicitly about those negative consequences.

Further in-depth analysis was necessary to find solutions, of which good recruitment practices were only one aspect. Incentives for local personnel to remain within their own country must be a priority. Both developed and developing countries should undertake personnel planning so as to meet their own needs in terms of health personnel. For the developed countries, that planning must lead to a reduction in the recourse to migrant health personnel.

Ms DLADLA (South Africa)¹ suggested that countries that had cooperated in workforce matters should use the draft code to build on existing relationships, which should also be consulted at regional level, in order to guide their collaboration. The draft code should be considered in conjunction with other cooperation instruments dealing with trade and investment.

One serious challenge was the lack of credible data, even at country level, on the health workforce. Investments should be made to mitigate that shortcoming. Since the draft code was to be voluntary, a monitoring system should be developed to ensure that it was adhered to.

South Africa called on international donor agencies and financial institutions to increase their technical and financial support to assist in the implementation of the code. Source countries needed

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

assistance to retain health personnel, while also allowing for an exchange of ideas, knowledge and technical expertise.

Ms NYAGURA (Zimbabwe)¹ said that the flight of health workers was a major concern for the African Region, as the recruitment practices of some Member States had led to the overstretching of countries' health sectors. The emigration had depleted health-care resources and widened the gap in health inequities. While the draft code was a positive step towards redressing the global imbalances, it was regrettable that its implementation would depend on the political will of the receiving countries. Zimbabwe therefore supported the establishment by WHO of a mechanism to monitor implementation of, and adherence to, the draft code.

Recalling that paragraph 2(4) of resolution WHA57.19 had requested the Director-General to support Member States in strengthening their planning mechanisms and processes in order to provide for adequate training of personnel, she proposed that the paragraph be inserted under paragraph 3 of the draft resolution, as it was relevant to Article 6 of the draft code of practice.

Mr ADAM (Israel)¹ said that his country attached great importance to the draft code, and was committed to voluntary implementation of those principles, both in the national and the private health system. Israel, too, suffered from the outbound migration of doctors and other health personnel, as well as from immigration of health personnel who were less trained and less skilled, particularly in the operation of modern medical equipment. Israel intended to maintain the high standards of its medical and health systems and to continue to support developing countries through its international cooperation and health programmes, in collaboration with United Nations agencies such as WHO.

Dr ALVIÁREZ (Bolivarian Republic of Venezuela)¹ said that the problem underlying the migration of health workers was the shortage of such workers in the developed countries, which did not have sufficient political will to train enough health professionals for their own needs. Therefore, the developed countries had to face up to their responsibilities.

Venezuela was currently training 25 000 doctors and more than 30 000 nurses a year, with the overall goal of training 200 000 doctors in 10 years, to meet its own need and those of certain Latin American countries. WHO should first analyse the shortfall in health professionals and technicians at all levels and then propose a global training programme for health workers. That could be financed largely by the developed countries.

Ms WISKOW (International Labour Organization) said that ILO considered the draft code of practice as an important and timely initiative. She recommended consistency in the wording of the draft code of practice with existing international instruments dealing with labour migration. For example, when the draft code of practice referred to equality of treatment and opportunities in Article 3.5, it spoke of "domestically trained health workforce" as a reference group. However, in international instruments, the reference group was "national workers". Even foreign workers or foreign students could be domestically trained, but that did not give them rights equivalent to national workers.

Dr GHEBREHIWET (International Council of Nurses), speaking at the invitation of the CHAIRMAN and also on behalf of the International Pharmaceutical Federation, the World Dental Federation and the World Medical Association which, together formed the World Health Professions Alliance, said that the numbers of migrating health workers had significantly increased, with patterns of migration becoming more complicated. He expressed concern that the migration of trained

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

personnel was further weakening health systems in crisis, and undermined the ability of those countries to achieve the Millennium Development Goals and national health targets. Health professionals would welcome special attention in the draft code to the 57 countries identified by WHO as facing alarming shortages in health workforces.

The Alliance welcomed the formulation of national and international policy instruments to mitigate the negative impact of migration of health personnel, while providing strong safeguards for their fair and equal treatment. Adherence to the objectives and guiding principles of the WHO code of practice would enhance a global coordinated approach to reduce migration of health workers, improve retention and enhance the performance of health systems.

The DIRECTOR-GENERAL observed that the discussion had revealed a strong desire on the part of Member States for further consultations on the topic, to be facilitated and organized by WHO, before the Sixty-second World Health Assembly. There had been a clear call for balanced stakeholder representation and avoidance of disadvantage to Member States unable to attend such consultations. Accordingly she proposed that an informal discussion session should be held to develop some ideas on how and when to organize such consultations, and to give consideration to issues of cost.

The CHAIRMAN took it that the Board agreed with that approach. The item would thus be kept open.

It was so agreed.

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

The meeting rose at 12:30.

NINTH MEETING

Friday, 23 January 2009, at 14:05

Chairman: Sir Liam DONALDSON
(United Kingdom of Great Britain and Northern Ireland)

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

Counterfeit medical products: Item 4.11 of the Agenda (Documents EB124/14, EB124/14 Add.1 and EB124/14 Corr.1)

Dr GIMÉNEZ CABALLERO (Paraguay), speaking on behalf of the Latin American and Caribbean Group, said that WHO was the forum for discussing means of ensuring the quality, safety and efficacy of medicines and health products, taking into account respect for national legislation and objective information on potential risks and adverse effects on health. WHO should concentrate on the public health aspects of the issue and on ensuring access to high-quality medicines.

Adulteration of medicines, lack of quality testing and noncompliance with good manufacturing practices were issues should be tackled as part of broader efforts to guarantee the quality and safety of medicines and health products. The Board's treatment of the matter must be evidence-based; and actions must be approved and negotiated between Member States and aim to strengthen the capacity of regulatory authorities responsible for medicines at country level.

WHO was not a suitable forum for the discussion of enforcement of intellectual property rights. WHO should confine its work on the quality of medicines to the health aspects and should not deal with issues that fell within the mandate of other multilateral forums.

Ms FARANI AZEVÊDO (alternate to Dr Buss, Brazil) said that her Government's concern about the quality, safety and efficacy of medicines and other medical products was reflected in its health policies. WHO was the proper forum to discuss methodologies to protect public health and promote access to medicines but not to discuss the enforcement of intellectual property rights. The Secretariat should help Member States to strengthen their regulatory capacities in safeguarding health.

Other issues related to intellectual property were, rightly, of interest to WHO and integral to the Global strategy and plan of action on public health, innovation and intellectual property.¹ Any norms or definitions on quality, safety and efficacy of medicines must be inclusive, evidence-based and derived from a process driven by Member States: for that reason, Brazil did not support the draft resolution contained in document EB124/14.

No definition of counterfeiting of medical products should be used to hinder access to legitimate generic medicines, especially in countries, such as her own, where they formed part of public health policies. Defects of quality and noncompliance with good manufacturing practice were detrimental to public health, but they should not be considered counterfeiting.

The previous day, her Government had stated concern at the seizure by the Dutch customs authorities of a shipment of the generic medicine losartan, en route from India to Brazil. Losartan, widely used to treat arterial hypertension in Brazil, was not protected by patents in either country and could be imported into either. The seizure, requested by a company that allegedly owned intellectual

¹ Resolution WHA61.21.

property rights over the medicine in the Netherlands, had not been authorized by the courts and the shipment had not actually entered Dutch territory. The Dutch authorities had acted according to the “precautionary principle”, which might be applied, for example, to prohibit the importation of foodstuffs because of claims of adverse health effects. The producer would have to disprove those claims, at a cost in both time and money. WTO had deemed the precautionary principle to be a non-tariff barrier to trade.

The Dutch authorities had seized and returned to India exported medicines that conformed to existing international standards. That was a blow to universal access to medicines, a distortion of the international intellectual property system and a setback to the spirit and provisions of the Doha Declaration on the TRIPS Agreement and Public Health. WHO should firmly oppose all such action. In that connection, she noted that the International Medical Products Anti-Counterfeiting Taskforce had sought to amend WHO’s position on generic medicines on the pretext of combating counterfeit medicines, in an attempt to impede legitimate trade in generics.

That action had cast doubt upon the commitment of European countries to the promotion of access to medicines for developing countries. Her Government defended the primacy of health over trade and the right to use the flexibilities of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) to ensure universal access to medicines, as reaffirmed in WHO’s Global strategy on public health, innovation and intellectual property.

Dr KÖKÉNY (Hungary), speaking on behalf of the Member States of the European Union, said that counterfeit medical products endangered human health and undermined health-care systems. The European Union appreciated WHO’s success in organizing stakeholders to address the issue. The European Commission had investigated the distribution of pharmaceuticals, including counterfeit medical products. It had drafted legislation that took into account the principles developed by the International Medical Products Anti-Counterfeiting Taskforce and aimed to counter the health threats posed by counterfeit products. The international campaign against counterfeit medicines called for cooperation and clear principles from institutions that included health and customs authorities, the police and financial institutions. WHO had a key role to play in coordinating international anti-counterfeit efforts, and the European Union therefore welcomed its leadership in the Taskforce.

Mr ABDOO (alternate to Dr Wright, United States of America) said that counterfeit medicines put the health of people at risk because those products might contain too much, too little or the wrong active ingredient, or might actually be toxic. A coordinated international approach to address that crime was essential. He acknowledged the expert coordinating work of the International Medical Products Anti-Counterfeiting Taskforce on the public health aspects of counterfeiting. His Government took seriously all reports of suspected counterfeit products, it resourced investigations and follow-up actions, including product recalls, public awareness campaigns and liaison with international regulators and law enforcement agencies. It helped other countries to strengthen quality of manufacture in medicines; to detect counterfeit products and track down those responsible; to deal with the effects of toxic products; and to raise public awareness.

The process of defining the concept “counterfeit medical product” had been lengthy. He was concerned to note that the original version of the draft resolution prepared by the Secretariat had wrongly referred to “intellectual property rights” rather than “patents” in its preamble. That wording had widened the scope of the draft resolution in a way that was unacceptable to his Government. He asked the Secretariat to explain that mistake. He had a number of amendments to propose, and suggested that an informal drafting group might be set up with a view to accommodating diverse perspectives and reaching consensus on a draft resolution. He looked forward to hearing the views of other members.

Dr ADITAMA (alternate to Dr Supari, Indonesia), speaking on behalf of the Member States of the South-East Asia Region, commended WHO’s efforts to tackle the public health risks associated

with substandard, spurious or falsely labelled medicines. The Member States of the Region were committed to preventing the use of such medicines. Those were defined in the various national legislations, and infringement of the relevant standards was a criminal offence. The International Medical Products Anti-Counterfeiting Taskforce had been set up in 2006 pursuant to the Declaration of Rome (18 February 2006) in order to combat counterfeiting and protect public health. However, the Declaration did not appear to have been discussed or endorsed by the Executive Board and Health Assembly as the basis for establishing the terms of reference, function and membership of the Taskforce. In fact, the Taskforce appeared to be composed mainly of representatives of developed countries and the pharmaceutical industry, with inadequate representation of developing countries.

The Member States of the Region did not accept the principles and elements developed by the Taskforce for the drafting of national legislation to combat counterfeit medical products. The process had not been inclusive and, in any case, the drafting of legislation was the prerogative of national governments. WHO should strengthen drug regulatory authorities through an intergovernmental process that stressed the public health risks of substandard, spurious or falsely labelled medical products. The Member States of the Region did not wish to consider the draft resolution.

Dr REN Minghui (China) said that counterfeit medicines posed a serious threat to public health. Since 2001, his Government had enacted legislation and monitoring that covered drug development, manufacturing, distribution and quality assurance. In response to global counterfeiting, it had strengthened the training of inspectors and regulation and control of medicine. The results of quality assurance tests were published regularly, and an electronic network had been established to prevent the circulation of counterfeit medical products. His country welcomed the work of WHO and the International Medical Products Anti-Counterfeiting Taskforce to promote international cooperation and the exchange of information, and would continue to collaborate with other countries in combating counterfeiting.

His Government was not satisfied with the definition contained in paragraph 10 of the report and repeated in the draft resolution, particularly the statement that medical products not authorized in one country but authorized elsewhere were not to be considered counterfeit. In his view, even if a product was licensed in another country, its ingredients, dosage and formula were not necessarily safe or effective for all people in all regions. Under Chinese law, any medicine entering the Chinese market without regulatory authorization was considered counterfeit. He called on the Secretariat to conduct surveys of national legislation and, based on its findings, define more precisely what constituted a counterfeit medical product.

WHO and the Taskforce should pay more attention to the problem of Internet sales of counterfeit medicines, as should the report and the draft resolution. A mechanism should be set up for the exchange of information and cooperation on the issue. All Member States should be fully consulted in the negotiations on the draft resolution.

Professor ALI (alternate to Professor Haque, Bangladesh) endorsed the statements made by the members for Brazil, Indonesia and Paraguay. His Government appreciated the Secretariat's efforts to sensitize Member States to meeting quality and safety standards for medicines but had some concerns regarding the report and the proposed draft resolution. It was concerned by the focus on counterfeit medical products as a public health issue. The term "counterfeit" most often referred to violations of intellectual property; such matters related to trade and should be dealt with elsewhere, not by WHO. A better understanding of the impact of counterfeit medical products on public health was needed. Without independent verified data, it was premature for WHO to address the issue.

National drug regulatory agencies were losing their authority on the issue in favour of law enforcement agencies, which lacked understanding of matters relating to the quality, safety and efficacy of medical products; their decisions could affect the supply of medicines. The Member States should strengthen their role in the activities of the International Medical Products Anti-Counterfeiting Taskforce. The heavy involvement of the private sector could lead to conflicts of interest. It was of

concern that some organizations participating in the Taskforce were also engaged in intellectual property protection and enforcement.

The definition of counterfeit medical products agreed by the Taskforce lacked precision: it might be construed as including legally produced generic products within its scope and could adversely affect access to, and production of, medicines in developing countries. All Member States should participate in formulating definitions destined for national legislation and those should exclude issues of intellectual property infringement.

His Government could not accept the report or support the draft resolution because of the emphasis on combating counterfeit medical products as an end in itself rather than for their impact on public health. It would, however, continue to act on the safety, quality and efficacy of medical products.

Dr DJIBO (Niger), speaking on behalf of the Member States of the African Region, said that a counterfeit medical product was one that had been deliberately mislabelled with the intention to mislead, an area of grave concern for African countries, particularly given their lack of control laboratories. The magnitude of the problem was difficult to estimate; however, a lack of appropriate legislation, the absence or weakness of national pharmaceutical regulatory authorities, and weak enforcement of laws and sanctions all contributed to the existence of counterfeit medical products. An instrument to collect data at national level would be tested in Kenya and Uganda.

He commended the work of the International Medical Products Anti-Counterfeiting Taskforce and noted with satisfaction the revision made to the sixth preambular paragraph of the draft resolution. He asked how long the work of the Taskforce would continue and whether WHO envisaged further institutional measures in order to sustain anti-counterfeiting initiatives. The Secretariat should propose a better definition of counterfeit medical products and should actively facilitate the exchange of information on the issue.

Dr BIN SHAKAR (United Arab Emirates), speaking on behalf of the Member States of the Eastern Mediterranean Region and welcoming the report, noted the increasingly complex threat to public health posed by counterfeit medical products. He welcomed the improved definition of counterfeit medical products, but proposed replacing the first sentence of the new definition with the first sentence of the 1992 working definition; and the remainder of the definition should remain unchanged. The report should focus on the protection of public health. A distinction should be made between counterfeiting and any issue relating to infringement of intellectual property. Generic medicines should not be considered counterfeit, nor should substandard batches of legitimate products. His country was a hub of trade and investment, encountered counterfeiting and played its part in combating the problem. His Government had assessed the magnitude of counterfeiting of medical products and had instituted anti-counterfeiting legislation; modernized the system of import and export for medicines; developed training for technical monitoring; and equipped mobile teams with laboratory and detection tools.

Dr MOHAMED (Oman), noting paragraph 4 in the report and the 10-fold increase in incidents recorded since 2000, suggested that the duration of patent protection, 20 years, might be contributing to the rise in counterfeiting. He asked how the Secretariat would assist Member States in strengthening their legislation and regulatory agencies, in protecting their supplies of vaccines and life-saving medicines and in dealing with incidents of counterfeiting.

Ms MIKHAILOVA (alternate to Dr Starodubov, Russian Federation) welcoming the Secretariat's efforts, said that improved monitoring and control of medical products would require improved legislation, import controls and international cooperation. Her Government was working with the Commonwealth of Independent States in order to prevent the import or export of counterfeit medical products and protect the health and well-being of citizens. Cooperation agreements had been

signed in order to develop scientific and research activity, standards and legislation. The Russian Federation aimed to coordinate that work and establish a network of testing laboratories.

It would be useful to establish a standing structure under the aegis of WHO that would facilitate international surveillance and coordinate exchange of information among regulatory and medical authorities. Effective methods for rapid identification of counterfeit medical products were needed, as were uniform definitions that could be incorporated into national legislation.

Professor HARPER (alternate to Sir Liam Donaldson, United Kingdom of Great Britain and Northern Ireland) said that the International Medical Products Anti-Counterfeit Taskforce had contributed significantly to engaging stakeholders in order to tackle the growing prevalence of counterfeit medicines, including training for police forces, customs authorities and regulatory bodies. WHO had a key role in coordinating the international collaboration required to combat the manufacture and distribution of counterfeit medical products. As countries strengthened controls and legislation, counterfeiting activities would shift to countries where profits remained high but the threat of legal action was low. In those vulnerable countries, the risks to public health would increase.

The proposed draft resolution was an important step forward. The new definition clarified that action against counterfeiting should not be confused with issues of patenting and did not threaten legitimate generic products. The United Kingdom supported the formation of a drafting group to examine issues such as substandard and dangerous medicines, taking account of the views expressed by members.

Dr JAYANTHA (alternate to Mr de Silva, Sri Lanka) endorsed the statement made by the member for Indonesia.

The CHAIRMAN observed that, despite the divergent views expressed, it seemed to be generally agreed that a proper definition of counterfeit medical products was needed, referenced to a proper source; that it was not just a matter of profiteering but of concern for the health and safety of patients; that international bodies could not interfere in the functions of national or regional statutory regulatory authorities; that much work was already being done in Member States to thwart counterfeiting and reduce the risks to patients; and that a suitable role must be defined for WHO. When the need for action was particularly great, the symbolism of WHO's public statements could be more important than their content, as in the case of the draft resolution on the humanitarian situation in the Gaza Strip. A failure by the Board to adopt a resolution on counterfeit medical products would simply reassure the counterfeiters and allow their life-threatening activities to continue unabated. He therefore suggested that a drafting group should be set up to shorten the unusually long text, reduce the time spent debating the wording, and enable the resolution to be adopted. The Health Assembly might add further details. He asked participants who were not members of the Board and wished to take the floor to save their comments for the drafting group.

Ms FARANI AZEVÊDO (alternate to Dr Buss, Brazil) and Professor ALI (alternate to Professor Haque, Bangladesh) wanted to hear what Member States not represented on the Board had to say before deciding on how to proceed.

Dr CHAUHAN (India)¹ said that the incident concerning the seizure of generic medicines described by the member for Brazil had confirmed fears about the use of non-tariff barriers to obstruct access to generic products. His country therefore aligned itself with the statement by the member for Indonesia, and endorsed the views expressed by the members for Bangladesh, Brazil and Paraguay. He

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

urged the Secretariat to provide detailed documentation enabling Member States to form a considered opinion on the matter of falsely labelled, spurious and substandard medical products before any drafting group was set up.

Dr SADRIZADEH (Islamic Republic of Iran)¹ expressed his concerns over how the draft resolution on counterfeit medical products and the report proposed to address the matter. If adopted, the draft resolution could serve the protection and enforcement of intellectual property rights through issues of public health. That would endorse the activities of the International Medical Products Anti-Counterfeiting Taskforce. The given definition of counterfeit medical products would prevent developing countries from gaining access to medicines and from gaining self-sufficiency in the manufacturing of pharmaceutical preparations, neither of which was acceptable. “Counterfeit” was a term used in trade agreements, mainly in connection with trademark violations, which was not a matter for WHO but for other specialized agencies operating under other rules and procedures.

The Organization should focus instead on falsely labelled, spurious and substandard medicines. Furthermore, the Taskforce had not been established by Member States or mandated by the Health Assembly to conduct discussions on counterfeit medical products. The Board should proceed with caution and seek comprehensive clarification and consultation, especially with regard to the unbalanced participation of stakeholders, the activities of the Taskforce, and of its views on counterfeit medical products.

Dr LANDOETA (Bolivarian Republic of Venezuela)¹ said that her Government was aware of the risks of counterfeit medical products in the mainstream supply chain, and supported the statements made by the member for Paraguay and the representative of the Islamic Republic of Iran. The word “counterfeit” could be misleading in the context of public health. It was used in the Agreement on Trade-Related Aspects of Intellectual Property Rights, and the definition proposed by the Taskforce could serve as a cover for the protection and enforcement of those rights. That would deprive most developing countries of access to medical products and prevent those countries from becoming self-sufficient manufacturers and suppliers of pharmaceuticals. Although that was not the aim of the Taskforce, it had lost its focus. The direct financing of its activities by special interests, together with the involvement of international law-enforcement agencies capable of interfering in a country’s sovereign affairs, cast doubt on its place within WHO. The right to health took precedence over business interests, and her country dissociated itself from the Taskforce and any other such initiative.

Mr SILBERSCHMIDT (Switzerland)¹ agreed with previous speakers that the main reason to combat counterfeit medical products was to protect public health; that to forego a resolution would allow those responsible to continue producing and distributing those harmful products; that discussions and negotiations on the matter should take place in intergovernmental forums such as the Executive Board and the Health Assembly; that the definition of counterfeit medical products needed refining; and that action must be coordinated with WHO’s work on quality, standards and safety. Much had been said about the mandate, inclusiveness, financing and other aspects of the Taskforce, but he had heard nothing about the technical quality of its work. He supported the proposal by the Chairman for a drafting group in order to produce a more generally acceptable version of the draft resolution for submission to the Health Assembly.

Dr TIPICHA POSAYANONDA (Thailand)¹ aligned herself with the statements made by the members for Brazil, Indonesia and Paraguay, and the representatives of the Islamic Republic of Iran and the Bolivarian Republic of Venezuela. She commended the report by the Secretariat but was

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

unable to support the draft resolution as the elements developed by the Taskforce were unacceptable. As substandard, spurious and falsely labelled medical products seriously undermined public health, she expressed support for strengthening of the regulatory environment and holding discussions at the intergovernmental level.

Ms FASTAME (Argentina)¹ aligned herself with the statement made by the member for Paraguay, and condemned the illegal counterfeiting of medical products. WHO, however, was not the right forum for dealing with the enforcement of intellectual property rights. Regarding regulatory mechanisms, Article 1.1 of the Agreement on Trade-Related Aspects of Intellectual Property Rights stated: “Members shall be free to determine the appropriate method of implementing the provisions of this Agreement within their own legal system and practice”. As such, her Government was opposed to guidelines and standards being developed to harmonize such mechanisms at a global level, and would not support the draft resolution in document EB124/14. The Agreement already contained a definition of trademark counterfeiting and there was no need to create a new one.

Mr VAYAS (Ecuador),¹ expressing support for the statement made by the member for Paraguay, also agreed that WHO was not the forum for discussing intellectual property rights. Such matters were dealt with by the relevant international organizations, for example under regulations established by the Agreement on Trade-Related Aspects of Intellectual Property Rights and WIPO’s Development Agenda. WHO should concentrate on its core mandate of ensuring the quality, safety and efficacy of medicines. It should take into account the high cost of medicines on local populations, and respect national legislation.

Dr GAD (Egypt)¹ expressed concern that the report in document EB124/14 failed to define clearly the issues regarding the role of WHO and the activities of the International Medical Products Anti-Counterfeiting Taskforce. WHO had a mandate to protect public health by supporting national regulatory authorities in order to ensure the safety and efficacy of medicines. In contrast, counterfeit medical products were a matter of trademark violation, dealt with under national legislation and by procedures governing the protection and enforcement of intellectual property rights or, at the international level, by the relevant organizations such as WTO and WIPO.

Substandard medicines were a far greater threat to public health than counterfeit medical products, and the two subjects must not be confused, above all at WHO. With regard to the Taskforce, he expressed concern about representation; conflicts of interest; objectivity of data; and that it had no mandate from WHO’s governing bodies to pronounce on issues that were the preserve of Member States. Hence, neither the draft resolution nor the report was a positive way forward.

Regarding the resolution on the situation in the Gaza Strip, it was a valuable contribution and contained language that his country expected WHO to act upon.

The CHAIRMAN expressed full agreement with the previous speaker’s closing remark and clarified his own earlier comment, saying that the reality was as important as the symbolism.

Mr SANTA CRUZ (Chile),¹ endorsing the statement made by the member for Paraguay, said that the draft resolution on counterfeit medical products was not ready for adoption. Its focus should be on products failing to meet the standards of quality, safety and efficacy rather than on intellectual property rights. Furthermore, there was too little transparency regarding the background, functioning, financing and composition of the Taskforce and the subject of its meetings. The matter should be addressed within WHO or by a working group formed by the Executive Board or the Health

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Assembly. Chile was ready to set up a group that would examine the subject, specify which situations needed addressing and even change the definition of counterfeit medical products which had underpinned relevant work since 1992. He acknowledged the existence of a problem; however, a drafting group formed hastily to resolve the matter at the present session of the Executive Board could only produce unsatisfactory results.

Dr KAMOTO (Malawi) said that the definition might be less than ideal but counterfeit products remained a major public health problem that must be addressed. Any consultative group established should find another definition of counterfeit products that would encompass substandard medicines. Africa was the dumping ground for such products and a global approach to the problem was desperately needed. Arguing about the composition of the Taskforce would not advance that agenda, she appealed to those Member States concerned about not being involved in it to put forward more constructive ideas.

Ms TRUCILLO (Uruguay)¹ said that, despite the interest in the availability of medicines of optimum quality and effectiveness, the subjects of counterfeiting and regulation concerned violations of intellectual property rights should be addressed in other forums, such as WIPO. She was therefore unable to support the draft resolution.

Dr BABB-SCHAEFER (Barbados)¹ said that the production of counterfeit medical products called for zero tolerance. Their consumption could have harmful consequences, including death. Barbados broadly supported the idea behind the draft resolution, since its central concern was to protect public health rather than enforce intellectual property rights. The sixth preambular paragraph, however, was a potential cause of confusion and should be deleted, since the issues of counterfeiting and the violation of intellectual property rights were sometimes inextricably linked. Although not all violations of intellectual property rights resulted in counterfeit products, all such products were violations of those rights.

Mr RAJALA (European Commission), responding to comments by the member for Brazil, said that the pharmaceutical shipment in Rotterdam (The Netherlands) appeared to be the subject of an intellectual property dispute raised by the rights holder and had been acted upon by customs authorities. The shipment was now on its way back to the country of origin in agreement with the parties. Brazil had also criticized European Union legislation, but the Board was perhaps not the appropriate forum for that. He strongly questioned the appropriateness of involving WHO in a trade dispute; such matters were dealt with in WTO which, unlike WHO, had the appropriate instruments and mechanisms. The European Commission was authorized to speak for the Member States of the European Union on trade matters and it was prepared to work with WHO in any follow-up envisaged on the issue.

Mr CHAN (International Pharmaceutical Federation – FIP), speaking at the invitation of the CHAIRMAN, said that his organization had been involved in the International Medical Products Anti-Counterfeiting Taskforce and had provided inputs for a number of technical documents on legislation, regulatory infrastructure, implementation, enforcement, technology development trends and communications to combat counterfeit medical products. Some of those practical tools had been useful in the countries in which the Federation worked. He urged Member States to support a draft resolution on counterfeit medical products and to reaffirm the pledge to ensure access to genuine

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medical products. The Federation promoted awareness among all health professionals and patients of the dangers of counterfeit medical products.

The Internet made information globally accessible, and increasingly, patients were researching their own medical issues and also trying to self-diagnose and self-treat based on what they read. In the worst cases, unsuspecting patients died, became sick or developed resistance to genuine antibiotics through the ingestion of counterfeit medical products. The phenomenon of counterfeit medical products would only be eradicated through an agreed framework of coordinated action at the global level.

Mr MWANGI (International Alliance of Patients' Organizations – IAPO), speaking at the invitation of the CHAIRMAN, said that his organization had worked closely on the issue of counterfeit medical products with WHO, through the International Medical Products Anti-Counterfeiting Taskforce and with the World Alliance for Patient Safety. It had produced a tool kit on patient safety that included information on how to identify potential counterfeit medical products and acquire safe and effective medicines. Coordinated action was needed by the Secretariat and Member States to communicate to patients the risks of counterfeit medical products and to keep patients safe, to encourage vigilance and to report suspect medicines. He reaffirmed his organization's commitment to action through the Taskforce and related bodies.

Dr DAHL-REGIS (Bahamas) said that the debate had reflected assumptions about the capacities of certain countries, particularly low- and middle-income countries and small-island States, to discharge regulatory functions. The criminal and trade activities to which many speakers had referred fell outside the sphere of health, and the report was not clear enough on what WHO was doing on the public health aspects of counterfeit medical products. The Board needed to look at how the Secretariat was providing technical support to countries and regions. All references to criminal and trade aspects of counterfeit medical products should be expunged from the report.

Dr ETIENNE (Assistant Director-General), responding to the many different views expressed, re-emphasized that counterfeit medical products constituted a serious public health problem of increasing frequency and severity. The relevant statistics had, however, been omitted from the document for the sake of brevity. She contrasted the definition of counterfeiting within the Agreement on Trade-Related Aspects of Intellectual Property Rights, in which the aggrieved party was the holder of intellectual property rights, and in the WHO context, wherein the real victims of counterfeiting were patients and, through loss of confidence, health systems and health authorities. The earlier definition of counterfeiting had failed to address three aspects: medical products, as well as medicines; cases in which the quantity of active ingredient in the counterfeit product did not match the amount stated on the label; and cases where a licensed manufacturer had masked substandard batches with forged manufacturing documents. She understood the concern of low-income and developing countries that nothing in the report or the draft resolution should be construed as to limit the use of generic medicines. That concern was addressed in the report, which also indicated that violations of patent rights must not be confused with counterfeiting. The discussion had shown the need for a fresh look at the nomenclature of counterfeiting and how it related to the definition of intellectual property rights.

The Secretariat had engaged in consultations on several occasions, including drug regulatory authorities, and through the International Medical Products Anti-Counterfeiting Taskforce, which entity brought together Member States, the industry and other stakeholders to discuss an important public health problem. In that, it did not differ from bodies and mechanisms that had assisted the Secretariat in working on other problems. Developing countries were fully represented in the Taskforce. Nevertheless, having heard the doubts raised about its legitimacy and transparency, she would seek ways of making it more transparent and turning it into a broader consultative group to let all Member States feel that they were contributing.

She further assured members that the Secretariat was fully alive to the notion that the quality, safety and efficacy of medicines was vital for ensuring the health of individuals and care of a high standard. To that end, it was working with drug regulatory authorities and Member States in the areas, inter alia, of advocacy and assistance with their legislative processes.

As to the question from the member for the United States about how reference to intellectual property rights had been made in the report, she said that its inclusion had been due to a drafting error devoid of any ulterior motive. The Secretariat was ready to respond to the needs and be guided by the recommendations of Member States, particularly on what mechanism was needed to take the process further. She appealed, however, for Member States to recognize that counterfeit medical products posed a serious public health problem that they could not afford to ignore.

The DIRECTOR-GENERAL said that developing countries were not alone in being affected by substandard, poor quality or falsified medicines, although the impact was greater there than in developed countries. She assured Member States that WHO would remain within its area of competency, public health, and would not digress into areas for which it had no mandate, such as trade or intellectual property disputes. On the other hand, she needed sharper guidance on how to proceed, given the diversity of comments.

The CHAIRMAN said the Board had conducted a debate of great quality with carefully argued positions. The Secretariat had provided reassurances that there was no hidden agenda to extend WHO's action beyond its purview. He asked for views on the proposal to form a consultative group to reconsider the draft resolution.

Professor ALI (alternate to Professor Haque, Bangladesh) said that, while he was grateful for the efforts made to provide clarification, he did not accept the proposal to set up a consultative group. Since the underlying premise of the report and the draft resolution was unacceptable, there could be no effective discussion. Instead, the Secretariat should identify counterfeiting as a public health concern and address the root causes, with the focus on strengthening drug regulatory authorities. Any discussion should be conducted inclusively and supported by independent and verifiable data. He asked whether the International Medical Products Anti-Counterfeiting Taskforce had ever been endorsed by the Health Assembly, and how Member States could be expected to critique the work of an entity whose legitimacy had been questioned by several of them. Dissatisfaction with the report should be recognized and any further discussion on the draft resolution deferred.

Dr DAHL-REGIS (Bahamas), while agreeing that WHO needed to communicate the importance of the item under consideration, also supported the position expressed by the member for Bangladesh. Referring to her earlier question on the technical support that was being made available to countries and regions, she requested a more detailed response from the Secretariat.

Ms FARANI AZEVÊDO (alternate to Dr Buss, Brazil) expressed appreciation to the Chairman for his leadership of the current discussion; however, she could not support the solution that he had put forward. The course of action suggested by the member for Bangladesh was preferable. Too many problems still remained that made the drafting of a resolution feasible at the present time, most notably, the need to define "counterfeit" in relation to WHO's mandate. Both the discussion and the report built on technical work that had been carried out by the International Medical Products Anti-Counterfeit Taskforce, a group that was not under the control of the Member States, and had not been critically assessed. It was also unclear whether the Taskforce had considered WHO guidelines, the role of patents and of pricing that stimulated counterfeiting. Matters that were within the remit of other organizations, such as WIPO and the WTO, should not be included in WHO's agenda. Counterfeit medical products had a political as well as a health dimension. One solution might be to hold a full open-ended discussion, possibly on the basis of a revised report that would be prepared by

the Secretariat. The discussion should focus on all the issues related to counterfeiting and falsification, including: access to medicines; research and development in developing countries; capacity-building; and substandard products.

Dr GIMÉNEZ CABALLERO (Paraguay) drew attention to the role of logistics in improving access to medicines and medical products through estimates of demand, selection of products, procurement, good warehousing and distribution practices, ensuring rational use, strict quality control and the strengthening of regulatory institutions. His Government was determined to combat all types of counterfeiting and had appointed representatives with legal authority to serve on relevant bodies at all levels. He agreed with the members for Bangladesh and Brazil on the need for further discussion before a resolution could be adopted, and supported the establishment of a working group with a mandate to draw up a proposal for submission to either the Sixty-second or the Sixty-third World Health Assembly.

Dr ADITAMA (alternate to Dr Supari, Indonesia) expressed support for the comments made by the member for Bangladesh. He was unable to agree to the establishment of a working group. The Secretariat should take note of the discussions and, if necessary, prepare a new report or proposal based on them.

Dr BIN SHAKAR (United Arab Emirates), speaking on behalf of the Member States of the Eastern Mediterranean Region, expressed support for the Chairman's suggestion that the Board should establish a working group to review the content of the draft resolution.

Mr HOHMAN (alternate to Dr Wright, United States of America) endorsed the comments of the member for Brazil concerning the Chairman's efficient handling of the discussion. The debate had persuaded him that his earlier suggestion regarding the establishment of a small informal group would not be practicable because of the time available. The issue of counterfeit medical products had important public health aspects, with regard to which WHO had a legitimate role. However, several members had expressed concern about related aspects and appropriate discussion forums. On that basis, he supported the proposals made by the members for Bangladesh, Brazil, Indonesia and Paraguay, namely, that the Director-General should be requested to prepare further material on the matters that had been discussed. The deliberations might then be continued, through an intergovernmental process if so decided, to a stage where the matter could be considered by the Sixty-second World Health Assembly. If that suggestion was approved by the Board, the Director-General would then need to take into consideration a possible overlap with the intergovernmental process currently under way.

Dr KÖKÉNY (Hungary) said that, despite the marked divergence in the views of several delegations, it was necessary to send a strong message regarding patient safety and public health. Regardless of the definition of counterfeiting, it constituted a growing scourge in both developed and developing countries and must be eliminated. He therefore endorsed the proposal by the member for the United States that the Director-General should be requested to further clarify all the issues involved and suggested that the Board should take a decision on it.

Dr MOHAMED (Oman) pointed out that, during the deliberations of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property, issues of trade, intellectual property and patents had all been discussed in the context of their linkage with public health. He asked whether it was necessary to reopen the discussion and, in particular, to establish an intergovernmental working group, as the member for the United States had suggested.

The DIRECTOR-GENERAL remarked that, in 30 years of attending WHO meetings, she had never heard such a robust, substantive and high-quality discussion. There had been marked divergence of opinion in the first round of the discussion, but, after listening to further comments from members, she had noted some points of convergence. In effect, the members for Bangladesh, Brazil, Hungary, Indonesia, Paraguay and the United States had all been asking the Secretariat to identify the public health concerns and focus on what the Secretariat was doing to support Member States in strengthening their drug regulatory authorities in that regard. The member for Indonesia had requested the Secretariat to prepare a new report addressing the public health dimension of the issue of counterfeit medical products. That report would, she hoped, be submitted to the Sixty-second World Health Assembly, without a draft resolution, because there did not yet appear to be a convergence on the issues. The revised report should provide Member States with more information, which, in turn, should enable them to agree on a way forward. The member for Oman had drawn attention to the linkage between the content of the Board's discussions and WHO's previous work in connection with the Global strategy and plan of action on public health, innovation and intellectual property. Therefore, if the Board so agreed, the Secretariat would consider the Global strategy and plan of action, which the Health Assembly had already adopted, in order to identify points that might be relevant to the revised report. After considering the revised report, the Health Assembly could advise her on what further action she should take. If followed, that procedure would obviate the need for an intergovernmental process.

Dr VIROJ TANGCHAROENSATHIEN (Thailand)¹ said that he looked forward to the revised report. He urged the Director-General to carry out a thorough investigation of the role, function and public health interests of the members of the International Medical Products Anti-Counterfeit Taskforce. He cited the example of the National Institute of Health and Clinical Excellence in the United Kingdom and the terms of reference with which its members had to comply in order to avoid any possible conflict of interest.

Replying to a request for clarification from the DIRECTOR-GENERAL, he confirmed that the information requested should be provided in a document separate to the revised report.

The CHAIRMAN said that in the absence of any objection, he took it that the Board endorsed the procedure outlined.

It was so agreed.

Human organ and tissue transplantation: Item 4.12 of the Agenda (Document EB124/15)

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union, the candidate countries Croatia, The former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilisation and Association Process and potential candidates Albania and Bosnia and Herzegovina, as well as Armenia and Ukraine, and recalling resolution WHA57.18, proposed a resolution on human organ and tissue transplantation which read:

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

The Executive Board,
Having considered the report on human organ and tissue transplantation,¹

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

The Sixty-second World Health Assembly,
Recalling resolutions WHA40.13, WHA42.5 and WHA44.25 on organ procurement and transplantation and WHA 57.18 requesting an update of the Guiding Principles;

Having considered the report on human organ and tissue transplantation;

Aware of the growing magnitude and utility of human cell, tissue and organ transplantation for a wide range of conditions in low- as well as high-resource countries;

Committed to the principles of human dignity and solidarity which condemn the buying of human body parts for transplantation and the exploitation of the poorest and most vulnerable populations and the human trafficking that result from such practices;

Determined to prevent harm caused by the seeking of financial gain or comparable advantage in transactions involving human body parts, including organ trafficking and transplant tourism;

Convinced that the voluntary, non-remunerated donation of organs, cells and tissues from deceased and living donors helps to ensure a vital community resource;

Conscious of the extensive cross-boundary circulation of cells and tissues for transplantation;

Sensitive to the need for surveillance of adverse events and reactions associated with the donation, processing and transplantation of human cells, tissues and organs as such and for international exchange of such data to optimize the safety and efficacy of transplantation;

1. ENDORSES the updated WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation as attached to the WHO report EB124/15, hereby also called “the Guiding Principles”;

2. URGES Member States:²

(1) to take account of the Guiding Principles in the formulation of their own policies and to implement these Guiding Principles in the law governing human cell, tissue and organ donation and transplantation where appropriate;

(2) to foster public awareness and understanding of the benefits created by the voluntary, non-remunerated provision of cells, tissues and organs as such from deceased and living donors, in contrast to the physical, psychological and social risks to individuals and communities caused by trafficking in material of human origin and transplant tourism;

(3) to oppose the seeking of financial gain or comparable advantage in transactions involving human body parts, organ trafficking and transplant tourism, including by encouraging health-care professionals to notify health authorities when they become aware of such practices;

¹ Document EB124/15.

² Refers also to regional economic integration organizations where appropriate.

- (4) to sustain equitable access to transplantation services, which provides the foundation for public support of voluntary donation;
 - (5) to improve the safety and efficacy of donation and transplantation by collaborating to harmonize global practices;
 - (6) to establish and support national or multinational authorities to provide oversight, organization and coordination of donation and transplantation activities, with special attention to maximizing donation from deceased donors and to protecting the health and welfare of living donors;
 - (7) to collaborate in collecting data including adverse events and reactions on the practices, safety, quality, efficacy, epidemiology and ethics of donation and transplantation;
 - (8) to recognize and implement globally consistent coding systems for human cells, tissues and organs as such in order to facilitate national and international traceability of materials of human origin for transplantation;
3. REQUESTS the Director-General:
- (1) to disseminate the updated Guiding Principles as widely as possible to all interested parties;
 - (2) to aid the efforts of Member States and nongovernmental organizations towards global harmonization of donation and transplantation practices, including the prevention of organ trafficking and transplant tourism;
 - (3) to continue collecting and analysing global data on the practices, safety, quality, efficacy, epidemiology and ethics of donation and transplantation of human cells tissues and organs;
 - (4) to facilitate Member States' access to appropriate information on the donation, processing and transplantation of human cells, tissues and organs, including data on severe adverse events and reactions;
 - (5) to provide, in response to requests from Member States, technical support for developing national legislation and regulation on, and suitable systems for, donation and transplantation of cells, tissues or organs, in particular by facilitating international cooperation;
 - (6) to review the Guiding Principles periodically in the light of national experience with their implementation and of developments in the field of transplantation of human cells, tissues and organs;
 - (7) to report to the Health Assembly at least every four years on actions taken by the Secretariat, as well as by Member States and other partners, to implement this resolution.

He commended WHO's provision of a global knowledge base on transplantation, following extensive consultation with experts. He also welcomed the revision of the WHO Guiding Principles on Human Organ Transplantation, as contained in the annex to the report, which provided an essential framework to support progress in transplantation of cells, tissues and organs. In particular, he welcomed the addition of the two new Guiding Principles.

The following countries were cosponsors of the draft resolution: Argentina, Austria, Belgium, Brazil, Bulgaria, Colombia, Cyprus, Czech Republic, Denmark, El Salvador, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Japan, Latvia, Lithuania, Luxembourg, Mali, Malta, Mexico, Netherlands, New Zealand, Paraguay, Poland, Portugal, Republic of Moldova, Romania, Serbia, Slovakia, Slovenia, Spain, Sweden and the United Kingdom of Great Britain and Northern Ireland.

Dr MAIGA (alternate to Mr Touré, Mali), speaking on behalf of the 46 Member States of the African Region, commended the report. She said that human organ and tissue transplantation was unfortunately practised in only a handful of countries in the African Region. The obstacles to advancing the use of organ transplants in Africa were many and included the lack of human and financial resources, especially kidneys and corneas; insufficient technical capacity; the absence of political and legal frameworks; and dysfunctional health systems. Low-income and middle-income countries were easy targets for the exploitation of poor and vulnerable people without legal protection. Transplant tourism and commercialization of the human body encouraged financial gain over the well-being of donor and recipient.

The transplantation rate in sub-Saharan Africa was only 0.2 per 1 million persons, dramatically lower than the rate elsewhere. African countries had a duty to catch up in this field and needed to establish legal frameworks before carrying out human organ and tissue transplantation.

She emphasized the need to strengthen collaboration between countries and with all stakeholders. The need for corneal transplantation was well established in her Region: the challenge was to raise public awareness of such possibilities and of procedures for acquiring and using immunosuppressant medicines at a lower cost. Increased access to organ transplants required the drawing up practical guides on how to arrange for kidney transplants in emerging countries. She endorsed the draft resolution.

Dr GARBOUJ (alternate to Dr Abdesselem, Tunisia), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the increased demand for organs and tissue and their limited availability had led to organ trafficking; indeed some countries in the Region were now destinations for transplant tourism. He commended the efforts of WHO to provide guidance; its emphasis on reducing the need for organ transplants; and the clarifications of, and additions to, the Guiding Principles. Increased awareness, encouraged by many organizations, and WHO's support for national initiatives, and combat of unethical practices, should all help to reduce trafficking.

Tunisia had undertaken public awareness campaigns, amended national legislation, established organ transplant banks and focused on policies related to transplants from deceased donors. Member States in the Region had established a network for exchange of information. A declaration of principle had been issued in Kuwait by experts from 17 Member States of the Region, banning organ trafficking and encouraging organ transplantation. In certain countries, religious and civil society leaders were promoting public awareness. The role of the media remained important in reinforcing ethical standards. The countries of the Region supported the revised Guiding Principles and would continue to cooperate with WHO on establishing guidelines and increasing awareness regarding transplantation.

Mr FISHER (Denmark) said that the report and Guiding Principles dealt appropriately with two areas of concern previously raised by Denmark, namely: the criminal exploitation of poor and powerless people; and the removal of tissue and organs from living minors and legally incompetent persons. The use of living donors in accordance with the Guiding Principles would reduce waiting time and thus reduce the illegal trade in organs. Transparency and registration, with national legislation regulating transplantation, were the most important ways of countering criminal and unethical practices. Countries that registered all transplantation activities in well-established regional or international registries were thus in control of those activities. A global system for coding transplantation material, registration of activities and cooperating with existing registries must be developed. National legislation should be based on Directive 2004/23/EC of the European Parliament and of the Council of 31 March 2004 on setting standards of quality and safety for the donation, and on procurement, testing, processing, preservation, storage and distribution of human tissues and cells. He also emphasized the directive of the European Parliament and of the Council on Standards of quality and safety of human organs intended for transplantation, proposed by the European Commission in December 2008. In that context, he supported the draft resolution.

Dr REN Minghui (China) said that his Government attached great importance to managing transplantation. In March 2007, with the support of the Secretariat, China had regulated organ transplantation, set forth the rights of recipients and donors, established an organ donation system and clarified relevant government functions. The Ministry of Health had approved a system for evaluation of hospitals and health professionals, and reduced the number that practised transplantation. China had been a destination for transplant tourism, but that had been explicitly prohibited since July 2007. China was currently examining how to set up a national system to manage donation allocation, transplantation and registration, in accordance with the Guiding Principles. It would also regulate the taking of donations from living donors. China supported the revised Guiding Principles and would continue to work with the Secretariat in order to legislate and combat illegal activities. He expressed support for the draft resolution, but had difficulties with specific subparagraphs and would discuss those informally with the sponsor.

Mr ABDOO (alternate to Dr Wright, United States of America) said that the report and, in particular, the Guiding Principles raised international awareness of human rights, and ethical and safety issues. WHO was to be congratulated on its leadership role in promoting those issues. While living organ donation had been the subject of serious abuses of human rights at the global level, it could have substantial health benefits for the recipient. Living donation was acceptable where diligent efforts had been made to ascertain that an offer to donate was truly altruistic. While he supported the Guiding Principles in general, he was concerned about the use of the word “endorses” in the draft resolution. He proposed that it be replaced with “welcomes”, since the Board should not be obliged to endorse each new review or revision of the Guiding Principles by means of a resolution.

Dr MAHILLO DURÁN (Spain)¹ welcomed the draft resolution. The Spanish National Transplant Organization was a WHO collaborating centre and housed the Global Observatory on Donation and Transplantation. Current activities examined the practice, security and quality of allogeneic transplants as well as related ethical aspects such as living donors; transplant tourism; trade in cells, tissues and organs; and trafficking in human beings that targeted the poorest and most vulnerable people. The shortage of available organs had caused many countries to establish systems to improve supply, but it had also boosted the trade in human organs, particularly from living donors unrelated to recipients. In that context, the Guiding Principles, and a resolution supporting them, could represent the legal and ethical framework for acquiring and transplanting organs, cells and tissues for therapeutic purposes. That would encourage donation while providing tools with which to prevent trade and trafficking.

The updated version of the Guiding Principles advanced the process through recognition of all the key elements, notably issues of consent, the protection of minors, donation and remuneration, coercion and compensation, and the setting of standards and procedures. The adoption of a supporting resolution might encourage countries to take the Guiding Principles into account when formulating pertinent legislation and establishing national and international mechanisms for the supervision, organization and coordination of donation and transplantation activities.

The meeting rose at 17:00.

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

TENTH MEETING

Saturday, 24 January 2009, at 09:05

Chairman: Mr N.S. DE SILVA (Sri Lanka)

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

Human organ and tissue transplantation: Item 4.12 of the Agenda (Document EB124/15) (continued)

Dr CHAUHAN (India)¹ welcomed the updated WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation. His Government was amending its domestic transplantation legislation in line with those principles. Nevertheless, WHO needed to be more proactive in creating capacity for the equitable and transparent distribution of organs, to include networks based on information technology. National and subregional networks, surveillance systems and registries were required to monitor transplant activities. He urged the Secretariat to provide the support for establishing affordable infrastructure, technical guidance, and the capacity-building needed by Member States. A global system for tracing transplantable material would be welcomed.

Mgr VITILLO (Holy See), speaking at the invitation of the CHAIRMAN, acknowledged the urgency of the matter under discussion. WHO estimated that some 10% of kidney transplants performed in 2007 had resulted from the illicit purchase and sale of kidneys; trafficking across borders; or removal of kidneys from involuntary donors in vulnerable population groups. Pope Benedict XVI had expressed grave concern about such abuses when receiving participants at an international conference on the topic in November 2008, and had appealed to the scientific and medical community to unite in rejecting such unacceptable practices. The determination of the Director-General to continue examining ethical, clinical and epidemiological issues related to human organ transplantation was greatly appreciated.

He emphasized the need to promote voluntary donation of organs, a noble act of solidarity. However, he reiterated the Holy See's view that care must be exercised in relation to organs from non-heartbeating donors, mentioned in paragraph 11 of the report. In all such cases it must be ensured that the cessation of vital functions was truly irreversible and certified by valid criteria. Respect for the life of the donor must always prevail. Additional research, including paediatric research, and interdisciplinary reflection were needed in order to truthfully inform the general public of the anthropological, social, ethical and legal implications of transplantation. Clinical research had demonstrated the therapeutic benefits of interventions using adult stem cells rather than embryonic cells, a direction that guaranteed respect for human dignity, even at the embryonic stage.

Professor CHAPMAN (The Transplantation Society), speaking at the invitation of the CHAIRMAN, said that in addition to transforming the health and well-being of people with end-stage organ failure, successful transplantation was also of economic benefit, especially in kidney failure, since it was less expensive and provided longer and higher quality of life than dialysis. However, the desperation of patients awaiting suitable organs had led to exploitation and trafficking of organs from

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

the most defenceless members of society. Donors became vendors in return for some illusory release from poverty; and purchasers suffered poor transplant outcomes and high mortality rates. The Transplantation Society applauded the objectives of the revised Guiding Principles. He agreed with the previous speaker, in relation to the transplantation of organs from non-heartbeating donors, that it was essential to ensure that the cessation of vital functions was truly irreversible and certified by valid criteria.

Donation of kidneys by live donors entailed risks. Even with rigorous donor assessment in the best conditions, the donor death rate was around 1 in 3000. The Transplantation Society had developed a professional consensus on the assessment and care of living organ donors. However, specific government oversight was needed to ensure their protection. The Declaration of Istanbul on Organ Trafficking and Transplant Tourism (Istanbul, April 2008) set out definitions of organ trafficking, transplant tourism and transplant commercialism and affirmed ethical solutions and practices. The Declaration should support Member States in combating the targeted sourcing of organs from poor people. Action by the medical profession was complementary to the WHO Guiding Principles, implementation of which should provide the global transparency and vigilance needed to ensure safety and improved outcomes. The challenge to Member States would be to entrench transparency in all programmes. He urged the Board to approve the revised Guiding Principles and recommend their adoption at the Sixty-second World Health Assembly.

Dr ETIENNE (Assistant Director-General) noted the broad consensus on the issue and the amendments proposed to the text, which the Secretariat would endeavour to effect. She re-emphasized the importance of monitoring, surveillance and registries. Traceability of cell tissue and organs for transplantation was a key component of safety and could be very important in combating trade. The global coding system had already been established and the Secretariat would work with Member States to ensure broad participation. She noted the requests for improved technical guidance, support and capacity-building within Member States. The Secretariat would seek to carry out their wishes.

The CHAIRMAN suggested that, as informal consultations on the draft resolution introduced during the ninth meeting were still ongoing, discussion should be continued at a subsequent meeting.

It was so agreed.

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

WHO's role and responsibilities in health research: Item 4.9 of the Agenda (Documents EB124/12, EB124/12 Add.1 and EB124/12 Add.2) (continued from the eighth meeting, section 2)

The CHAIRMAN drew attention to a revised version of the draft resolution on WHO's role and responsibilities in health research incorporating amendments proposed by several members, which read:

The Executive Board,
Having considered the draft of the WHO strategy on research for health,¹

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

¹ Document EB124/12.

The Sixty-second World Health Assembly,
 Recalling resolution WHA58.34 on the Ministerial Summit on Health Research and resolution WHA60.15 on WHO's role and responsibilities in health research;

Recognizing the contribution of research to the development of solutions to health problems and the advancement of health worldwide;

Aware that, in a rapidly changing world facing significant environmental, demographic, social and economic challenges, research will be increasingly essential for clarifying the nature and scope of health problems, and for identifying effective life-saving interventions and strategies;

Realizing the increasingly multidisciplinary and intersectoral nature of research for health improvement;

Affirming the roles and responsibilities of WHO, as a leading global health organization, in health research; [Indonesia]

Recognizing the need to strengthen the capacity of public sectors in health research; [Indonesia]

Acknowledging that research activities in the private and public sectors can be mutually supportive and complementary in improving health globally;

Conscious of the need to strengthen the conduct, management and coordination of WHO's activities in health research;

Cognizant of the need to better communicate WHO's research activities and results, especially to its Member States and partners;

~~Noting Welcoming~~ [USA] the references to research for health in resolution WHA61.21 on the Global strategy and plan of action on public health, innovation and intellectual property and relevant conclusions and recommendations of the WHO Commission on Social Determinants for Health;

Taking into account the outcomes of the Global Ministerial Forum on Research for Health (Bamako, 17–19 November 2008),

1. ENDORSES the WHO strategy on research for health **annexed hereto [USA]**;
2. URGES Member States:
 - (1) to recognize the importance of research for improving health and health equity and to adopt and implement policies for research for health that are aligned with national health plans, that include the participation of all relevant sectors, public and private, that align external support around mutual priorities, and that strengthen key national institutions;
 - ~~(2) to support the implementation of the research for health strategy according to their own national circumstances and contexts, and as part of their overall policies on health and health research; [USA]~~
 - ~~(3)~~ (2) to strengthen national health research systems by improving leadership and management of research for health, by focusing on national needs, by establishing effective institutional mechanisms for research, by using evidence in health policy development, and by harmonizing and coordinating national and external support (including that of WHO);
 - ~~(4)~~ (3) to establish, as necessary **and appropriate**, [USA] governance mechanisms for research for health, to ensure rigorous application of good research norms and standards, **including protections for human subjects involved in research**, [USA] and to promote an open dialogue between policy-makers and researchers on national health needs, capacities and constraints;

- (54) to improve the collection of reliable health information and data and to maximize, **where appropriate, [USA]** their free and unrestricted availability in the public domain;
- (65) to promote intersectoral collaboration and high-quality research in order to produce the evidence necessary for ensuring that policies adopted in all sectors contribute to improving health and health equity;
- (76) to initiate or strengthen intercountry collaboration with the aim of obtaining efficiencies of scale in research through the sharing of experiences, best practices and resources, the pooling of training and procurement mechanisms, and the use of common, standardized evaluation methods for research;
- (87) to consider, where appropriate, establishment of regional collaborating mechanisms, such as centres of excellence, in order to facilitate access by Member States to the necessary research and expertise to meet health challenges;
3. ~~INVITES CALLS UPON~~ **[USA]** the health research community, international organizations, supporters of research, the private sector, civil society and other concerned stakeholders:
- (1) to provide support to the Secretariat ~~and Member States~~ **[USA]** in implementing the research for health strategy and in monitoring and evaluating its effectiveness;
- (2) to collaborate with the Secretariat ~~and Member States~~ **[USA]**, within the framework of the strategy, in identifying ~~global~~ **[USA]** priorities for research for health, ~~in agreeing norms and standards relating to research for health, [USA]~~ and in the collection of health information and data;
- (3) to assist the Secretariat and WHO's research partners in mobilizing enhanced resources for the identified global priorities for research for health;
- (4) to pay particular attention to the research needs of low-income countries, notably in areas such as technology transfer, research workforce, and infrastructure development **and other determinants of health [Indonesia]** particularly where this will contribute to the achievement of the Millennium Development Goals, health equity and better health for all **and to collaborate with the Secretariat and Member States to better align, coordinate and harmonize the global health research architecture and its governance through the rationalization of existing organizations, to improve coherence and impact, and to increase efficiencies and equity; [UK]**
- (5) to support, where appropriate, technical cooperation among developing countries in research for health;
4. REQUESTS the Director-General:
- (1) **to provide leadership in identifying global priorities for research for health; [Netherlands seconded by UK]**
- (2) to implement the strategy within the Organization at all levels and with partners, **and in coordination with the Global strategy and plan of action on public health, innovation and intellectual property [UK];**
- (3) to improve the quality of research within the Organization ~~and strengthen WHO's leadership in research for health; [Netherlands seconded by UK]~~
- (4) to provide adequate core resources in proposed programme budgets for the implementation of the research for health strategy;
- (5) to ensure that the highest norms and standards of good research are upheld within WHO, including technical, ethical and methodological aspects and the translation into practice, use and dissemination of results **and to review and**

streamline the architecture and governance of the Organization's research activities and partnerships; [UK]

~~(5) to provide support to Member States, upon request and as resources permit, in implementing the strategy in order to strengthen national health research systems and intersectoral collaboration; [USA]~~

~~(6) to align better the work of WHO collaborating centres involved in research with the goals of the research for health strategy;~~ **to strengthen the role of WHO collaborating centres as a well-established, effective mechanism for cooperation between the Organization and countries in the field of research for health; [Russian Federation]**

(7) to report to the Sixty-fifth World Health Assembly on the implementation of this resolution, through the Executive Board, in 2012.

Mr HOHMAN (alternate to Dr Wright, United States of America) requested time for informal consultations on the revised draft resolution with a view to reaching consensus, as he had further amendments to propose.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) suggested that the words "review and streamline" in subparagraph 4(5) should be altered to avoid any implication of budget cuts.

The CHAIRMAN suggested that the item should be left open pending the results of informal consultations on the draft resolution.

It was so agreed.

(For resumption of the discussion, see below.)

Public health, innovation and intellectual property: global strategy and plan of action: Item 4.13 of the Agenda (Documents EB124/16, EB124/16 Add.1 and EB124/16 Add.2)

Ms KRISTENSEN (alternate to Mr Fisker, Denmark) commended the Secretariat's development of the global strategy and plan of action by the Intergovernmental Working Group, and work on the Quick Start Programme. The medium-term framework for research and development relevant to diseases that disproportionately affected developing countries would contribute much to achieving the Millennium Development Goals. The establishment of the expert group would enhance the strategy and plan of action. Denmark expected that, through continuing consultations, Member States would resolve their remaining differences concerning the text of the plan of action with a view to adoption at the Sixty-second World Health Assembly.

Dr ZARAMBA (Uganda), speaking on behalf of the Member States of the African Region, commended the development by the Intergovernmental Working Group and the Secretariat of the draft global strategy and plan of action, parts of which had been adopted at the Sixty-first World Health Assembly. He welcomed the proposed progress indicators set out in the report.

At its fifty-eighth session, the Regional Committee for Africa had suggested the need to take account of: a range of Health Assembly resolutions; progress reports from Member States; and synergies with the 2008 Algiers Declaration, arising from the Ministerial Conference on Research for Health in the African Region, and the 2008 African Union Pharmaceutical Manufacturing Plan for Africa. It had also recommended that the subject should be discussed in subsequent sessions.

The proposed indicators would form the basis for regular reporting to the Health Assembly on performance and overall progress. However, Member States must actively implement the global

strategy. He urged the Director-General to focus technical and financial support on African Member States, which would continue working on the text of the plan of action and looked forward to its finalization at the Sixty-second World Health Assembly.

Professor ALI (alternate to Professor Haque, Bangladesh) also commended the work achieved. He noted the innovative genetic mapping of indigenous resources, such as herbs and medicinal plants in developing countries, through the application of biotechnology. However, those activities were commercially driven and would lead to a takeover of resources by the multinational companies. The strategy should protect the right of countries to own their indigenous resources. WHO should enhance the capacity of developing countries to acquire the competence and technical know-how for exploiting the newer technologies and expanding their research in those areas. Bangladesh had developed a strategy to promote and prioritize research, to develop traditional medicine and to encourage technology transfer.

Mr HOHMAN (alternate to Dr Wright, United States of America) said that, given the difficulty of developing appropriate progress indicators, he welcomed the Secretariat's approach in seeking just a few for each element of the global strategy and plan of action. However, he was unsure of the action requested of the Board in respect of the proposed progress indicators set out in document EB124/16 Add.1. Further work was needed as some of the indicators would be hard to measure and some were not clearly aligned with the plan of action. The costs projected in document EB124/16 Add.2 were staggering, and it would be difficult for Member States to mobilize such sums. He welcomed the continuing work on the text of the plan of action and looked forward to its finalization at the forthcoming Health Assembly.

Mr VIEGAS (alternate to Dr Buss, Brazil) said that Brazil had participated in the work on developing the global strategy and plan of action regionally and internationally. Implementation would significantly improve access to innovations that responded to the health needs of developing countries. Brazil was committed to applying the recommendations contained in resolution WHA61.21. The Regional Committee for the Americas/PAHO Directing Council had adopted resolution CD48.R15, which *inter alia* called on Member States to collaborate with PAHO in promoting regional action. Together with other Member States of the Region of the Americas and in collaboration with PAHO, Brazil had hosted in November 2008 a first meeting on high-cost medicines which had emphasized: mapping regional specificities; challenges relating to access to essential medicines; and implementing the global strategy. Brazil was also promoting access to essential medicines through its universal free health system. He welcomed the establishment by WHO of a group of experts on financing mechanisms for research and development. Brazil requested the Secretariat to prepare a report on the activities conducted under the Quick Start Programme.

The proposed progress indicators were largely quantitative, which would not fairly assess the implementation of the global strategy and Member States were urged to adopt qualitative indicators. His Government was providing financial support for implementation of the global strategy, in line with paragraph 15 of the strategy.

Dr VARGAS (Bolivarian Republic of Venezuela)¹ welcomed the contribution of the Secretariat to guaranteeing universal access to medicines. He enquired about the composition of the expert working group referred to in paragraph 6 of the report, the criteria used for selecting members, and whether the group had already been formally established.

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

The proposed progress indicators should not be based on disease classification alone. There should be clear instruments to measure management progress; and the indicators themselves should be analysed and reviewed on a regular basis.

The documents under discussion were a valuable starting point but further regional and subregional examination was required, notably on the development and application of the proposed indicators and how they would affect research at national level.

Dr BABB-SCHAFER (Barbados)¹ asked whether the expert group set up by the Director-General would in due course examine proposals on a prize-fund model.

Mr ROSALES LOZADA (Bolivia)¹ drew attention to the need for more thorough debate on the relationship between innovation, intellectual property and health, and specifically the multilateral intellectual property standards that allowed the patenting of living materials. Bolivia's new Constitution, if approved in the following day's referendum, would ban such patenting; it would establish clearly that negotiating, adhering to and ratifying international treaties should be governed by the principles of harmony with nature, defending biodiversity and prohibiting forms of private ownership that led to the exclusive use and exploitation of living materials. Bolivia was pursuing initiatives in various forums with a view to amending or clarifying international standards in order to prohibit, first, the patenting of all forms of living materials and, secondly, biological processes for the production of living organisms, as in the case of some provisions of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), which was usually taken as a point of reference in relations between innovation and intellectual property.

Bolivia opposed the patenting of living materials because it contradicted the morals and culture of most of the world's peoples. There were insufficient technical and scientific grounds for patenting such materials and their associated processes that existed in nature. Those were not inventions. International law, including the TRIPS agreement, recognized the monopoly rights of private parties without recognizing the collective ownership by indigenous peoples of their traditional knowledge and genetic resources. Thus international intellectual property standards were out of step with various international agreements, in particular the 2007 United Nations Declaration on the Rights of Indigenous Peoples.

The above principles should be taken into account in the future decision-making activities of the Intergovernmental Working Group and related bodies. He echoed the request made by the member for Barbados regarding the status of proposals submitted in April 2008, and asked when they would be published in all official languages on the WHO web site.

Mr SILBERSCHMIDT (Switzerland)¹ said that the technical nature of work on progress indicators should be carried out by the Secretariat alone rather than through formal negotiations. Funding requirements should be met by all stakeholders, including the private sector and not just by Member States. He asked the Secretariat to clarify the process for integrating the outstanding components of the plan of action and whether there would be a decision at the Sixty-second World Health Assembly to incorporate them in resolution WHA61.21.

His country was committed to the implementation of the global strategy and plan of action. He encouraged countries, nongovernmental organizations and industry to do as his country had done, by developing their own implementation plan.

Ms WISEMAN (Canada)¹ commended the Secretariat's work and prioritization of the areas requiring further action. She was pleased to note the establishment of the expert working group. Her

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

Government was considering further collaboration in the fields of traditional medicine, humanitarian licensing, transfer of research technology and strengthening of regulatory capacity.

Mr RAJALA (European Commission) said that the European Commission would actively implement the global strategy and plan of action. He highlighted the need for additional research, and for further collaboration between the Secretariat and Member States in regard to bilateral agreements affecting developing countries. He asked for clarification of the single-figure million US dollar amounts given in document EB124/16 Add.2; certain points of that document might require clarification at a later date.

Mr CHAN (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, said that he supported the fundamental objectives of the global strategy. Challenges lay ahead in ensuring health equity while creating incentives to develop innovative therapies. Drawing attention to Element 6 of document EB124/16 Add.1 on improving delivery and access, policies were needed to increase professional training and provide incentives for retaining health personnel. In that regard, his Federation had been working closely with the Global Health Workforce Alliance and the WHO Secretariat. He urged both the Secretariat and Member States to focus on strengthening the pharmaceutical workforce, which was crucial to successful implementation of the global strategy.

Mr BALASUBRAMANIAM (Churches' Action for Health), speaking at the invitation of the CHAIRMAN, supported the implementation of the global strategy and plan of action and welcomed the creation of an expert working group. He urged WHO and all its partners to initiate action as set out in paragraph 5.3(a) of the plan of action. In that regard, he noted the proposals put forward by the representatives for Barbados and Bolivia to create a prize fund for a low-cost diagnostic test for tuberculosis, and another for developing new treatments for Chagas disease.

He asked WHO to provide further guidance on intellectual property issues, particularly on use of the flexibilities in the TRIPS agreement. Referring to action 2.3(c), he favoured the creation of a treaty on health, biomedical research and development.

Ms CHILDS (Médecins Sans Frontières (MSF) International), speaking at the invitation of the CHAIRMAN, said that her organization was cosponsoring a new initiative to conduct clinical trials for multidrug-resistant tuberculosis. She placed high expectations on the expert working group to identify new sources of funding and propose alternative financing mechanisms. The views of all stakeholders should be represented in the expert working group. She asked for clarification of how the Secretariat would build on the discussions of the expert working group, and when further meetings would be held.

Mr BOŠTJAN (alternate to Dr Voljč, Slovenia) thanked the Secretariat for its work and supported the adoption of the global strategy and plan of action. He commended the expert working group and looked forward to finalizing the outstanding components of the plan of action at the Sixty-second World Health Assembly.

Dr KEAN (Executive Director, Office of the Director-General) thanked Board members and other speakers for their constructive comments. On behalf of the Director-General, he also thanked Member States and other bodies for their support of the Secretariat's work on the global strategy and plan of action, including their assistance with the progress indicators, their financial support and, in some instances, through the secondment of their staff. The item had been included on the agenda as a means of indicating progress made, before submission of the full report to the Sixty-second World Health Assembly. He acknowledged the work, and progress made, on the text in brackets.

The expert working group would consider the proposals made by the members for Barbados and Bolivia at its next meeting. He had noted comments made by previous speakers concerning areas that required additional work.

A decision adding to resolution WHA61.21, based on the supplementary information provided by the Director-General and Member States, would be proposed to the Sixty-second World Health Assembly. There would be further consultation on the way in which that decision would be presented.

Dr RENGANATHAN (Executive Secretary, WHO Secretariat on Public Health, Innovation and Intellectual Property) said that, with regard to the progress indicators, the Secretariat had followed the guidance given by the Intergovernmental Working Group, namely to devise a manageable set of indicators covering 107 specific actions. The comments provided by the members for the United States of America and Brazil, the representatives of Venezuela (Bolivarian Republic of) and Switzerland, and others were appreciated, and he looked forward to receiving further comments on how to refine the progress indicators further.

With regard to costing, in reply to the question from the European Commission regarding the single-digit million US dollar figure given in document EB124/16 Add.2, he said that an “ingredients approach” had been taken, similar to that adopted in different global strategies. The work had been led by the health systems financing team with support from a number of different departments. Document EB124/16 Add.2 provided further insight into how the estimates had been made; paragraph 8 of the costing document explained the context of the global total of research and development spending.

The expert working group had met for the first time in January 2009 and would meet again in June and in November 2009. Innovative proposals for financing would be reviewed at the second meeting, and the experts had requested the Secretariat to give Member States and stakeholders the opportunity to provide input in that regard.

The Board noted the report.

Chagas disease: control and elimination: Item 4.14 of the Agenda (Document EB124/17)

The CHAIRMAN drew attention to a proposed draft resolution on Chagas disease: control and elimination proposed by El Salvador on behalf of the Latin American and Caribbean Group, which read:

The Executive Board,

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

The Sixty-second World Health Assembly,

Having considered the report of the Secretariat on Chagas disease: control and elimination,

Expressing its satisfaction at the considerable progress achieved by countries towards the goal of eliminating Chagas disease by 2010, as recommended in resolution WHA51.14 of the Fifty-first World Health Assembly;

Underlining that 2009 will mark the 100th anniversary of the description of this disease by Dr Carlos Chagas;

Acknowledging the progress made with vector-control strategies;

Recognizing the success achieved through the intergovernmental initiatives in Latin America;

Taking into account the need for the harmonization of diagnostic and treatment procedures;

Recognizing the need for the provision of adequate care for late complications of the disease;

Underlining the need for more effective, safe and adequate drugs, including paediatric formulations, and for better coverage and distribution of those currently available;

Recognizing that the risk of transmission through blood transfusion, organ transplantation and congenital transmission is increasing;

Acknowledging the significant collaboration and support among Member States and the support of other partners and appreciating their continuous assistance,

1. URGES Member States:

- (1) to reinforce efforts to strengthen and consolidate national control programmes and to establish them where there are none;
- (2) to establish mechanisms to ensure broad coverage of adequate control measures, including the promotion of decent and healthy living conditions, prevention and the integration of specific actions within health services based on primary care;
- (3) to harmonize systems and strengthen capacities for surveillance, data collection and analysis and dissemination of information;
- (4) to promote and encourage operational research on control of Chagas diseases in order to:
 - (a) interrupt transmission by domestic insect vectors;
 - (b) develop more suitable, safer and more affordable drugs;
 - (c) reduce the risk of late complications of the infection;
 - (d) establish systems of early detection, in particular for the detection of new infections, of congenital infections in newborns and the reactivation of the disease in immunocompromised patients;
 - (e) harmonize blood-screening procedures;
- (5) to develop public health measures in non-endemic countries for the prevention of transmission through blood transfusion and organ transplantation, early diagnosis of congenital transmission and management of cases;

2. REQUESTS the Director-General:

- (1) to draw attention to the burden of Chagas disease and to the need to provide equitable access to medical services for the management and prevention of the disease;
- (2) to strengthen implementation of vector-control activities in order to achieve interruption of transmission and to promote research to improve or develop new prevention strategies;
- (3) to support the countries of the Americas in order to strengthen intergovernmental initiatives and the technical secretariat of PAHO/WHO as a successful form of technical cooperation among countries;
- (4) to collaborate in order that countries and intergovernmental initiatives set objectives and new goals for the elimination of the transmission of the disease;
- (5) to support the mobilization of national and international, public and private financial and human resources to ensure achievement of the goals;
- (6) to promote research on elimination of Chagas disease;
- (7) to support efforts at collaboration among multisectoral actors, networking among organizations and other interested parties to support the development and implementation of Chagas disease control programmes;
- (8) to report on progress in the elimination of Chagas disease to future World Health Assemblies.

The financial and administrative implications for the Secretariat were:

1. Resolution Chagas disease: control and elimination	
2. Linkage to programme budget	
Strategic objective:	Organization-wide expected result:
1. To reduce the health, social and economic burden of communicable diseases.	1.3 Effective coordination and support provided to Member States in order to provide access for all populations to interventions for the prevention, control, elimination and eradication of neglected tropical diseases, including zoonotic diseases.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
The resolution aims to strengthen activities linked with the following:	
<ul style="list-style-type: none"> • the information and surveillance system on the epidemiological distribution of Chagas disease • an enhanced and renewed strategy towards the elimination of Chagas disease. 	
3. Financial implications	
(a) Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)	
A maximum of US\$ 2 million per year including:	
<ul style="list-style-type: none"> • one staff member in the professional category for five years (at US\$ 188 000 per year) • distribution of medicines for five years (at US\$ 300 000 per year) • documentation costs, including guidelines and dissemination for five years (at US\$ 100 000 per year) • technical support to regions and countries for five years (at US\$ 1.4 million per year). 	
(b) Estimated cost for the biennium 2008–2009 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)	
<ul style="list-style-type: none"> • Distribution of medicines (US\$ 350 000) • Documentation costs including guidelines and dissemination (US\$ 150 000) • Technical support to regions and countries (US\$ 500 000) 	
(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009?	
This is a new initiative, the planned activities for which were not budgeted in the original workplan.	
(d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)	
Through an agreement with a pharmaceutical company (expected to be finalized in due course).	

4. Administrative implications**(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)**

Headquarters in collaboration with regional and country offices.

(b) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile)

No additional staff required beyond those planned for the biennium 2008–2009.

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

About 60 months.

Dr SERPAS MONTOYA (alternate to Dr Larios López, El Salvador) said that the Group of Latin American and Caribbean countries had studied the report, the achievements reached and new challenges. An estimated 16 to 18 million people worldwide were infected with the disease, 50 000 of whom died each year. The disease was prevalent in 19 countries in Latin America, and the number of cases identified in Europe and the United States of America was increasing as a result of migration. El Salvador had been implementing an integrated plan involving surveillance, education, prevention and control aimed to identify acute cases. Between 100 and 110 new cases were identified each year, mainly in children under 15 years of age, all of whom were treated.

The countries of the Latin American and Caribbean Group had submitted the draft resolution recognizing that the considerable progress made by countries was not sufficient to achieve the goal of eliminating Chagas disease by 2010, as recommended by the Health Assembly in resolution WHA51.14. Its adoption would provide for continued support and would strengthen prevention and control, and research into the disease.

Dr DJIBO (Niger), speaking on behalf of the Member States of the African Region, expressed support for the draft resolution. Chagas disease, like its sister disease human African trypanosomiasis, was a neglected tropical disease, and the African group welcomed WHO's efforts to combat such diseases. He thanked the Drugs for Neglected Diseases Initiative for its efforts to encourage pharmaceutical companies to develop more effective, non-toxic and affordable medicines. He highlighted their work on diseases which, because they affected poor populations who could not afford medicines, suffered from a lack of research and were neglected by manufacturers.

Mr ABDOO (alternate to Dr Wright, United States of America) said that his country attached priority to combating neglected tropical diseases. It welcomed WHO's efforts to combat Chagas disease and encouraged continued technical assistance to countries attempting to control its spread. His Government supported the screening of blood for *Trypanosoma cruzi* in both non-endemic and endemic countries in order to prevent transmission through blood transfusion, organ transplantation and pregnancy. Accordingly, he suggested that the text of subparagraph 1(4)(e) of the draft resolution be replaced with: "optimize blood transfusion safety in endemic and non-endemic areas". The words "endemic and" should also be inserted in subparagraph 1(5) after "health measures in".

Dr DAHL-REGIS (Bahamas), commending WHO's efforts to combat Chagas disease, said that her country wished to sponsor the draft resolution.

Mr VIEGAS (alternate to Dr Buss, Brazil) said that neglected diseases such as Chagas disease were directly related to poverty and relevant to the social determinants of health, access to medicines, safe blood donation, primary care, and the strengthening of health systems. The report did not give a

balanced representation of the achievements of the Region of the Americas in their efforts to eliminate transmission of Chagas disease by 2010.

Brazil had been certified as a country free of vector-borne transmission. All donated blood was screened for the causative parasites. Brazil provided free treatment for all citizens and, in partnership with the Drugs for Neglected Diseases Initiative, it would be producing paediatric formulation of benznidazole. He was pleased that the item had been placed on the Board's agenda, particularly in the centenary year of the discovery of the disease by the Brazilian, Dr Chagas, and noted that an exhibition on Dr Chagas would be taking place at the Palais des Nations during the Sixty-second World Health Assembly.

Dr ADITAMA (alternate to Dr Supari, Indonesia) said that, although Member States in the South-East Asia Region did not suffer from Chagas disease, they had to deal with other neglected tropical diseases including leprosy, lymphatic filariasis and yaws. Indonesia supported the draft resolution. Greater priority should be given to tackling neglected tropical diseases around the world.

Dr NAKATANI (Assistant Director-General) thanked the Board for its guidance and support concerning neglected tropical diseases in general. Remarkable progress had been made in controlling Chagas disease in Latin America in the 100 years since its discovery, as a result of efforts by the countries themselves, which deserved congratulation, with technical support from PAHO/WHO Regional Office for the Americas. However, the disease had not yet been eliminated and cases were being reported from a wider geographical area. Noting the broad implications of the disease, he said that it was timely in the centennial year of its discovery to reaffirm commitment to addressing old and new challenges. The Secretariat was committed to working harder with Member States in order to transform the Board's guidance into broad action, and confident of achieving further progress.

Dr ALVIÁREZ (Bolivarian Republic of Venezuela),¹ having endorsed the draft resolution, said that more emphasis should be given to education and active community participation in research and control of the disease. In his country the disease was not confined to rural communities; the vector had been identified in heavily populated and sometimes affluent urban communities. The expansion of the disease meant that it must be tackled at the international level and with the close involvement of local communities.

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

Dr SERPAS MONTOYA (alternate to Dr Maza Brizuela, El Salvador) said that the countries of the Latin American and Caribbean Group wished to consider the amendments further. Mr VIEGAS (alternate to Dr Buss, Brazil) endorsed that position.

Dr DAHL-REGIS (Bahamas) said that she supported the minor amendments made by the member for the United States and wished to adopt the draft resolution.

Dr GIMENÉZ CABALLERO (Paraguay) said that he wanted to consider the proposed amendments further.

The meeting was suspended briefly for informal discussions on the proposed wording of the draft resolution.

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

Dr KEAN (Executive Director, Office of the Director-General) said that, following the informal consultations, it was proposed that in subparagraph 1(4)(e) “harmonize blood screening procedures” should be replaced by “optimize blood transfusion safety and screening procedures in endemic and non-endemic countries, with special focus on endemic areas”. It was further proposed that the beginning of subparagraph 1(5) should be amended to read: “to develop public health measures in endemic and non-endemic countries, with special focus on endemic areas”, with the paragraph then continuing unchanged from “for the prevention of transmission ...”.

Dr ALVIÁREZ (Bolivarian Republic of Venezuela)¹ said that, although his Government supported the draft resolution as amended, he wished to stress the importance of community participation. He also emphasized that financing might be public or private.

The resolution, as amended, was adopted.²

WHO’s role and responsibilities in health research: Item 4.9 of the Agenda (Documents EB124/12, EB124/12 Add.1 and EB124/12 Add.2) (resumed)

Mr HOHMAN (alternate to Dr Wright, United States of America) said that, following informal consultations, a change had been agreed in paragraph 63 of the strategy, which might perhaps be read out at a later time. In the draft resolution, it was proposed that the latter part of subparagraph 3(4) of the draft resolution should read: “... and to collaborate with WHO Member States and the WHO Secretariat to better align and coordinate the global health research architecture and its governance through the rationalization of existing global health research partnerships, to improve coherence and impact, and to increase efficiencies and equity”.

It was also proposed that the latter part of subparagraph 4(2) should read: “and in coordination with the references to research for health in the ...”, with the paragraph then continuing unchanged from “Global strategy ...”. It was further proposed to incorporate the amendment submitted by the member for the United Kingdom, replacing the word “streamline” with “align” in subparagraph 4(5).

The rationale for his Government’s proposal to delete “Member States” from subparagraphs 3(1) and 3(2) was that the research strategy was an internal strategy of the Secretariat, not a negotiated strategy for Member States, which made it inappropriate to refer to Member States implementing that strategy.

Ms ROCHE (New Zealand) suggested that in the fifth preambular paragraph “WHO, as a leading global health organization” should be changed to “WHO, as the leading global health organization”.

Dr LUKITO (alternate to Dr Supari, Indonesia) requested that time be allowed for additional informal consultations on the draft resolution.

The CHAIRMAN took it that the Board wished to postpone further consideration of the draft resolution.

It was so agreed.

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

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

² Resolution EB124.R7.

Capacity-building to constructively engage the private sector in providing essential health-care services: Item 4.15 of the Agenda (Document EB124/18)

The CHAIRMAN drew attention to a draft resolution entitled “Capacity building to constructively engage the private sector in providing essential health-care services” proposed by Bangladesh, China, Oman, Republic of Korea, Sri Lanka and Thailand, together with its financial and administrative implications for the Secretariat, which read:

The Executive Board,

Having considered the report on capacity building to constructively engage the private sector in providing essential health care-services,¹

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

The Sixty-second World Health Assembly,

Recalling resolution WHA58.33 on sustainable health financing, universal coverage and social health insurance which calls for the collaboration between public and private providers and health financing organizations to achieve universal coverage;

Recognizing the significant health expenditure in and services provided by private health sectors;

Recognizing that in Africa as a whole the private health-care sector is expected to grow by more than 100% between 2005 and 2016, compared with an increase of about two thirds in the public health sector, which underscores the potential role of private health sector in achieving the national health systems goals;

Noting the wide range of private sector providers, including formal and informal providers, and that the cost and quality of care may vary considerably;

Concerned that in the context of emerging and re-emerging diseases where substantial cases of notification diseases were managed by private health sector and this information is not covered by the national surveillance systems;

Noting the limitation of health information systems in particular developing countries, in relation to the private health sector which hampers appropriate policy interventions;

Noting in particular developing countries, the poorly resourced and lack of staff in accreditation agencies, the limited size of social health insurance agencies hamper the opportunity to engage private health sector to achieve the health systems goals;

Recognizing the fact that where there is government institutional capacity to govern the private health sector and where relations between public and private are well-managed, private providers can play a significant role in providing essential health services;

Concerning over the international agencies advocate the role of private providers in expanding access to care, but limited attention has invested in enhancing the role and capacity of government in providing policy guidance, exercising oversight, defining and enforcing the mix of incentives and regulation needed;

Aware that trust and constructive policy dialogues between public and private health sector results in improved human resources planning;

¹ Document EB124/18.

Concerned that the information, administrative and political constraints impede the capacity and stewardship function of the government in relation to private sector role;

Noting the WHO's ongoing work on the renewal of primary health care can contribute to consolidate experience, document best practice and plan the way ahead, particularly regarding the role of private providers,

1. URGES Member States:

- (1) to assess the relationship between the public and private health sector in order to achieve the national health systems goals effectively;
- (2) to assess, build up and strengthen the capacity of the public sector, professional councils where appropriate, through adequate funding and staffing; strengthen the insurance agencies to involve private health sector through their role of purchasing, price setting and providing information to consumers;
- (3) to strengthen and support the role of governmental and nongovernmental health-consumer protection agencies including patient groups;
- (4) to establish policy forum to facilitate continued dialogues between public and private sector to enhance trust building, joint infrastructure and human resources planning in order to synergize the role of public and private health sectors;
- (5) to develop and strengthen disease surveillance and information sharing networks between the public and private health sector to achieve an effective disease prevention and control;
- (6) to accelerate the expansion of public health insurance and its roles in re-orienting public and private providers towards a proper mix of personal care and public health interventions through purchasing and contractual arrangements;

2. REQUESTS the Director-General:

- (1) to convene technical consultations on health systems and policy research agenda in relation to public-private partnership;
- (2) to compile, synthesize and disseminate lessons and good practices from developed and developing countries on the role of private health sector in providing essential health services and achieving national health systems goals;
- (3) to provide technical assistance to Member States, upon request, in their efforts to strengthen the capacity of the ministries of health and other regulatory and financing agencies in order to improve the capacity of the private health sector;
- (4) to collaborate with and support development partners, nongovernmental organizations, private foundations, private health institutions and other global and regional partnerships, in their support for strengthening the capacity of the government and other relevant agencies in Member States to work constructively with the private health sector.

1. Resolution Capacity building to constructively engage the private sector in providing essential health care services	
2. Linkage to programme budget	
Strategic objective:	Organization-wide expected result:
10.To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research.	10.2 National capacities for governance and leadership improved through evidence-based policy dialogue, effective governance and leadership, institutional capacity building for policy analysis, greater transparency and accountability for

performance, and more effective intersectoral collaboration.

(Briefly indicate the linkage with expected results, indicators, targets, baseline)

The resolution is fully consistent with both the expected result and the indicators associated with it. Implementation of the strategy is expected to contribute to meeting the target set for the expected result. The relevant baselines will remain largely the same.

3. Financial implications

(a) Total estimated cost for implementation over the life-cycle of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)

In line with previous practice with regard to draft resolutions, the estimated cost only relates to the convening of the technical consultations; the cost of the other activities that the Organization is requested to perform – knowledge dissemination, technical assistance and collaboration with partners – is not included. The cost of technical consultations, if held in all regions, will be US\$ 900 000.

(b) Estimated cost for the biennium 2008–2009 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)

US\$ 450 000, incurred in the regional offices and at headquarters.

(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities for the biennium 2008–2009?

None

(d) For the amount that cannot be subsumed under existing programmed activities, how will the additional costs be financed? (indicate potential sources of funds)

Voluntary funds will need to be mobilized.

4. Administrative implications

(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant)

Headquarters and regional offices

(b) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile)

None

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

For the technical consultations, implementation would take place during 2009 and 2010. Activities related to the other elements of the resolution are part of the continuing work of the Secretariat.

Mr JAYANTHA (alternate to Mr de Silva, Sri Lanka) observed that the private health sector existed in all countries and the quality of the health services that were provided ranged from very good to poor. The intention of the draft resolution was to build the capacity of Member States to steer the private sector in a proper manner, not to expand the role of the sector. Sri Lanka had set up a special

council to guide the private sector in providing affordable high-quality care to supplement government services. He urged adoption of the draft resolution.

Dr JAKSONS (Latvia) said that the recommendations in the report could be broader, and could be important for countries in transition and for those reforming their health-care systems, particularly in the current economic crisis. Some issues remained unresolved with regard to the engagement of the private sector including how best to use public money in strengthening health-care systems; how to purchase cost-effective and quality services by the use of benchmarking; and which services should be offered exclusively by the public sector.

The draft resolution acknowledged the advantages offered by private health-care providers and emphasized the role of purchasing as a regulating mechanism. It made recommendations on the role of the public sector, government bodies and nongovernmental organizations in providing quality of care and consumer protection. He supported it but suggested that the title should be expanded to include “in low- and middle-income countries”. He also suggested that subparagraph 2(1) should call for an evaluation of best practices in public–private cooperation leading to recommendations or principles for making effective use of public money.

Dr KÖKÉNY (Hungary), speaking on behalf of the Member States of the European Union, recognized that the private sector could have an important role in health service provision and welcomed the draft resolution. However, some countries considered that the estimated costs for implementation were too high, particularly those for the technical consultations that the Director-General was asked to convene. Speaking as the member for Hungary, he endorsed the comments made by the member for Latvia.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) acknowledged the important role of the private sector in the delivery of health care, but suggested that in some parts of the draft resolution the emphasis was misplaced. For example, the third preambular paragraph referred to the “potential role of the private health sector in achieving national health systems goals”. He was not aware of any evidence for such a role. The draft resolution seemed to emphasize the limitations of health information systems, whereas in his view the principal limitation of the private sector had to do with its impact on equity of access to health services. The resolution should include some reference to that potential for inequity.

The draft resolution seemed to emphasize all the positives of the private sector, rather than suggest the use of resources to strengthen health services in publicly run systems. The draft resolution had not been intended to offer an uncritical promotion of the role of the private sector, but that was inadvertently suggested by some of its language. He looked forward to a more balanced revised draft.

Dr KAMOTO (Malawi), speaking on behalf of the Member States of the African Region, said that almost half the total expenditure on health in the African Region (and 58% in Malawi) was spent on private providers. Perceptions of greater respect and confidentiality, and greater availability of medicines favoured private providers. In some countries the trend towards greater involvement in health care by the private sector had been associated with the start of the AIDS epidemic. A country such as Malawi, with an HIV prevalence of 12% and a weak health system, could not have afforded to treat the entire population in need of antiretroviral therapy through its public health services and had therefore designed its antiretroviral programme to include all health-care providers as part of a single national system. It had improved access to safe, affordable, quality services. Government control enhanced relations of trust with the private sector and improved accountability and transparency.

Following the International Conference on Primary Health Care and Health Systems in Africa (Ouagadougou, 28-30 April 2008), at which Member States had been urged to promote public–private partnerships, many international agencies had focused on private providers, but without sufficient attention to equity, cost and affordability. The countries of the African Region called upon the

Director-General to help governments to enhance their ability to provide policy guidance, exercise oversight and apply the mix of incentives and regulations needed in order to protect people from the harm they might suffer as a result of seeking medical services from unregulated private providers. Malawi wished to become a sponsor of the draft resolution.

Professor ALI (alternate to Professor Haque, Bangladesh) said that efficient operation of public services was a great challenge to developing countries. The private sector might, in special conditions, be involved in providing such services, although the government's intentions regarding the outsourcing of health services might be misinterpreted. Patients might have to cover the cost of certain medicines or medical tests because the government lacked the money. Such fees could be invested in the improved quality and maintenance of services. Active community involvement could help to improve the behaviour of providers, the supply of medicines and the quality of services.

The involvement of the private sector, as a partner of the public sector in the provision of high standards of essential health-care, should be pursued. The revitalization of primary health care would require the direct engagement of the private sector and of all development partners. He called on the Secretariat to support countries in establishing harmonious relations between the public and private sectors in a mutually beneficial environment.

Mr TSESHKOVSKIY (alternate to Dr Starodubov, Russian Federation) said that the market for fee-paying medical services was growing in the Russian Federation. Heavy maintenance expenditures on the health-care infrastructure had necessitated private fees for certain services in State institutions in order to preserve the public nature of the health-care system. However, that had adversely affected the moral climate in such institutions and had blurred the distinction between the services provided by the State free of charge and paid medical services. That had led to the growth of under-the-counter payments, reduced access to care and had adversely affected the medical profession.

The issue of public-private partnerships within the health-care field was of increasing concern both to the public and to medical professionals in his and other countries. In many countries the transition from a State health-care system to a mixed public-private system was creating challenges, such as the privatization of jobs in the health sector and the threat of privatization in the social sector. He welcomed the Board's discussion of the matter, which would encourage sharing of experiences, identify best practices and planning for future work.

The report allowed for different ideological interpretations. The Secretariat had not taken any position with regard to managing public-private partnerships or the privatization of certain medical services, nor had it prioritized particular strategies for enhancing the role of the public sector in such partnerships. The report gave the impression that the Secretariat's activities were geared towards analysing and encouraging the participation of the private sector in primary health care. However, the experience of the Russian Federation and other countries had showed that the privatization of medical services had reduced the access to, and quality of, medical services and had undermined the effectiveness of health-care systems. The Secretariat should focus on identifying the optimal balance between the public and private sectors in the delivery of health services.

Dr BIN SHAKAR (United Arab Emirates) said that in his country the private sector was a crucial partner not only in the provision of health services but also in education, training and research. Nevertheless, the provision of health-care services in the private sector should be closely monitored in order to protect public health. Unregulated and unlicensed private providers, to which the report made reference, might provide counterfeit medicines, a problem which had occurred in his country. WHO should support the establishment and strengthening of international information networks in that area.

Dr REN Minghui (China) said that private providers were important to his country's national health system. China encouraged and supported private funding of health-care services and promoted complementarity between the private and public sectors in order to meet the nation's health needs.

Private-sector engagement in essential health-care services should be encouraged, and guidance and supervision strengthened. The private sector must be required to respect regulations and standards and to put into practice quality control schemes in order to improve services and safety. He looked forward to working with other members in order to improve the draft resolution.

Dr GIMENÉZ CABALLERO (Paraguay) expressed support for the report. Although he agreed with the intent of the draft resolution, he could not approve it as currently drafted. The penultimate preambular paragraph referred to the constraints impeding the stewardship function of the government in relation to the private sector. The resolution should emphasize the stewardship role of health ministries and the leadership that they should exercise within the system.

Subparagraph 1(2), regarding the private sector, referred exclusively and restrictively to insurance companies. As mentioned in the report, the private sector comprised both for-profit and non-profit-making entities, and there were different categories within those groups, not only insurance companies. The same was true in subparagraphs (4) and (6). Subparagraph 1(6) contained a proposal relating to the various types of entities that constituted the private sector.

In Paraguay, the private sector accounted for only 7% of health-care services. The Government wished to expand its public sector coverage, as 38% of the population had been excluded from health services owing to social and economic inequities. Subparagraph 1(4) should emphasize stewardship and leadership. Subparagraph 2(3), which referred to improving the capacity of the private health sector, again seemed to limit the role of health ministries.

The draft resolution should also provide opportunities to focus on important areas mentioned in the report, such as the primary health care strategy which should be given special emphasis.

The draft resolution should deal with the issue of shared risk. Privately insured patients with limited insurance coverage often incurred high treatment costs. Thus the economic burden again fell on the public sector, and there was no mechanism for offsetting costs between the public and private sectors. With regard to HIV, not all insurance companies and private insurance models covered all aspects of HIV prevention and treatment, such as treatment of opportunistic infections. The same was true for other catastrophic illnesses.

Although he shared the strategic view of the item and believed that public-private and public-public linkages would help to strengthen health systems, the draft resolution did not cover all the issues that had been mentioned, even those in the report. For that reason he recommended that a working group should be established to continue enriching the document.

Dr MOHAMED (Oman) said that, in the Eastern Mediterranean Region, the private sector played a major role in delivery of health services. In some countries, the public sector purchased health services from the private sector. Certain other countries depended almost entirely on the public sector. As noted in the draft resolution, the spread of health services in such a manner could at some point fail to fulfil the health-care requirements.

Many countries in the Region had implemented policies whereby the health ministries performed essential public health functions and turned to the private sector for secondary or tertiary services, or even for primary health care. That had been true 10 years earlier, when the trend had been towards privatization. Genuine partnership was needed between the sectors so that the private sector could play a constructive role, rather than simply harnessing profits. In many countries the private sector did not deal with communicable diseases; in Oman, for example, tuberculosis was considered to be within the purview of the public sector. For that reason, Oman had joined other Member States in submitting the draft resolution, which aimed to encourage the private sector to assume more responsibility. He welcomed the suggestion by the United Kingdom and China that a working document should be prepared that would meet the requirements of other partners.

Dr DAHL-REGIS (Bahamas) said that most governments were engaged in some form of private health-care delivery. She welcomed the statement by the member for Latvia and the experience which

he had shared in that regard. She observed that capacity-building to constructively engage the private sector in providing health-care services appeared to focus on low- and middle-income countries. She expressed concern that many of the countries that needed such support would be excluded, particularly in the Caribbean region.

Her Government had submitted a number of proposed amendments to the draft resolution. The draft resolution referred exclusively to insurance agencies, and there was no recognition of the inequities that resulted from private arrangements. The document should distinguish arrangements were for-profit from those that were non-profit-making, which were beneficial and which were exploitative, and highlight the best practices. It should also recognize that policy must be established by governments and not by private services. She acknowledged the importance of the draft resolution and looked forward to participating in its redrafting.

Mr HOHMAN (alternate to Dr Wright, United States of America) said that the private sector was one element, albeit a crucial one, that complemented the public and nongovernmental sectors in providing health services around the world. He supported efforts to build constructive relationships between public sector and private providers. In view of the mixed public-private nature of health-care delivery in his country, the building of trust between the two sectors was needed, as reflected in the report. He supported the general thrust of the draft resolution but wished to take part in further discussions to improve the text.

Ms TOELUPE (Samoa) said that the private health-care sector was in its infancy in many small Pacific island States. Samoa would require technical assistance from WHO in the areas of national policy guidance; the ability to exercise oversight; and in defining and enforcing the mix of incentives and regulations that were needed. She looked forward to the revised version of the draft resolution.

Ms ROCHE (New Zealand) said that the private sector could play an important role in financing and delivering health care. However, there were also potential negative effects from its involvement, as the member for the United Kingdom had stated.

The draft resolution should clearly establish that any private-sector involvement in providing essential health care aimed to improve health outcomes among the population; and that that involvement should not contribute to health inequities. The private sector should be subject to similarly appropriate regulation and monitoring as that of the public sector, in order to ensure that safe and effective care was delivered.

She had several amendments to propose to the draft resolution and looked forward to working with other members in order to achieve consensus.

Dr ALVIÁREZ (Bolivarian Republic of Venezuela)¹ said that he did not concur with the report, and supported the member for Paraguay in his rejection of the draft resolution. In his country, private insurance existed but the Constitution required, and his Government strove to ensure, that public insurance and social security had the widest coverage. Since most WHO documents gave due weight to the private sector, he questioned the need for a resolution aiming to strengthen or stimulate the private sector. The private sector always had a profit motive, and thus had always been excluded from health care. His Government believed that the public sector should exercise stewardship, and that any role of the private sector should be regulated. If a draft resolution implied the need to regulate the private sector, his Government was prepared to support it, otherwise, it would reject it. He proposed that the title of the resolution should be changed to “Strengthening the State’s regulatory capacity in order to constructively engage the private sector in providing essential health-care services”.

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

Dr MUÑOZ (Chile)¹ said that it was essential to strengthen the regulatory capacity of governments in order to make proper use of public and private health resources. In many countries, the for-profit and non-profit-making private sector met the health needs of a large share of the population. The difficulty of defining the private sector, which could encompass a private general practice, a nongovernmental organization, large clinics or a health insurance industry, sometimes prevented focus on the main points of the draft resolution.

He recalled recent debates concerning the impact of health services on efforts to achieve the Millennium Development Goals. Clearly, proper coordination between both public and private services would contribute to the achievement of those goals.

Private health care often lacked coordination and regulation by the health authorities, with resulting difficulties in complying with plans for rational management of health services. He also believed that the unregulated use of fees for health services contributed to a disproportionate increase in the cost of medical care. It was vital, therefore, to promote efficient public health services.

Chile supported the draft resolution's basic concept of engaging the private sector and would participate in its further drafting. He suggested that the development of health services should be coordinated with the work of other agencies, such as the work carried out by the ILO on community health insurance.

Dr BABB-SCHAEFER (Barbados)¹ said that the private health-care sector in small island developing States faced particular challenges, such as the high cost of labour and the lack of economies of scale. Accordingly, in the interest of equity, particular assistance in capacity-building to engage the private sector should be given not only to low- and middle-income countries, but also to small high-income countries such as Barbados and others in the subregion. She supported the statement by the member for Bahamas.

Ms MATSAU (South Africa)¹ said that South Africa had a long history of public-private partnerships. She emphasized effective regulatory frameworks, as well as complementarity between sectors and health-care services, in order to ensure the correct balance. The government must be able to identify strategic areas where the private sector would achieve optimum results.

She shared the views expressed by the member for Paraguay. The draft resolution asserted in the third preambular paragraph that in Africa the private health-care sector was expected to grow by more than 100% between 2005 and 2016. That was extremely unlikely to happen, in South Africa at least, because of poverty and lack of access to services. Since it was recognized that about 80% of the population of developing countries depended on the public health-care system, she questioned why WHO was putting forward a resolution which appeared to support the growth of the private sector. The drafting of a resolution should seek to enhance the capacity of the public sector to exercise its leadership and stewardship role. She supported the proposal to establish a working group in which South Africa would wish to participate.

Dr VIROJ TANGCHAROENSATHIEN (Thailand)¹ said that, in searching the Health Assembly resolutions in WHO's electronic database, he had found only one that dealt with the role of the private sector. The other resolutions supported the role of governments in health-care services. However, the private sector was engaged to one degree or another in nearly all countries, and its existence must be acknowledged. It was necessary to work constructively with the private sector to achieve health goals.

There appeared to be some misunderstanding with regard to subparagraph 1(6) of the draft resolution, which read "to accelerate the expansion of public health insurance". Although he could not

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

read Spanish, he doubted that, in the Spanish version of the draft resolution, “public health insurance” was translated as “insurance companies”. If so, that was a factual error. Otherwise, there was a misunderstanding on the part of a member of the Board or a Member State that the draft resolution proposed the accelerated expansion of private insurance companies, which was not the case. The draft resolution proposed to expand public health insurance, or social health insurance, in accordance with resolution WHA58.33. The role of social health insurance was to engage both the public and the private sector in achieving health-system goals through contracting arrangements, purchasing functions and methods of payment by providers, thereby expanding efficient and equitable health-care services. He welcomed further consideration of the draft resolution by a drafting group with a view to achieving consensus.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) explained that, despite his constructive criticisms of the draft resolution, he strongly favoured the emergence of a resolution from the working group. In the United Kingdom, the National Health Service used Government funding to purchase care from private providers for its patients, while also providing public services. His Government regarded that as good practice; the private sector brought skills, modernization and a challenge to the system. However, the population was universally covered, whether people were treated in a public or a private hospital. The Government did not tell its citizens that they should find insurance coverage or draw on their funds, and he could not foresee that happening.

The population of every country was divided into, first, those who had access to safe, high-quality health services and, secondly, those who did not, either because no care was available or because of their social or economic circumstances. The main purpose of the draft resolution was to increase numbers in that first category and reduce those in the second.

Dr ETIENNE (Assistant Director-General) requested clarification on the balance that should be brought to the report. It had been suggested that the report should be entitled “Strengthening the leadership role of the government to engage with the private sector”, thus placing more emphasis on supporting the government in that role. Millions of people depended on private health services, even for their primary care. Good leadership and governance were also essential. Governments must respond to the reality that the private sector existed, and must do so as part of their efforts to increase access to, and equity of, health care. The scaling up of primary health care with a view to achieving the Millennium Development Goals clearly required Member States to take all providers into account; and to ensure that all care was provided in an ethical, safe and high-quality manner. Moreover, it should be affordable.

There was an issue with regard to evidence. The Secretariat needed more time to conduct a literature review in order to identify and analyse the available evidence and any gaps, and bring it to the Board in a more effective form. Government bodies responsible for engagement with the private sector should strengthen their oversight and regulatory capacity. The Secretariat would work with Member States to support and improve their stewardship and leadership role. Support must also be provided for monitoring, evaluation, guidance and the creation of a policy environment for stronger public–private engagement.

The DIRECTOR-GENERAL said that the representative of Thailand had articulated the importance for the Board of deliberating the role of the private sector. The private sector participated in the health-care system of every country, depending on the government’s policy and the country’s socioeconomic, cultural or historical circumstances. An unregulated private sector was a major concern for many Member States. An important issue for the Board to consider was how governments could engage constructively with the private sector, while exercising stewardship functions. She asked whether Member States were prepared to take on that challenge in a way that ensured that fewer people would be denied access to health care, irrespective of how the care was provided. It could be

provided by the public sector, by the profit-making private sector, or by the non-profit-making private sector. The term “private sector” should not be seen as unacceptable. One member had asked whether WHO was being used to promote the private sector. That was a decision for the Board to make. The Secretariat had no hidden agenda. The Secretariat encouraged the Board to have a robust discussion on the subject, and stood ready to assist the Board in its further deliberations on the draft resolution.

Professor ALI (alternate to Professor Haque, Bangladesh) suggested that an open-ended working group should be convened to discuss improvements to the draft resolution.

Mr HOHMAN (alternate to Dr Wright, United States of America) said that, in listening to the discussion, he had not heard overwhelming support for a resolution on the subject. The subject was complex and controversial. The Director-General and the Assistant Director-General had said that the Secretariat needed further guidance. Even if an informal working group were to be convened, as proposed by the member for Bangladesh, there were only two days left for it to work. He suggested that, rather than rushing to adopt a resolution at the current session, the Board should postpone its discussion of the issue pending further work.

Dr JAKSONS (Latvia), replying to the points raised by the member for the United Kingdom, said that there was a danger that the draft resolution would try to cover too much ground, from the relationship between private and public providers and financing mechanisms to governance, equality and transparency. He also understood from the debate that many African countries needed to know how they could ensure patient safety in situations where private health-care providers had entered the field because no other health care existed. It might be possible to formulate some narrow provisions on how to regulate that process as a first step. Otherwise, he agreed with the statement by the member for the United States of America.

Dr KÖKÉNY (Hungary) supported the statements by the members for Latvia and the United States. The private sector played a significant role in many countries, as emphasized by the Director-General’s statement in that regard. The Board should take note of its debate up to that point and ask the Secretariat to undertake further analysis with a view to considering a draft resolution at a later stage.

Dr REN Minghui (China) supported the proposal by the member for Bangladesh. Informal consultations should be held during the following week. That would at least provide guidance for the Secretariat in preparing a revised report and draft resolution.

The DIRECTOR-GENERAL requested that, if an informal working group were to be convened, as proposed by the members for Bangladesh and China, it should give guidance to the Secretariat on the elements to be included in the next version of a document, to be submitted to the Sixty-second World Health Assembly. On the basis of such guidance, the Secretariat could determine whether there was a need for a draft resolution and, if so, what its focus should be, given the complexity of the issue and the urgency of supporting the capacity of Member States to regulate the private sector.

Dr VIROJ TANGCHAROENSATHIEN (Thailand)¹ said that the Secretariat should make available more evidence on the strengths and weaknesses of both public and private health-care services. Thus, Member States would be better informed when they discussed any new draft resolution on the subject at the Health Assembly.

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

Mr HOHMAN (alternate to Dr Wright, United States of America), replying to the Director-General, said that the new report to be prepared by the Secretariat for the Health Assembly should include a draft resolution.

The CHAIRMAN said that, in the absence of any objections, he would take it that the Board wanted informal intersessional consultations on the subject to be held.

It was so agreed.

The meeting rose at 12:55.

ELEVENTH MEETING

Monday, 26 January 2009, at 09:10

Chairman: Mr N.S. DE SILVA (Sri Lanka)

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

Primary health care, including health system strengthening: Item 4.5 of the Agenda (Document EB124/8) (continued from the fifth meeting)

The CHAIRMAN invited the Board to consider the following draft resolution on primary health care, including health system strengthening, prepared by an informal drafting group and sponsored by Afghanistan, Argentina, Australia, Bangladesh, Canada, Chile, China, Egypt, El Salvador, India, Indonesia, Iran (Islamic Republic of), Japan, Kazakhstan, Malawi, Mali, Mauritania, Mauritius, Monaco, Morocco, New Zealand, Niger, Oman, Paraguay, Peru, Republic of Korea, Republic of Moldova, Russian Federation, Samoa, Singapore, Switzerland, Thailand, Tunisia, Turkey, Uganda, United Arab Emirates, Uruguay, Venezuela (Bolivarian Republic of) and Zimbabwe:

The Executive Board,

Having considered the report on primary health care, including health system strengthening,¹

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

The Sixty-second World Health Assembly,

Welcoming the efforts of the Director-General and recognizing the central role that WHO plays in promoting primary health care globally;

Having considered the report on primary health care, including health system strengthening;

Recalling the Declaration of Alma-Ata (1978), the Ottawa Charter for Health Promotion (1986), the United Nations Millennium Declaration (2000) and subsequent relevant resolutions of WHO's regional committees and Health Assemblies;²

Recalling also the discussions at the series of summits and global, regional and national conferences that have reaffirmed the commitment of Member States to primary health care and strengthening health systems;³

¹ Document EB124/8.

² Resolutions WHA54.13, WHA56.6, WHA57.19, WHA58.17, WHA58.33, WHA60.22, WHA60.24, WHA60.27, WHA61.17 and WHA61.18.

³ Including summits on health system strengthening, such as the G8 Hokkaido Toyako Summit (2008), International Conference on Global Action for Health System Strengthening (Tokyo, 2008), International Conference dedicated to the 30th Anniversary of the Alma-Ata Declaration of WHO/UNICEF on primary health care (Almaty, 2008), Latin American Social Summit (2006) and G15 Summit (2004); WHO regional meetings on primary health care, such as those at Buenos Aires (2007), Beijing (2007), Bangkok (2008), Tallinn (2008), Ouagadougou (2008), Jakarta (2008) and Doha (2008); and conferences on health promotion, such as Ottawa (1986), Adelaide (1988), Sundsvall (1991), Jakarta (1997), Mexico City (2000), Bangkok (2005) and the MERCOSUR Task Force on Health (since 1995).

Noting the growing consensus in the global health community that vertical approaches, such as disease-specific programmes, and integrated health systems approaches are mutually reinforcing and contribute to achieving the health-related Millennium Development Goals;

Recognizing the need to draw on the experiences, both positive and negative, of primary health care in the years since the Declaration of Alma-Ata and the Millennium Declaration;

Welcoming *The world health report 2008*,¹ published on the thirtieth anniversary of the international conference of Alma-Ata, that identifies four broad policy directions for reducing health inequalities and improving health for all: tackling health inequalities through universal coverage, putting people at the centre of care, integrating health into broader public policy, and providing inclusive leadership for health and also welcoming the Commission on Social Determinants of Health's final report;²

Reaffirming the need to build sustainable national health systems, strengthen national capacities, and fully honour financing commitments made by national governments and their development partners, as appropriate, in order to better fill the resource gaps in the health sector;

Reaffirming also the need to take concrete, effective and timely action, in implementing all agreed commitments on aid effectiveness and to increase the predictability of aid, while respecting recipient countries' control and ownership of their health system strengthening, more so given the potential effects on health and health systems of the current international financial and food crises and of climate change;

Strongly reaffirming the values and principles of primary health care, including equity, solidarity, social justice, universal access to services, multisectoral action and community participation as the basis for strengthening health systems;

1. URGES Member States:

(1) to ensure political commitment at all levels to the values and principles of the Declaration of Alma-Ata, keep the issue of strengthening health systems based on the primary health care approach high on the international political agenda, and take advantage, as appropriate, of health-related partnerships and initiatives relating to this issue, particularly to support achievement of the Millennium Development Goals;

(2) to accelerate action towards universal access to primary health care by developing comprehensive health services and by developing national equitable and sustainable financing mechanisms, mindful of the need to ensure social protection and protect health budgets in the context of the current international financial crisis;

(3) to put people at the centre of health care by adopting, as appropriate, delivery models focused on the local and district levels that provide comprehensive primary health care services, including health promotion, disease prevention, curative care and end-of-life services, that are integrated and coordinated according to need;

¹ *The world health report 2008: Primary health care – now more than ever*. Geneva, World Health Organization, 2008.

² Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health*. Geneva, World Health Organization, 2008.

- (4) to promote active participation by all people, in the processes of developing policy and improving health and health care, in order to support the renewal of primary health care;
- (5) to train adequate numbers of health workers, able to work in a multidisciplinary context, in order to respond effectively to people's health needs;
- (6) to ensure that vertical programmes, including disease-specific programmes, are developed and implemented in the context of integrated primary health care;
- (7) to improve access to appropriate medicines, health products and technologies, all of which are required to support primary health care;
- (8) to develop and strengthen health information and surveillance systems relating to primary health care in order to facilitate evidence-based policies and programmes and their evaluation;
- (9) to strengthen health ministries, enabling them to provide inclusive, transparent and accountable leadership of the health sector and to facilitate multisectoral action as part of primary health care;

2. REQUESTS the Director-General:

- (1) to ensure that WHO reflects the values and principles of the Declaration of Alma-Ata in its work and that the overall organizational efforts across all levels contribute to the renewal of primary health care;
- (2) to strengthen the Secretariat's capacities to support Member States in their efforts to deliver on the four broad policy directions for renewal of primary health care identified in *The world health report 2008*;
- (3) to collate and analyse past and current experiences of Member States in implementing primary health care and facilitate the exchange of experience, evidence and information on good practice;
- (4) to foster alignment and coordination of global interventions for health system strengthening, basing them on the primary health care approach, in collaboration with Member States, relevant international organizations, international health initiatives, and other stakeholders in order to increase synergies between international and national priorities;
- (5) to report to the Sixty-third World Health Assembly, and subsequently every two years to the World Health Assembly, through the Executive Board, on progress regarding this resolution, including reporting on the effectiveness of WHO in its support to countries in the implementation of primary health care.

Professor SOHN Myong-sei (Republic of Korea), supported by Dr MOHAMED (Oman), thanked the members of the informal drafting group for their work and the Secretariat for its expert advice. The new draft combined the main elements of two earlier draft resolutions with new input from other delegations.

Dr DAHL-REGIS (Bahamas), while commending the work accomplished on the new draft text, expressed concern at carrying out the monitoring and evaluation activities within the time set out in the draft resolution; perhaps e-health technology would assist the completion of the allotted tasks. Bahamas wished to be included as a sponsor of the draft resolution.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) and Dr KÖKÉNY (Hungary), speaking as the member for Hungary, asked for their countries to be included as sponsors of the draft resolution.

Mr BLOOMFIELD (alternate to Ms Roche, New Zealand) commended the members for Japan and the Republic of Korea for their leadership in the work on the new draft.

Dr ETIENNE (Assistant Director-General), replying to the member for the Bahamas, said that the Secretariat would carry out monitoring and evaluation by means of country focus activities, health system performance assessments and monitoring at the global level. The monitoring and evaluation system included an e-health component consisting of a web-based application of country profiles.

The draft resolution was adopted.¹

The CHAIRMAN invited the Board to consider the following draft resolution on traditional medicine, based on an earlier draft and sponsored by China, Djibouti, Malawi, Mexico, New Zealand, Republic of Korea, Republic of Moldova, Samoa, Singapore, South Africa, Sri Lanka and Thailand:

The Executive Board,

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

The Sixty-second World Health Assembly,

Having considered the report on Primary health care, including health system strengthening;²

Recalling resolutions WHA22.54, WHA29.72, WHA30.49, WHA31.33, WHA40.33, WHA41.19, WHA42.43, WHA54.11, and WHA56.31 **and WHA61.21**;

Recalling the ~~International Conference on Primary Health Care at Declaration of Alma-Ata 30 years ago and noting~~ **which stated, inter alia**, that **“The people have the right and duty to participate individually and collectively in the planning and implementation of their health care”, and “Primary health care relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community”**; ~~which may include access to traditional medicine~~

Noting that the term “traditional medicine” covers a wide variety of therapies and practices, which may vary greatly from country to country and from region to region, ~~and that traditional medicine may also be referred to as alternative or complementary medicine~~;

Recognizing traditional medicine as one of the resources of primary health-care services ~~to increase availability and affordability and to~~ **that could** contribute to improved health outcomes, including those ~~mentioned~~ in the Millennium Development Goals;

Recognizing that Member States have different domestic legislation, approaches, regulatory responsibilities and delivery models **related to primary health care**;

Noting the progress of ~~that~~ many governments ~~to date in integrating~~ **have made to include** traditional medicine into their national health systems;

Noting that progress in the field of traditional medicine has been ~~obtained in~~ **achieved by** a number of Member States through implementation of the WHO ~~t~~**Traditional m**edicine sStrategy 2002–2005;³

¹ Resolution EB124.R8.

² Document EB124/8.

³ Document WHO/EDM/TRM/2002.1.

Expressing the need for action and cooperation by the international community, governments, and health professionals and workers, to ensure proper use of traditional medicine as an important component contributing to the health of all people, in accordance with national capacity, priorities and relevant legislation;

Noting that the WHO Congress on Traditional Medicine took place from 7 to 9 November 2008, in Beijing, **China**, and ~~that~~ **adopted** the Beijing Declaration on Traditional Medicine ~~was adopted by the Congress on 8 November 2008;~~

Noting that African Traditional Medicine Day is commemorated annually on 31 August; in order to raise awareness and the profile of traditional medicine in ~~that~~ **the** African region, as well as to promote its integration into national health systems,

1. **URGES Member States, in accordance with national capacities, priorities, relevant legislation and circumstances:**

(1) to **consider** ~~adopting~~ and ~~implementing~~ the Beijing Declaration on Traditional Medicine in accordance with national capacities, priorities, relevant legislation and circumstances;

(2) to respect, preserve, ~~promote~~ and widely communicate, **as appropriate**, the knowledge of traditional medicine, treatments and practices, appropriately based on the circumstances in each country, **and on evidence of safety, efficacy and quality**;

(3) ~~to recognize the government's responsibility for the health of their people, and~~ to formulate national policies, regulations and standards, as part of comprehensive national health systems, to ~~ensure~~ **promote** appropriate, safe and effective use of traditional medicine;

(4) ~~to take action to integrate~~ **consider, where appropriate, including** traditional medicine into their national health systems based on national capacities, priorities, relevant legislation and circumstances, **and on evidence of safety, efficacy and quality**;

(5) to **further** develop ~~further~~ traditional medicine based on research and innovation ~~in line with the~~ **giving due consideration to the specific actions related to traditional medicine in the implementation of the** Global strategy and plan of action on public health, innovation and intellectual property ~~adopted in resolution WHA61.21~~ ~~governments, international organizations and other stakeholders should collaborate in implementing the global strategy and plan of action~~;

(6) to **consider, where appropriate**, establishing systems for the qualification, accreditation or licensing of traditional medicine practitioners and to assist traditional medicine practitioners to upgrade their knowledge and skills ~~based on national requirements~~ **in collaboration with relevant health providers**;

(7) to **consider** strengthening communication between conventional and traditional medicine providers and, **where appropriate**, ~~to~~ **establishing** appropriate training programmes for health professionals, medical students and relevant researchers;

(8) ~~to commemorate Traditional Medicine Day on days as individual Member States may decide, in order to provide education and understanding of traditional medicine as one of the resources of primary health care services~~ **to cooperate with each other to share knowledge and practices of traditional medicine and exchange training programmes on traditional medicine, consistent with national legislation and relevant international obligations,**

2. REQUESTS the Director-General:
- (1) to support Member States, **as appropriate and upon request**, in implementing the Beijing Declaration on Traditional Medicine;
 - (2) to update **the WHO's traditional medicine strategy on traditional medicine 2002–2005**, based on countries' progress and current new challenges in the field of traditional medicine;
 - (3) to **give due consideration to the specific actions related to traditional medicine in the implementation of the Global strategy and plan of action on public health, innovation and intellectual property, particularly through starting the agreed parts of the plan of action related to traditional medicine without prejudice to the existing mandates**;
 - (4) to continue providing policy guidance to countries on how to integrate traditional medicine into health systems, ~~step by step~~, especially to promote, **where appropriate**, the use of traditional/**indigenous** medicine for primary health care, **in line with evidence of safety, efficacy and quality**;
 - (5) to continue providing technical guidance ~~in order~~ to support countries to ensure the safety, efficacy and quality of traditional medicine;
 - (6) to strengthen cooperation with WHO collaborating centres, research institutions and nongovernmental organizations ~~in order~~ to share evidence-based information and to ~~organize various~~ **support** training programmes for national ~~capacity building~~ **capacity building** in the field of traditional medicine;
 - (7) ~~to provide support to the traditional medicine programme to implement above mentioned requests.~~

Dr REN Minghui (China) thanked all delegations, particularly that of the European Commission, for their contribution to the negotiations on the draft resolution.

The draft resolution was adopted.¹

WHO's role and responsibilities in health research: Item 4.9 of the Agenda (Document EB124/12) (continued from the tenth meeting)

The CHAIRMAN invited the Board to consider the following draft resolution on WHO's role and responsibilities in health research, based on an earlier draft and incorporating amendments proposed by Indonesia, Netherlands, New Zealand, Russian Federation, United Kingdom of Great Britain and Northern Ireland and United States of America:

The Executive Board,
Having considered the draft of the WHO strategy on research for health,²

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

The Sixty-second World Health Assembly,
Recalling resolution WHA58.34 on the Ministerial Summit on Health Research and resolution WHA60.15 on WHO's role and responsibilities in health research;

¹ Resolution EB124.R9.

² Document EB124/12.

Recognizing the contribution of research to the development of solutions to health problems and the advancement of health worldwide;

Aware that, in a rapidly changing world facing significant environmental, demographic, social and economic challenges, research will be increasingly essential for clarifying the nature and scope of health problems, and for identifying effective life-saving interventions and strategies;

Realizing the increasingly multidisciplinary and intersectoral nature of research for health improvement;

Affirming the roles and responsibilities of WHO, as a the [New Zealand] leading global health organization, in health research; [Indonesia]

Recognizing the need to strengthen the capacity of public sectors in health research; [Indonesia]

Acknowledging that research activities in the private and public sectors can be mutually supportive and complementary in improving health globally;

Conscious of the need to strengthen the conduct, management and coordination of WHO's activities in health research;

Cognizant of the need to better communicate WHO's research activities and results, especially to its Member States and partners;

Noting Welcoming [USA] the references to research for health in resolution WHA61.21 on the Global strategy and plan of action on public health, innovation and intellectual property and relevant conclusions and recommendations of the WHO Commission on Social Determinants for Health;

Taking into account the outcomes of the Global Ministerial Forum on Research for Health (Bamako, 17–19 November 2008),

1. ENDORSES the WHO strategy on research for health **annexed hereto [USA]**;
2. URGES Member States:
 - (1) to recognize the importance of research for improving health and health equity and to adopt and implement policies for research for health that are aligned with national health plans, that include the participation of all relevant sectors, public and private, that align external support around mutual priorities, and that strengthen key national institutions;
 - (2) **to consider drawing on the strategy on research for health according to their own national circumstances and contexts, and as part of their overall policies on health and health research; [Indonesia]**
or
~~(2) — to support the implementation of the research for health strategy according to their own national circumstances and contexts, and as part of their overall policies on health and health research; [USA]~~
 - (32) to strengthen national health research systems by improving leadership and management of research for health, by focusing on national needs, by establishing effective institutional mechanisms for research, by using evidence in health policy development, and by harmonizing and coordinating national and external support (including that of WHO);
 - (43) to establish, as necessary **and appropriate, [USA]** governance mechanisms for research for health, to ensure rigorous application of good research norms and standards, **including protections for human subjects involved in research, [USA]** and to promote an open dialogue between policy-makers and researchers on national health needs, capacities and constraints;

- (54) to improve the collection of reliable health information and data and to maximize, **where appropriate, [USA]** their free and unrestricted availability in the public domain;
- (65) to promote intersectoral collaboration and high-quality research in order to produce the evidence necessary for ensuring that policies adopted in all sectors contribute to improving health and health equity;
- (76) to initiate or strengthen intercountry collaboration with the aim of obtaining efficiencies of scale in research through the sharing of experiences, best practices and resources, the pooling of training and procurement mechanisms, and the use of common, standardized evaluation methods for research;
- (87) to consider, where appropriate, establishment of regional collaborating mechanisms, such as centres of excellence, in order to facilitate access by Member States to the necessary research and expertise to meet health challenges;
3. ~~INVITES CALLS UPON~~ **[USA] Member States, [Indonesia]** the health research community, international organizations, supporters of research, the private sector, civil society and other concerned stakeholders:
- (1) to provide support to the Secretariat ~~and Member States~~ **[USA]** in implementing the research for health strategy and in monitoring and evaluating its effectiveness;
- (2) to collaborate with the Secretariat ~~and Member States~~ **[USA]**, within the framework of the strategy, in identifying ~~global~~ **[USA]** priorities for research for health, ~~in agreeing norms and standards relating to research for health, [USA] in developing guidelines relating to research for health [Indonesia]~~ and in the collection of health information and data;
- (3) to assist the Secretariat and WHO's research partners in mobilizing enhanced resources for the identified global priorities for research for health;
- (4) to pay particular attention to the research needs of low-income countries, notably in areas such as technology transfer, research workforce, and infrastructure development **and other determinants of health [Indonesia]** particularly where this will contribute to the achievement of the Millennium Development Goals, health equity and better health for all **and to collaborate with WHO the Secretariat and Member States and the Secretariat [USA] to better align, and [USA] coordinate and harmonize the global health research architecture and its governance through the rationalization of existing organizations global health research partnerships [USA], to improve coherence and impact, and to increase efficiencies and equity; [UK]**
- (5) to support, where appropriate, technical cooperation among developing countries in research for health;
4. REQUESTS the Director-General:
- (1) **to provide leadership in identifying global priorities for research for health; [Netherlands seconded by UK]**
- (2) to implement the strategy within the Organization at all levels and with partners, **and in coordination with the references to research for health in [USA] the Global strategy and plan of action on public health, innovation and intellectual property [UK];**
- (3) to improve the quality of research within the Organization ~~and strengthen WHO's leadership in research for health;~~ **[Netherlands seconded by UK]**
- (4) to provide adequate core resources in proposed programme budgets for the implementation of the research for health strategy;

(45) to ensure that the highest norms and standards of good research are upheld within WHO, including technical, ethical and methodological aspects and the translation into practice, use and dissemination of results **and to review and streamline align [UK] the architecture and governance of the Organization's research activities and partnerships; [UK]**

~~(5) to provide support to Member States, upon request and as resources permit, in implementing the strategy in order to strengthen national health research systems and intersectoral collaboration; [USA]~~

or

(5) to provide support to Member States, upon request and as resources permit, in taking relevant actions to strengthen national health research systems and intersectoral collaborations; [Indonesia]

~~(6) to align better the work of WHO collaborating centres involved in research with the goals of the research for health strategy; to strengthen the role of WHO collaborating centres as a well-established, effective mechanism for cooperation between the Organization and countries in the field of research for health; [Russian Federation]~~

(7) to report to the Sixty-fifth World Health Assembly on the implementation of this resolution, through the Executive Board, in 2012.

Mr HOHMAN (alternate to Dr Wright, United States of America) said that he had two further editorial changes to propose and asked for more details on the proposed amendments to paragraph 63 of the draft WHO strategy on research for health (document EB124/12).

Dr KÖKÉNY (Hungary), speaking on behalf of the Member States of the European Union, said that he supported the amendments that had been proposed by member for the United Kingdom of Great Britain and Northern Ireland and representative of the Netherlands.

Dr LUKITO (alternate to Dr Supari, Indonesia) said that his delegation's proposed amendment to subparagraph 2(2) was intended to resolve the ambiguity of the original draft. Paragraph 3 should be addressed to Member States as well as the health research community, international organizations and other bodies listed, and the reference to Member States should accordingly be retained both in the heading and in subparagraph 2.

His delegation had proposed a reference to developing guidelines relating to research for health in subparagraph 3(2). If WHO had not yet developed any such guidelines then a new subparagraph requesting the Director-General to do so should be added in paragraph 4.

Dr MAIGA (alternate to Mr Touré, Mali) said that obtaining financing for health research was an acute problem for the countries of Africa. She proposed that a subparagraph should be added to paragraph 4 calling upon the Director-General to promote the provision of increased financing for health research, particularly for developing countries.

Dr EVANS (Assistant Director-General) said that it was proposed to amend paragraph 63 of the draft WHO strategy on research for health to read: "[access] ... to data, tools, materials and literature, which may arise due to restrictions placed on their use ...".

Replying to the member for Indonesia, he said that, in the section of the draft strategy entitled "Standards goal", it was stipulated that the Secretariat should develop norms and standards for best practice in the management of research (paragraph 59(b)). The point was therefore covered by subparagraph 4(2) of the draft resolution.

Replying to the member for Mali, he said that, as indicated in the section of the draft strategy entitled "Priorities goal", WHO played the role of an advocate for financial support for research for health. It would not, however, necessarily mobilize funding itself.

The DIRECTOR-GENERAL said that the Secretariat's advocacy role in supporting research for health was mentioned at several points in the draft strategy. She could probably play no greater role than that in the mobilization of funding for research for health and it might, therefore, be inappropriate to mention the issue explicitly in the draft resolution.

The CHAIRMAN suggested that the agenda item should be suspended for a short time, to allow the Secretariat to search for precedents in the wording of earlier resolutions that might reflect the concerns of the member for Mali.

It was so agreed.

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

International recruitment of health personnel: draft global code of practice: Item 4.10 of the Agenda (Documents EB124/13, EB124/13 Add.1 and EB124/INF.DOC./2) (continued from the eighth meeting, section 2)

Dr ETIENNE (Assistant Director-General) recalled that informal discussions had been held to consider a consultative process on the draft WHO code of practice on the international recruitment of health personnel. Participation, timing, methodology and cost-effectiveness had been considered in those discussions. Reaching consensus on the code of practice would necessitate further consultation and effective Member State participation. Member States had identified that the process should be driven by Member States and open-ended, with the widest inclusion of stakeholders, particularly source countries. Global consultations should build on those held at national and regional levels. It was unlikely that an effective and broad-based process could be completed before the Sixty-second World Health Assembly. One approach would be to hold consultations at all levels, leading to consideration of a revised draft code by the Executive Board at its 126th session in January 2010, with the possible submission of that revised draft to the Sixty-third World Health Assembly.

The Board still needed to consider how to advance the process; two options had been proposed: the first would mean that the item remained under the remit of the Executive Board; it would not be placed on the provisional agenda of the Sixty-second World Health Assembly but would be noted as part of the report of the Executive Board on its 124th session. The Director-General would request the Regional Directors to place the item on the provisional agendas of the regional committee sessions to be held later in 2009, and would subsequently report to the Executive Board at its 126th session. The second option would be to place the item on the provisional agenda for the Sixty-second World Health Assembly in order to allow broader debate within the ongoing consultation process. The report could be noted by the Executive Board at its 124th session and the Director-General would prepare a report to present to the Sixty-second World Health Assembly.

Mr HOHMAN (alternate to Dr Wright, United States of America) expressed a preference for the first option as a way forward given the different views on the issue. The regional discussions and revised code of practice that had been proposed would avoid the need for further exhaustive discussion of the matter at the Sixty-second World Health Assembly.

Dr KÖKÉNY (Hungary) said that, in order to achieve a balanced code, appropriate emphasis should be placed on the sustainability of health systems.

He preferred the first option, agreeing with the reasoning put forward by the member for the United States. It would be helpful if the Director-General could emphasize the issue in her report and call for further action from the Member States and regional committees.

Dr ZARAMBA (Uganda) stated that the African Region agreed with the preference for the first option as it would allow for wide stakeholder consultation. The Director-General's report should provide a clear explanation of the process so that all Member States were aware of the need to finalize it in 2010.

Professor ALI (alternate to Professor Haque, Bangladesh) expressed his preference for the first option and agreed with the argument put forward by the member for the United States.

Dr DAHL-REGIS (Bahamas) said that she preferred the first option. Regarding stakeholder consultation, she requested that the report should reflect the need to engage source countries in the process.

Ms ROCHE (New Zealand) also supported the first option. In order to achieve the widest possible participation, she requested the Secretariat to ensure that the Sixty-second World Health Assembly would provide full Member State participation by holding informal meetings on the topic.

Dr VIROJ TANGCHAROENSATHIEN (Thailand)¹ supported the first option and urged the Director-General to maximize participation of stakeholders in the consultative process. He asked which version of the revised text would be used for the national and regional committee discussions.

Dr MOHAMED (Oman) expressed a preference for the first option. Further time would be needed for Member States to consult and produce a suitable text. He agreed with the member for New Zealand that the Sixty-second World Health Assembly would provide the opportunity to hold consultation meetings on the draft code of practice.

The document should provide examples of agreements or memoranda of understanding between Member States. The experiences of other countries would be useful in formulating a solution with regard to compensation.

Mr SAMRI (Morocco)¹ questioned whether a third option could be considered whereby the item would be included on the provisional agenda of the Sixty-second World Health Assembly and, depending on the outcome of those discussions, consideration could be given to the next steps to be taken, including the possibility of regional consultation.

Ms ROCHE (New Zealand) requested clarification on the process that was needed to ensure that the item was added to the provisional agendas of the regional committees on a formal basis.

The DIRECTOR-GENERAL, noting the broad consensus in favour of the first option, proposed to find a way forward that would respond to the suggestions and comments made. The Secretariat would prepare a document to be used in both national consultations and the technical briefing that could be held in parallel to the Sixty-second World Health Assembly. Based on the outcome of those discussions, the Secretariat would prepare a report to send to all Regional Directors. The item could be formally placed on the provisional agenda for regional committee meetings and the outcome of all discussions at that stage would be reported back to the Secretariat, with a view to capturing as many

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

regional and national views as possible; she would then prepare a report for submission to the Executive Board at its 126th session and the Sixty-third World Health Assembly in 2010.

Responding to the query from the member from Thailand on the text that would be used in national consultations, she proposed that the paper prepared by the Secretariat would broadly capture all the views and concerns put forward and discussed at the technical briefing and would then be used as a basis for the regional consultations.

The CHAIRMAN noted that broad consensus had been reached on the issue. He took it that the Board agreed with the Director-General's proposal and wished to take note of the report.

The Board noted the report.

2. FINANCIAL MATTERS: Item 6 of the Agenda

Scale of assessments 2010–2011: Item 6.1 of the Agenda (Document EB124/21)

Dr DAHL-REGIS (Bahamas), speaking in her capacity as Chairman of the Programme, Budget and Administration Committee, noted that no change had been proposed to the current scale of assessments. In December 2009, the United Nations was expected to adopt a new scale for the period 2010–2012 and the Sixty-third World Health Assembly would be invited to use that scale to calculate the WHO scale for the second year of the biennium (2011). The Committee recommended that the Executive Board should recommend that the Sixty-second World Health Assembly adopt the proposed scale of assessments.

The CHAIRMAN, observing that no comments had been made, took it that the Board wished to invite the Health Assembly to consider adopting the proposed scale of assessments.

It was so agreed.

The Board took note of the report.

Amendments to the Financial Regulations and Financial Rules: Item 6.2 of the Agenda (EB124/22)

Dr DAHL-REGIS (Bahamas), speaking in her capacity as Chairman of the Programme, Budget and Administration Committee, said that the Committee had noted that the changes proposed to the Financial Regulations and Financial Rules were primarily a result of the implementation of the International Public Sector Accounting Standards. Discussion had made it clear that interest earned on assessed contributions would continue to be credited to that account and so continue to be available to Member States under Regulation 5.1. Questions had been raised about the term "surplus" and the reference in the Financial Rules to the possibility of a separate budget for capital expenditure. The Secretariat had proposed a few amendments to the Financial Regulations, which the Committee had reviewed. It recommended that the Board adopt the resolution contained in paragraph 5 of document EB124/22, with the amended Annex 1.

The resolution, together with the amended Financial Regulations, was adopted.¹

3. MANAGEMENT MATTERS: Item 7 of the Agenda

Partnerships: Item 7.1 of the Agenda (EB124/23)

Dr DAHL-REGIS (Bahamas), speaking in her capacity as Chairman of the Programme, Budget and Administration Committee, said that the Committee had expressed satisfaction with the report on partnerships and the annexed draft policy guidelines. The Committee had noted WHO's long tradition of collaborating with multiple stakeholders and sectors and the complexity of the issues surrounding its work in the existing collaborations. Those issues included how to decide on and manage involvement in partnerships; problems relating to formal partnerships hosted by WHO but governed separately; and the application of WHO's accountability and managerial frameworks to all its partnerships and collaborative arrangements. Committee members had welcomed the new approaches to partnerships and collaborative arrangements in the Proposed programme budget 2010–2011.

The Committee had noted with appreciation that the draft guidelines referred to consultations with the Board on consideration by the Secretariat of the hosting of partnerships and asked whether they applied to formal as opposed to informal partnerships. Although formal partnerships linking Member States, the private sector, academia and civil society were appreciated for their contributions to global health, it was unclear how the Secretariat and the governing bodies could influence them and ensure coherence. The Secretariat needed to support strong coordination between partnerships both at country level and within the Organization.

The Committee recommended that the Board should consider endorsing the guidelines and give consideration to other future action based on the suggestions made during the Committee's discussion.

Mrs CHRISTENSEN (alternate to Mr Fisker, Denmark) welcomed the draft policy guidelines on global health partnerships. The organization of global health was changing, with consequences for the structure of WHO's budget, in which voluntary contributions and partnerships were playing a growing role. Although partnerships created new opportunities, she was concerned that the system might become so complex that Member States lost oversight and influence, which would jeopardize governance and accountability. Maintaining the ability of Member States to steer the work of the Organization through its governing bodies was of the utmost importance.

She welcomed the new guidelines and notably the provision that the Board would be consulted on proposals for WHO to host formal partnerships, although she would have preferred that proposals be submitted to the Board for approval. She welcomed the notion that the goals of partnerships should be consistent with the strategic objectives approved by Member States. Both the risks and the benefits of partnerships should be considered and periodically evaluated. Her Government would follow the issue closely with a view to maintaining the influence of Member States and accountability of the Secretariat towards the governing bodies.

Dr MOHAMED (Oman) said that partnerships between the public and private sectors, and greater involvement of nongovernmental organizations, would be desirable. He would submit written comments for the wording of the guidelines to the Secretariat.

¹ Resolution EB124.R10.

Mr HOHMAN (alternate to Dr Wright, United States of America), aligning himself with the comments by the member for Denmark, said that it was unclear exactly what the Board was expected to do with respect to the draft policy guidelines. On the one hand, it was useful for them to be reviewed by a governing body but, on the other, they were not yet final. If the Board endorsed them forthwith, they could no longer be changed. On the other hand, the Board should in some manner express its approval of the guidelines. He asked whether they needed to be submitted to the Health Assembly.

Dr DOS RAMOS (Sao Tome and Principe), speaking on behalf of the Member States of the African Region, said that the growing complexity of aid and increased partnerships in the health sector had fragmented development assistance to countries, and so reduced its efficacy. The need to adhere to the principles in the Paris Declaration on Aid Effectiveness was gaining international recognition. United Nations agencies, the World Bank and the African Development Bank had set up a cooperation framework to harmonize action at country level. Different types of partnership arrangements had been studied and meetings with development partners held. The Regional Office for Africa had established several new institutions for technical support, quality assurance and oversight of the assistance provided in the health sector to governments by United Nations country teams. In view of the restructuring of the African Union, a new framework agreement had been negotiated which would strengthen cooperation with the African Union and the regional economic communities.

The many challenges ahead included: harmonizing aid, since fragmentation resulted in high transaction costs and excessive demands on the governments of recipient countries; inducing donors to refocus health programmes on national priorities; and setting up coordinating mechanisms for the follow-up and evaluation of activities.

Dr JAKSONS (Latvia) said that the report represented progress, and Part 1 of the draft policy guidelines contained well-defined terminology. Part 2 lacked clarity, notably on the distinction between partnerships and collaborative arrangements. That part should be revised by the Secretariat.

Dr LHOTSKA (Consumers International), speaking at the invitation of the CHAIRMAN, said that the draft policy guidelines identified global health partnerships as a means of achieving public health goals, not as an end in themselves. Nevertheless, mechanisms and structures should be better defined, ensure transparency and accountability, and stipulate that the Secretariat would provide Member States and the general public with a registry of all partnerships in which WHO was involved. They should define conflicts of interest, elaborate safeguards, and explain the mechanisms that would make WHO staff better able to make such assessments. WHO's guidelines on interaction with commercial enterprises should be updated to reflect recent experience, and the ethical framework mentioned should be further developed. The draft policy guidelines should explicitly note that representatives of the private sector engaged in partnerships must not be involved in policy-making. The guidelines should also include a provision on periodic review and updating of the policy.

Dr PRADHAN (Assistant Director-General) reaffirmed that several initiatives aimed at strengthening WHO's role and clarifying partnerships were under way, including some in the regional offices. Board members had made valuable comments on the need to show more clearly which of the arrangements identified were formal partnerships as opposed to collaborative arrangements, and how the necessary oversight of them could be exercised by WHO's governing bodies. She undertook to make the necessary revisions to both the report and the draft policy guidelines. She recalled that the valuable partnerships and collaborative arrangements in place greatly furthered much of the Organization's work, both globally and in regions and countries.

Mr BURCI (Legal Counsel), responding to the question by the member for the United States on the nature of guidelines, said that the Secretariat proposed guidelines either for the use of outside

parties or stakeholders or for its own internal use. Such guidelines were not always submitted to the governing bodies for approval since they were mandated by those very governing bodies. In other cases, however, guidelines were submitted to the governing bodies because they comprised a policy component. Such, in his opinion, was the case with the draft policy guidelines on WHO's involvement in global health partnerships. Admittedly, however, that document was something of a hybrid: Part 1 raised policy and strategic issues, whereas Part 2 responded to the constitutional and governance issues that partnerships hosted by WHO raised for the Organization. In view of the governance and policy implications of partnerships, the Board might wish to submit the draft policy guidelines to the Health Assembly for further consideration and approval. They could be further revised and improved on the basis of the current discussion before submission to the Health Assembly.

The CHAIRMAN said that he took it that the Board wished to recommend that the guidelines be submitted to the Sixty-second World Health Assembly for review and endorsement.

It was so agreed.

Multilingualism: implementation of action plan: Item 7.2 of the Agenda (Document EB124/24)

Dr GOPEE (Mauritius), speaking on behalf of the Member States of the African Region, recalled resolution EB122.R9 on implementation of the action plan on multilingualism, the aim of which was to ensure that linguistic diversity was respected throughout the Organization and that publications and other services were made available in WHO's working languages. The Organization might therefore wish to consider making WHO publications and documents available in Portuguese, which was a working language of the African Region.

In paragraphs 6 to 8 of the report, the numbers of web pages already published and to be published during the 2012–2013 biennium in English were not listed. In the African Region, simultaneous interpretation, as well as documents, was provided in English, French and Portuguese at official meetings held by the Member States. Those documents were also published on the Intranet in order to facilitate regional access. The library continued to constitute a digital archive for all the documents and to record data submitted by anglophone, francophone and lusophone African countries and from the Forum for African Medical Editors in the database of the African Index Medicus in all three languages. He called on the Secretariat to ensure that all technical documents were in future made available in the official languages as promptly as possible.

Dr XING Jun (alternate to Dr Ren Minghui, China) commended the improved quality of the Chinese web pages and the progress made in implementing the action plan since the adoption of resolution WHA61.12. Following informal consultations between the Chinese delegation and the Secretariat, it had been decided to establish a WHO consultative committee to decide on translation priorities for WHO publications. Involving outside publishers and partners might secure funding for the translation of WHO publications, but a better option would be continued support from the regular budget.

Dr BIN SHAKAR (United Arab Emirates), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that achieving a balance between languages in the translation of documents would allow countries to participate more widely in consultations and decision-making. The needs of countries should be met on the basis of defined priorities. He urged the Secretariat to make more information available on the WHO web site in the official languages. He commended the efforts made to provide a better service for the Arab countries. However, additional funding would allow more official documents to be translated, which would benefit health workers and also improve the performance of health systems. Unfortunately, some major WHO documents were still not being made available in all the official languages. For example, *The world health report 2008* had not been

translated into Arabic, Chinese or Spanish. With regard to the resources required for implementing the action plan between 2008 and 2013, he asked whether the total amount of US\$ 19 926 925 shown in the document had already been allocated and whether current multilingualism costs would be deducted from the amount.

Dr STARODUBOV (Russian Federation) said that the translation of documents into all official languages increased participation by countries. In 2008, his Government's health and social welfare ministries had decided to establish an expert committee to set priorities for the translation of WHO documents into Russian. The figures set for the translation of web site pages into Russian was acceptable. However, the Russian language pages should cover all WHO's priority areas of work. It was of the utmost importance that translations should be of the highest quality since members of the medical profession in the Russian-speaking countries relied on them heavily. In the near future, it would be necessary to compile a WHO glossary for health and medical products with the assistance and participation of experts from countries speaking the relevant languages. He supported the action plan as a lead to enhanced coordination between WHO and national health ministries.

Ms ARENDT (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN, welcomed the report. A master list of planned translations for the 2008–2009 biennium would help in planning and coordination of programme. Recent documents on breastfeeding should be translated and made available to non-English speaking countries. Translation of policies and information on capacity-building tools would facilitate national implementation of that essential child-survival strategy. The revised course for training health-care professionals involved in maternity care could significantly assist hospitals in fulfilling the accreditation requirements for becoming UNICEF/WHO baby-friendly hospitals. Translation of the revised assessment tools for the Baby Friendly Hospital Initiative, and the evidence on the long-term effects of breastfeeding were both urgently needed as guidance for policy-makers.

Dr EVANS (Assistant Director-General), replying to the comments of the member for Mauritius, drew attention to the efforts being made to accelerate production of documents in Portuguese through the ePORTUGUESe initiative. With regard to his second question, web pages in English numbered about 10 000.

Replying to the member for the United Arab Emirates, he pointed out that *The world health report 2008* was now available in all official languages, both electronically and in hard copy. The budget stated in document EB124/24 was specifically for the activities described therein.

He informed the member for the Russian Federation that a WHO health and product glossary was included in the plan.

The Board took note of the report.

Reports of committees of the Executive Board: Item 7.3 of the Agenda

- **Standing Committee on Nongovernmental Organizations** (Document EB124/25)

Dr MOHAMED (Oman), speaking on behalf of the Chairman of the Standing Committee on Nongovernmental Organizations, said that the Committee had expressed its appreciation of the work of the applicant organizations and those whose activities had been reviewed. Section IV of the report contained the Committee's recommendations, set out as a draft resolution and a draft decision.

Mr LOGAR (alternate to Dr Voljč, Slovenia), conveying apologies from Dr Voljč for his unavoidable absence, thanked his fellow Committee members, Dr Dos Ramos (Sao Tome and

Principe), Dr Mohamed (Oman), Dr Ren (China) and Dr Vallejos (Peru), and the Secretariat for their assistance.

The CHAIRMAN said that he took it that the Board wished to adopt the draft resolution and draft decision contained in document EB124/25.

The resolution and the decision were adopted.¹

- **Foundations and awards** (Document EB124/26)

Léon Bernard Foundation Prize

Decision: The Executive Board, having considered the report of the Léon Bernard Foundation Committee, decided not to award the Léon Bernard Foundation Prize in 2009.

Dr A.T. Shousha Foundation Prize

Decision: The Executive Board, having considered the report of the Dr A.T. Shousha Foundation Committee, awarded the Dr A.T. Shousha Foundation Prize for 2009 to Dr Huda Zurayk (Lebanon) for her significant contribution to public health in the Eastern Mediterranean Region. The laureate will receive the equivalent of 2500 Swiss francs in United States dollars.²

Jacques Parisot Foundation Fellowship

Decision: The Executive Board, having considered the report of the Jacques Parisot Selection Panel, awarded the Sixteenth Jacques Parisot Foundation Fellowship to Ms Livesy Abokyi Naaffoe (Ghana) for her proposal to undertake a population-based study of the health-seeking behaviour of persons suffering from persistent cough in the Kintampo North and South Districts of Ghana. The laureate will receive a medal and US\$ 5000.³

Ihsan Dogramaci Family Health Foundation Prize

Decision: The Executive Board, having considered the report of the Ihsan Dogramaci Family Health Foundation Selection Panel, decided not to award the Ihsan Dogramaci Family Health Foundation Prize in 2009.

In addition, **the Board took note of the Panel's decision to revise Article 4 of the Statutes** of the Ihsan Dogramaci Family Health Foundation.

Sasakawa Health Prize

Decision: The Executive Board, having considered the report of the Sasakawa Health Prize Selection Panel, awarded the Sasakawa Health Prize for 2009 to Dr Amal Abdurrahman Al Jowder

¹ Resolution EB124.R11 and decision EB124(1).

² Decision EB124(2).

³ Decision EB124(7).

(Bahrain) for her outstanding innovative work in health development. The laureate will receive US\$ 30 000.¹

United Arab Emirates Health Foundation Prize

Decision: The Executive Board, having considered the report of the United Arab Emirates Health Foundation Selection Panel, awarded the United Arab Emirates Health Foundation Prize for 2009 jointly to the Integrated Perinatal Care Project, KK Women's and Children's Hospital (Singapore) and the Georgian Respiratory Association (Georgia) for their outstanding contribution to health development. The laureates will each receive US\$ 20 000.²

State of Kuwait Prize for Research in Health Promotion

Decision: The Executive Board, having considered the report of the State of Kuwait Health Promotion Foundation Selection Panel, awarded the State of Kuwait Prize for Research in Health Promotion for 2009 jointly to Dr Shaikha Salim Al Arrayed (Bahrain) and the National Centre for Workplace Health Promotion (Poland) for their outstanding contribution to research in health promotion. The laureates will each receive US\$ 20 000.³

Dr LEE Jong-wook Memorial Prize for Public Health

Decision: The Executive Board, having considered the report of the Dr LEE Jong-wook Memorial Prize Selection Panel, awarded the Dr Lee Jong-wook Memorial Prize for Public Health for the first time to the Infectious Diseases, AIDS and Clinical Immunology Research Center (Georgia) for its outstanding contribution to research into and prevention, treatment and control of HIV/AIDS and research into and control of communicable diseases. The laureate will receive US\$ 85 000.⁴

Provisional agenda of the Sixty-second World Health Assembly and date and place of the 125th session of the Executive Board: Item 7.4 of the Agenda (Documents EB124/27, EB124/27 Add.1 and EB124/27 Add.2)

Dr YOUNES (Governing Bodies) said that, as the Board had already agreed to postpone the subitem on the "International recruitment of health personnel: draft global code of practice" until the Sixty-third World Health Assembly in order to allow further consultation, subitem 12.9 would therefore be deleted from the provisional agenda and the subsequent subitems renumbered accordingly. The subitem entitled "Chagas disease: control and elimination" would thus become subitem 12.12. The item entitled "Capacity-building to constructively engage the private sector in providing essential health-care services" had been inadvertently omitted from the provisional agenda for the Sixty-second World Health Assembly and would be included as new subitem 12.13. The member for Slovenia had proposed (document EB124/27 Add.1) the inclusion of an item entitled "Strategic Approach to International Chemicals Management" and China had proposed (document EB124/27 Add.2) the inclusion of an item entitled "Prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis"; if the Board agreed, both items

¹ Decision EB124(3).

² Decision EB124(4).

³ Decision EB124(5).

⁴ Decision EB124(6).

would be placed on the provisional agenda as subitems 12.14 and 12.15. The current subitem 12.14, entitled "Progress reports on technical and health matters", would become subitem 12.16. All the subitems mentioned would be included in the work programme of Committee A.

Dr BIN SHAKAR (United Arab Emirates), supported by Dr GARBOUJ (alternate to Dr Abdesselem, Tunisia) and Mr LOGAR (alternate to Dr Voljč, Slovenia), said that the Board had expressed an intention during the current session to include a separate item on food safety in the provisional agenda. He therefore called for it to be added.

Professor AZAD (alternate to Professor Haque, Bangladesh), supporting the proposal to include food safety in the provisional agenda of the forthcoming Health Assembly, said that the important issue of food security should also be included.

Dr REN Minghui (China), supported by Professor AZAD (alternate to Professor Haque, Bangladesh), Dr ADITAMA (alternate to Dr Supari, Indonesia), Dr GOPEE (Mauritius) and Dr BIN SHAKAR (United Arab Emirates), said that multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis posed a serious threat to public health, in particular in developing countries. In 2007, seven million people had died of those diseases. The number of cases was steadily increasing, with only a small number of cases diagnosed and treated. Multidrug-resistant tuberculosis had for the first time emerged in more than 50 countries, while in the African Region the combination of tuberculosis and HIV/AIDS posed a grave threat to health and economic development. He drew the Board's attention to a number of global initiatives and meetings aimed at finding responses to the issue and, in that context, recommended that the Sixty-second World Health Assembly should consider the item.

Mr LOGAR (alternate to Dr Voljč, Slovenia) said that the Fifty-ninth World Health Assembly had already discussed the Strategic Approach to International Chemicals Management. Further discussion to assess the current situation and identify new challenges and goals for WHO in the field would be timely. He invited the Secretariat to prepare a progress report on the implementation of resolution WHA59.15.

The second session of the International Conference on Chemicals Management, the governing body for the Strategic Approach to International Chemicals Management, was due to meet in Geneva in May 2009, immediately before the Sixty-second session of the World Health Assembly. The Health Assembly could look at the public health aspects of the issue; that might lead to a possible resolution on further collaboration between WHO and the Strategic Approach to International Chemicals Management.

He expressed concern about the health consequences of obsolete pesticides and other dangerous chemicals. The health sector was faced with responsibilities resulting from increased production and use of dangerous chemicals, along with chemical waste stocks in developing countries and countries with economies in transition. The worldwide production and use of chemicals was increasing, and global stocks of obsolete pesticides were estimated to amount to at least 350 000 tons, of which two thirds were thought to be in central and eastern Europe and the countries of the former Union of Soviet Socialist Republics. If the Board agreed to the inclusion of the agenda item, Slovenia would be prepared to draft a resolution on obsolete pesticides and other dangerous chemicals, and provide elements for further action.

Professor AZAD (alternate to Professor Haque, Bangladesh), Dr KÖKÉNY (Hungary), Dr JAKSONS (Latvia), Dr GOPEE (Mauritius), Ms MORENO (alternate to Dr Giménez Caballero, Paraguay), Dr GARBOUJ (alternate to Dr Abdesselem, Tunisia), Professor AYDIN (Turkey) and Dr BIN SHAKAR (United Arab Emirates) expressed support for the proposal by the member for Slovenia.

Mr CAMPOS (alternate to Dr Buss, Brazil), supported by Dr AHMADZAI (Afghanistan), proposed the inclusion of an agenda item on viral hepatitis. For instance, some 2000 million people were infected with hepatitis B virus alone, with a mortality rate due to acute and chronic disease of 600 000 every year. He proposed that the Secretariat should prepare a report on the subject. His Government would submit a draft resolution proposing that a world day for viral hepatitis be established.

Mr HOHMAN (alternate to Dr Wright, United States of America), observing that it was far more efficient to deal with agenda items for the Health Assembly beforehand in the Executive Board, encouraged delegations proposing new items to circulate draft resolutions well ahead of the next Health Assembly in order to give other Member States time to consider them in advance.

Dr ABABII (Republic of Moldova), emphasizing the need to tackle the combination of tuberculosis and other diseases, expressed support for the additional agenda item proposed by the member for China. The positions of the members for Hungary and Slovenia should be taken into account.

Dr MOHAMED (Oman), referring to the additional agenda item proposed by the member for Bangladesh, asked whether a distinction could be drawn between food safety and food security, and whether both came within the purview of WHO.

Professor AZAD (alternate to Professor Haque, Bangladesh) said that not to include food security in the item would be a major omission.

Dr ZARAMBA (Uganda) requested clarification of the ways in which items were added to the provisional agenda of the Health Assembly.

The DIRECTOR-GENERAL said that, although it was the prerogative of Member States to propose items for the provisional agenda of the Health Assembly, the latter had recommended that technical items, especially those with draft resolutions, should be discussed first by the Executive Board. Experience had shown that otherwise the deliberations tended to be long, complex and often indecisive, but it was for the Board to decide whether to transmit an item direct to the Health Assembly.

Dr DAHL-REGIS (Bahamas) said that Member States should decide whether they were prepared to accept an extended session of the Health Assembly.

Dr YOUNES (Governing Bodies) confirmed, at the CHAIRMAN's request, that additional items had been proposed for the provisional agenda of the Sixty-second World Health Assembly on capacity-building to constructively engage the private sector in providing essential health-care services; the Strategic Approach to International Chemicals Management; the prevention and control of multidrug-resistant and extensively drug-resistant tuberculosis; food safety and food security; and viral hepatitis.

Dr ZARAMBA (Uganda) suggested that, in view of the comments by the Director-General and given the importance of the subject matter, the proposed items should be considered by the Executive Board before being added to the provisional agenda of the Health Assembly.

Mr LOGAR (alternate to Dr Voljč, Slovenia), while supporting the previous speaker's suggestion, reminded the Board that the Fifty-ninth World Health Assembly had already discussed the

Strategic Approach to International Chemicals Management, and said that Slovenia's proposal was intended merely to ensure that the discussions continued at the Sixty-second World Health Assembly.

Dr YOUNES (Governing Bodies) confirmed that the subject had indeed been on the agenda of the Fifty-ninth World Health Assembly, in response to a request from the first International Conference on Chemicals Management for support for WHO's involvement in implementing the Strategic Approach to International Chemicals Management. However, in the resulting resolution the Health Assembly noted the Strategic Approach but did not require the Secretariat to report back to the Health Assembly.

Dr MOHAMED (Oman), noting that the second International Conference on Chemicals Management was meeting a week before the Sixty-second World Health Assembly, said that it would be a good opportunity to present Member States with its findings rather than wait another eight months until the next session of the Executive Board. He endorsed the comments by the member for the United States that delegations with draft resolutions on additional agenda items should circulate them for Member States to examine in advance, but said that not adding any items would amount to a lost opportunity to consider such important matters as hepatitis B without delay.

The CHAIRMAN asked the Board whether it wished to add all five items to the provisional agenda of the next Health Assembly or to choose an order of priority.

Dr REN Minghui (China), acknowledging the importance of the proposed additional items, said that if they were added to the provisional agenda of the Sixty-second World Health Assembly it would be hard, given how time-consuming the process was, to achieve a consensus without prior consultation and discussion by the Executive Board.

Mr HOHMAN (alternate to Dr Wright, United States of America) requested clarification of the item on food safety and food security since he doubted whether there were legitimate grounds for WHO to deal with food security.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) noted that it would be an unusual procedure for the Executive Board to pass agenda items on to the Health Assembly without discussing them first. He suggested that, in future, Member States with important topics that they wished to see discussed at a subsequent Health Assembly should submit them to the Board's agenda-setting process. Had they done so in the case of the five items in question, the Board might have been able to consider them at the present session without departing from its normal practice.

The DIRECTOR-GENERAL asked whether the member for Bangladesh would be willing to confine the proposed item to food safety since the topic of food security raised questions about the lead agency and the mandate of WHO. FAO and even the World Bank had invested more resources, capacity and core competencies in supporting developing countries in the context of rural development. Responding to the observation that food safety and food security were interrelated and that compromised food security could disrupt food safety by driving people to seek cheaper, unhygienic foods, she said that such concerns could be covered under an item entitled "food safety"; experience had shown that the term "security" meant different things to different Member States.

Dr DAHL-REGIS (Bahamas) expressed concern that adding the five proposed items, valuable as they were, to the provisional agenda of the Sixty-second World Health Assembly might make it hard for Member States, at a meeting of more than 190 delegations, to exercise due diligence regarding the items on which they had worked so hard to secure a resolution.

The DIRECTOR-GENERAL said that that was precisely the point. Since she did not believe that the addition of the five proposed items to the provisional agenda of the Sixty-second World Health Assembly was intended to bypass the governance of the Executive Board, she proposed that in the long term Member States should follow the advice of the member for the United Kingdom and seek to have important items placed on the agenda of the Board in advance, which would enable it to exercise its due diligence and governing role.

On the more immediate matter of the five additional items, an agreement had already been reached with regard to the item on engaging the private sector. For the Strategic Approach to International Chemicals Management she reaffirmed that resolution WHA59.15 did not include a requirement for reporting to the Health Assembly but she agreed that discussions could usefully continue at the Health Assembly in May, especially in view of the fact that the second International Conference on Chemicals Management would meet the preceding week. As to the other three topics – food safety, viral hepatitis, and multidrug-resistant and extensively drug-resistant tuberculosis – the member for China, supported by the member for the United States, had suggested that technical documents should be prepared without a draft resolution. When a draft resolution was required, it should be submitted to the Secretariat to be sent out to Member States far enough in advance for national consultations to take place, especially on such subjects as food safety, which could go well beyond the health sector. Should that approach be acceptable, the Secretariat could assist in preparing the technical documents and the Board could lay down a timetable for Member States to discuss them ahead of the Health Assembly.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) reiterated his view that it would take the Health Assembly much longer to discuss subjects not previously considered by the Executive Board. In view of the potentially extended deliberations, he suggested that any items put forward should, regardless of their format, be clearly identified in a separate part of the agenda as matters not having been previously considered by the Executive Board.

Ms ROCHE (New Zealand) said that she supported the suggestion by the previous speaker.

The meeting rose at 12:30.

TWELFTH MEETING

Monday, 26 January 2009, at 14:00

Chairman: Mr N.S. DE SILVA (Sri Lanka)

1. MANAGEMENT MATTERS: Item 7 of the Agenda (continued)

Provisional agenda of the Sixty-second World Health Assembly and date and place of the 125th session of the Executive Board: Item 7.4 of the Agenda (Documents EB124/27, EB124/27 Add.1 and EB124/27 Add.2) (continued)

Dr REN Minghui (China) agreed with the suggestion by the Director-General that the proposed item on Strategic Approach to International Chemicals Management should be dealt with as a progress report. He would support inclusion of an item on “food safety” but not on food security, since the discussion should focus on the public health aspects rather than the broader concept. He suggested that the four items – on capacity building to constructively engage the private sector in providing essential health-care services, the prevention and control of multidrug-resistant and extensively drug-resistant tuberculosis, food safety, and viral hepatitis – should all be placed on the provisional agenda of the Health Assembly.

Mr CAMPOS (alternate to Dr Buss, Brazil) said that it would be preferable to rely on the experience of the Director-General in selecting which of those items should be included and which ones still needed more prior discussion.

Ms ROCHE (New Zealand) suggested that the Board consider the proposed items one by one.

Dr DAHL-REGIS (Bahamas) asked for clarification of the process that would be followed; it appeared that the Director-General would provide an update on the Strategic Approach to International Chemicals Management. Any proposed items that contained a draft resolution would have to be circulated to Member States in sufficient time if those were to be accepted on the provisional agenda. That could lead to lengthy and inconclusive discussions.

Mr BOŠTJAN (alternate to Dr Voljč, Slovenia) welcomed the suggestion by the Director-General and was ready to accept it; he also pointed out that Slovenia’s proposal, which had been submitted in advance of the current Board session, had received wide support. The Board should take note of those factors when taking its decision. Any proposed draft resolution by Slovenia would be submitted at least one month before the Health Assembly.

Dr REN Minghui (China) asked whether Board members had a mandate to propose new items for inclusion on the provisional agenda of the Health Assembly. As he understood it, discussion on a draft resolution would be deferred to a subsequent meeting if it did not obtain consensus.

Mr BURCI (Legal Counsel) said that Rule 5 of the Rules of Procedure of the World Health Assembly stated that the Executive Board “shall” include in the provisional agenda “any item proposed by a Member or by an Associate Member”. In practice, that Rule led to the automatic inclusion of any request from a Member State (whether or not that Member designated a member of the Executive Board) that was received in writing by the Director-General.

Board members sometimes proposed a new item when the Board discussed the provisional agenda of the Health Assembly. In practice, however, such items were always treated as proposals to the Board made during the discussion of an item. The Board had final authority to approve whether to include such items in the provisional agenda of the Health Assembly.

Dr MOHAMED (Oman) supported the suggestion by member for New Zealand that the items should be discussed one by one.

Dr YOUNES (Governing Bodies) said that a decision regarding the item on capacity building had already been taken. The second one was the item on Strategic Approach to International Chemicals Management.

The DIRECTOR-GENERAL said that she had received a letter from the Government of Slovenia well before the present session of the Board and had been able to issue an Addendum to document EB124/27. The correct procedure had therefore been respected.

Mr HOHMAN (alternate to Dr Wright, United States of America) thanked the Legal Counsel for his explanation. Nobody questioned the prerogative of Member States to propose items for the Health Assembly. He favoured the suggestion by the member for the United Kingdom that a special category be established in the provisional agenda of the Health Assembly for items that had not been considered by the Executive Board. He did not support placing them among the progress reports, as those reports did not usually include draft resolutions. It would be preferable if all four items were placed under a separate heading.

The DIRECTOR-GENERAL commended that suggestion, adding that she had noted that Slovenia wished to include a draft resolution. It would not be good practice to include it among the progress reports. The Board might prefer to include it as an independent item on the provisional agenda of the Sixty-second World Health Assembly.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) suggested that all the proposed items should be included in a separate section of that provisional agenda, labelled "Matters not having had prior consideration by the Executive Board".

Dr REN Minghui (China) considered that the Board had a mandate to decide the provisional agenda of the Health Assembly but he did not understand why there should be a special category. Did it mean that there should be no discussion of those items in the Board?

Mr BURCI (Legal Counsel) said that he had sought to explain a procedural matter. The requests by the members for Slovenia and China had been received by the Director-General in writing before the Board considered the provisional agenda of the Sixty-second World Health Assembly; therefore, in accordance with the Rules of Procedure of the World Health Assembly, they would automatically be included in the provisional agenda, even if the Board had not examined the substantive aspects of the proposals.

Dr KÖKÉNY (Hungary), supported by Mr CHOCANO BURGA (alternate to Mr Vallejos, Peru), said that all four items were important. However, a separate category would not be required if a footnote were included in the provisional agenda to the effect that the items had not been discussed by the Board.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) said that he had suggested that the items be separately identified so that experts, nongovernmental organizations

and others attending the Health Assembly would know that prior consideration had not been given to them.

The CHAIRMAN suggested that all the proposed items should be included in the provisional agenda. It could be decided afterwards whether to incorporate a footnote.

Dr ZARAMBA (Uganda) said that it was not right to include subjects that had not been discussed by the Board, except in the case of an emergency. The issues concerned could be discussed at a later date.

The CHAIRMAN said that it was clear, after the explanation given by the Legal Counsel, that an item, even one not discussed beforehand by the Board, could be included in the provisional agenda of the Health Assembly. As the debate was not advancing and there appeared to be no consensus as to how such items should be included, the most practical solution would be to include all five items in the provisional agenda of the Sixty-second World Health Assembly. He took it that the Board wished to adopt the draft decision contained in paragraph 3 of document EB124/27.

The decision was adopted.¹

Representation of the Executive Board at the Sixty-second World Health Assembly

The CHAIRMAN said that since the Board had elected two new officers it would be appropriate to revise the decision taken in May 2008 regarding representation of the Board at the Sixty-second World Health Assembly. He therefore asked the Legal Counsel to read out the proposed draft decision.

Mr BURCI (Legal Counsel) read out the text of the draft decision:

“Further to decision EB123(5) of 26 May 2008, and in accordance with paragraph 1 of resolution EB59.R7, the Executive Board decided to appoint its Chairman, Mr N.S. de Silva (Sri Lanka), ex officio, and three of the Vice-Chairmen, Sir Liam Donaldson (United Kingdom of Great Britain and Northern Ireland), Mr C. Vallejos (Peru) and Mr O.I. Touré (Mali), to represent the Board at the Sixty-second World Health Assembly. It was understood that, if any of those members were not available for the Health Assembly, the other Vice-Chairman, Dr H. Abdesselem (Tunisia) and the Rapporteur, Dr Ren Minghui (China) could be asked to represent the Board.”

The decision was adopted.²

Date and place of the 125th session of the Executive Board (continued)

The CHAIRMAN proposed that the 125th session of the Executive Board be held immediately after the Sixty-second World Health Assembly, from 28 to 30 May 2009.

It was so decided.³

¹ Decision EB124(9).

² Decision EB124(8).

³ Decision EB124(10).

The CHAIRMAN said that the provisional agenda for the 125th session of the Board would be drawn up by the Director-General and circulated to Member States and Associate Members within four weeks of the closure of the present session.

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

WHO's role and responsibilities in health research: Item 4.9 of the Agenda (Documents EB124/12, EB124/12 Add.1, EB124/12 Add.2) (continued from the eleventh meeting, section 1)

The CHAIRMAN recalled the revised draft resolution on the draft of the WHO strategy on research for health, which the Board had considered in its previous meeting. He understood that the working group had achieved consensus, and invited the Secretariat to present the outcome of its work.

Dr KEAN (Executive Director, Office of the Director-General) said that, after discussion, the working group had proposed three amendments to the text. The sixth preambular paragraph should read: "Recognizing the need to strengthen the capacity of the public sectors in health research". In paragraph 2, the member for Mali had proposed the addition of a new subparagraph: "to continue to pursue financing of research for health as articulated in resolution WHA58.34". In the third line of paragraph 3(4) the words "and other determinants of health" should be replaced by the words "and the determinants of health". In paragraph 4 there was a mistake in the numbering of the subparagraphs: subparagraph 4(5), beginning "to provide support to Member States", should be numbered 4(6) and the next two subparagraphs renumbered accordingly.

The resolution, as amended, was adopted.¹

Human organ and tissue transplantation: Item 4.12 of the Agenda (Document EB124/15) (continued from the tenth meeting)

Dr KEAN (Executive Director, Office of the Director-General) read out proposed amendments to the draft resolution on human organ and tissue transplantation which had been introduced at the ninth meeting of the Board. In paragraph 1, "welcomes" should replace "endorses" and the word "updated" should be deleted. Footnote 1, referring to paragraph 2, should read: "and regional economic integration organizations where appropriate." Paragraph 2(1) should be amended to read: "to implement the Guiding Principles in the formulation and enforcement of their own policies, laws and legislation regarding human cell, tissue and organ donation and transplantation where appropriate;". In paragraph 2(2), the words "created by" should be replaced with "as a result of". In paragraph 2(3), "health authorities" should be changed to "relevant authorities" and the words "in accordance with national capacities and legislation" should be added at the end. Paragraph 2(4) should be amended to read: "to promote equitable access to transplantation services in accordance with national capacities, which provide the foundation for public support of voluntary donation;". At the end of paragraph 2(5), the words "by collaborating to harmonize global practices" should be altered to "by promoting international best practices". The first section of paragraph 2(6) should be amended to read "to strengthen national and multinational authorities and/or capacities to provide oversight, organization and coordination"; the rest of the paragraph would remain unchanged. The words "to recognize and implement" at the beginning of paragraph 2(8) should be altered to "to encourage the implementation

¹ Resolution EB124.R12.

of". Paragraph 3(2) should be amended to read: "to support Member States and nongovernmental organizations to ban trafficking in material of human origin and transplant tourism;". The word "human" should be inserted before "cells, tissues or organs" in paragraph 3(5). Lastly, the words "and other partners" should be deleted from paragraph 3(7).

The CHAIRMAN took it that the Board agreed to adopt the draft resolution with the above amendments.

The resolution, as orally amended, was adopted.¹

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

Human resources: annual report (including employment and participation of women in the work of WHO): Item 8.3 of the Agenda (Documents EB124/30 and EB124/30 Add.1)

The CHAIRMAN introduced the report contained in document EB124/30, and the staffing profile contained in document EB124/30 Add.1, and drew attention to the comments of the Programme, Budget and Administration Committee (paragraphs 43 and 44 of document EB124/3).

Dr KAMOTO (Malawi) asked whether the professional staff based at WHO headquarters were required to travel extensively to the regions; if that were the case, then the distribution of professional officers should give greater weight to where strategic action was taking place.

Dr DAHL-REGIS (Bahamas), speaking in her capacity as Chairman of the Programme, Budget and Administration Committee, said that the distribution of staff had been discussed by the Committee even though the staffing profile and geographical representation data set out in EB124/30 Add.1 had not been available to the Committee at that time. She asked whether the distribution of WHO field staff was aligned with the priorities of the Organization, notably in regard to achieving the Millennium Development Goals, particularly the indicator on maternal mortality. She asked how countries assessed the performance of technical work carried out by WHO at country level.

Mr AITKEN (Assistant Director-General), responding to the questions raised, explained that, in addition to the fact that some professional staff, such as auditors and translators, were stationed at headquarters but served the entire Organization, the distribution of professional staff was based on managers' judgement, exercised in line with the results-based management approach to ensure an appropriate balance between delivery at country level and the performance of the Organization overall. Regional officers received regular feedback from country officials on WHO's performance.

The DIRECTOR-GENERAL explained that there were historical reasons for the current distribution of professional staff, connected in part with the relatively limited degree of staff mobility and the availability of the requisite finances. WHO did encourage staff mobility as a matter of principle. Of greater importance, however, was the need to have clarity on the division of responsibility between the three levels of the Organization. It should also be emphasized that WHO was not an implementing agency but a technical one, providing normative standards and guidelines, much of which was still done in headquarters. Nevertheless, regional offices could take on

¹ Resolution EB124.R13.

responsibility for such work; for instance, the South-East Asia Regional Office was leading WHO's global leprosy programme.

She intended to conduct a careful review of the work being done by the Organization in order to match the best skill sets to the regions: for example, a great deal of experience on Chagas disease existed in the Region of the Americas and PAHO. If the Organization was to change itself into an implementing agency, then responsibilities would have to be allocated differently. Currently, staff from operational clusters, such as the Health Security Environment and the Health Action in Crises clusters, were deployed in situations of disease outbreak, conflict or natural disasters, while other departments invested more time in developing standards and guidelines. The success of the Organization would depend on the Secretariat's ability to support Member States. WHO had neither the mandate nor the resources to replace governments, but it would continue to provide technical support to help countries to build capacity in the health sector. WHO needed to be more forward-looking, and she would hold discussions with her assistant directors-general and regional directors to ensure that WHO was responding to the wishes and priorities of its Member States, including scaling up to achieve the Millennium Development Goals, action on the social determinants of health and strengthening health systems through primary health care.

Dr DAHL-REGIS (Bahamas), speaking in her capacity as Chairman of the Programme, Budget and Administration Committee, emphasized the urgency of acting to reduce maternal mortality rates and the need to find time to discuss and take action on the issue.

The DIRECTOR-GENERAL agreed that strengthening of country and regional capacity would be essential in order to reduce maternal mortality. She was already making staffing adjustments to ensure that the necessary skill sets were in place in various offices to tackle that and other problems. Millennium Development Goal 5 (Improve maternal health) had the highest priority, as it was the one towards which the least progress had been made.

She wished to raise another staffing issue: WHO's Financial Rule 112.2 required her to appoint a technically qualified head of the unit responsible for internal oversight after consultation with the Executive Board. She was also required to consult the Executive Board before any termination of the incumbent of that office. The current holder of the post of Director, Office of Internal Oversight Services, Mr Kenneth Langford, would be retiring in October 2009. She paid tribute to Mr Langford who had served WHO for many years with professionalism and integrity. She wanted a fair and transparent process for the recruitment of his successor. Following current review of the job profile, the vacancy would be widely advertised and made known to the largest possible pool of suitable candidates with particular efforts to attract candidates from developing countries. She urged Member States also to make the position known to national oversight services and professional bodies. She suggested that a director of internal audit from another United Nations organization should be invited to join the selection panel. She sought the Board's views on the proposed recruitment process and assured members that they would be kept informed of progress.

Mr HOHMAN (alternate to Dr Wright, United States of America) added his tribute to Mr Langford and supported the recruitment procedure outlined by the Director-General.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland), echoing the comments of the member for the United States, said that it was important to find somebody with the right qualities, and an expert in the same field from another United Nations organization would be of great help.

Mr CAMPOS (alternate to Dr Buss, Brazil), Dr AHMADZAI (Afghanistan), Dr REN Minghui (China), and Dr MOHAMED (Oman) also supported the proposed recruitment procedure.

The CHAIRMAN took it that the Board wished to note the report and endorse the Director-General's proposals for the recruitment procedure for the post of Director, Office of Internal Oversight Services.

It was so agreed.

Report of the International Civil Service Commission: Item 8.4 of the Agenda (Documents EB124/3 and EB124/31)

The CHAIRMAN drew attention to the report contained in document EB124/31 and to the report of the Programme, Budget and Administration Committee (document EB124/3), which had discussed the Report of the International Civil Service Commission at its ninth meeting.

The Board took note of the report.

Amendments to the Staff Rules and Staff Regulations: Item 8.5 of the Agenda (Documents EB124/3, EB124/34 and EB124/34 Add.1)

The CHAIRMAN drew attention to three draft resolutions contained in paragraph 20 of document EB124/34, together with their financial and administrative implications.

Dr DAHL-REGIS (Bahamas), speaking as Chairman of the Programme, Budget and Administration Committee, said that, in relation to draft resolution 1, the Committee had queried the amendment to Staff Rule 550.3, which proposed that staff members in the category of national professional officer should become eligible to receive the language allowance. The Secretariat had indicated that, in consulting with the International Civil Service Commission, it would promote its view that there should be a common United Nations system approach to the payment of the incentive to that category. The Committee had therefore recommended that, pending a decision on the matter by the United Nations General Assembly, draft resolution 1 should be amended by deleting the words "language incentive" and that the Board should adopt resolution 1 as amended. Accordingly, the existing text of Staff Rule 550.3 should be retained. The Committee had also recommended that the Board should adopt draft resolutions 2 and 3 concerning amendments to the Staff Regulations and remuneration of staff in ungraded posts and the Director-General.

Resolution 1,¹ as amended, and resolutions 2² and 3,³ as set out in paragraph 20 of document EB124/34, were adopted.

Statement by the representative of the WHO staff associations: Item 8.6 of the Agenda (Document EB124/INF.DOC./1)

Dr VAN MAAREN (representative of the WHO Staff Associations) delivered the statement, highlighting in particular the staff associations' concerns about the problems experienced since the introduction of the Global Management System at headquarters and in the Western Pacific Region.

¹ Resolution EB124.R14.

² Resolution EB124.R15.

³ Resolution EB124.R16.

Mr HOHMAN (alternate to Dr Wright, United States of America) expressed sincere appreciation for the work done by WHO staff at the international, regional and national levels. The United States and a number of other Member States shared the concern expressed by the representative of the WHO staff associations about the difficulties that had arisen since the introduction of the Global Management System. The staff associations should be made aware of the robust discussion about those problems by the Programme, Budget and Administration Committee, which had also expressed concerns.

The DIRECTOR-GENERAL said that she would convey to the WHO staff associations the appreciation expressed by the member for the United States of America of their valuable contribution to the work of the Organization. The expressions of concern about the Global Management System were justified. Nevertheless, it was clear that Member States appreciated the potential value of the System in improving the transparency of WHO's work and providing better detail in reporting on inputs, activities and outcomes. Efforts would be made in other WHO offices to prepare better for the transition to the Global Management System, for example by improving the quality of data for entry into the system. The system would not be introduced in those offices until it was operating smoothly.

In reply to a question from Ms TOELUPE (Samoa) on the current gender imbalance, she said that efforts were continuing to improve the gender and geographical balances as requested by the governing bodies. However, selection of the best candidate for the job remained the overriding concern in the recruitment of staff. Therefore, recruitment procedures included wide advertising to reach the highest possible number of candidates. If candidates were equally qualified, then preference in the selection process would generally be given to women and candidates from underrepresented developing countries.

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

4. MATTERS FOR INFORMATION: Item 9 of the Agenda

Reports of expert committees and study groups: Item 9.1 of the Agenda (Documents EB124/32 and EB124/32 Add.1)

The CHAIRMAN, drawing attention to the reports, informed the Board that the full report of the fourth meeting of the WHO Study Group on Tobacco Product Regulation would be published as No. 951 in the WHO Technical Report Series and was currently in press.

Dr REN Minghui (China) urged the WHO Study Group to gather further evidence to determine whether smokeless tobacco could be used as an aid to smoking cessation or as a method for harm reduction. Smokeless tobacco should be included within the scope of the WHO Framework Convention on Tobacco Control in order to facilitate management and regulation. With regard to the recommendation in paragraph 12 of the report, he disagreed that toxicant concentrations should be compared using units per milligram of nicotine in cigarette smoke and suggested that they should be compared using units per milligram of tar instead. With regard to the recommendation in paragraph 17 of the report, he pointed out that the fifth meeting of the working group on Articles 9 and 10 of the WHO Framework Convention on Tobacco Control had recommended that both the International Organization for Standardization regimen and the Canadian "intense" regimen should be used for testing. The relevant point was to specify which regimen had been used.

Mr PUSKA (Finland)¹ echoed the comments made by the member for China regarding the need for further evidence on smokeless tobacco. He observed that, in Finland, smoking rates had fallen. In all European Union countries except one, the sale of smokeless tobacco was prohibited; he could see no justification for the sale of a harmful, addictive product with damaging consequences for young people. He urged great caution in any consideration of whether to recommend smokeless tobacco as an aid to smoking cessation or as a method for harm reduction. Alternative evidence-based pharmacological and psychosocial methods for cessation and prevention should be actively supported as part of the tobacco control measures outlined in the WHO Framework Convention on Tobacco Control.

Mr RAJALA (European Commission) said that he shared the concerns of the previous speakers, which should be transmitted to the Study Group on Tobacco Product Regulation and considered by the Secretariat in its future actions. The independent Scientific Committee of the European Commission had found that smokeless tobacco was addictive and could directly cause adverse health effects, including various forms of cancer. The Committee had concluded that it was not possible to extrapolate the trends in smoking and oral tobacco use if smokeless tobacco products were made available in a country where they were currently unavailable. The Study Group would need to produce conclusive evidence that, firstly, smokeless tobacco could be used safely as an aid to smoking cessation and, secondly, that it could be safely introduced into markets where it was currently unavailable.

Dr BETTCHER (Tobacco Free Initiative) assured the previous speakers that their comments would be transmitted to the Study Group. He emphasized that the Organization did not and would not endorse or promote smokeless tobacco products as a smoking cessation aid or as a form of harm reduction. The Study Group had stated in its report that the evidence in that regard was inconclusive. Indeed, the link between smokeless tobacco and numerous forms of cancer had been proven and, therefore, it would be entirely inappropriate for WHO to endorse its use. He noted that the work of the Study Group had been conveyed to the Conference of the Parties to the WHO Framework Convention on Tobacco Control and he explained that the use of both the International Organization for Standardization regimen and the Canadian “intense” regimen had been recommended in order to allow a range of testing for cigarettes, from a low to a high threshold.

The CHAIRMAN thanked the experts who had taken part in the Study Group and asked the Secretariat to follow up on its recommendations.

The Board noted the report.

Progress reports: Item 9.2 of the Agenda (Documents EB124/33, EB124/33 Add.1 and EB124/33 Add.2)

A. Poliomyelitis: mechanism for management of potential risks to eradication (resolution WHA61.1)

Dr MOHAMED (Oman) urged poliomyelitis-endemic countries to consider eradication as a national priority and to overcome operational issues so that all children could be vaccinated. Countries where poliovirus had been reintroduced should react rapidly to prevent further international spread. Strategies to eradicate poliomyelitis were working, and transmission of indigenous wild poliovirus had been interrupted in most areas of the world. The Eastern Mediterranean Region, however, had suffered

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

some setbacks in 2008, particularly in Pakistan, a country which had previously been poliomyelitis-free, and in Afghanistan and the Sudan. The number of poliomyelitis cases had risen considerably, reaching almost epidemic levels in some parts of Afghanistan. The security situation in some of those areas made it difficult to carry out vaccination programmes. Still, the Region hoped to eradicate poliomyelitis by 2010.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) said that his Government was concerned that the current strategies were insufficient to achieve the eradication of poliomyelitis, exemplified by new outbreaks, notably in Africa. Despite numerous campaigns, more than 60% of children remained under-immunized in the high-risk northern part of Nigeria and that prolonged the risk of international spread. He called on the Secretariat and Member States to ensure that high-level political engagement was translated into more effective operations to reach every child. Strengthening routine immunization programmes in addition to conducting specific vaccination campaigns was critical. Governance was key in securing political will and commitment from the four endemic countries, and in optimizing the effectiveness of the Global Polio Eradication Initiative.

The evaluation of the intensified eradication effort must be frank, and clearly establish why children were not being vaccinated in some areas and determine action to correct those failures. Funding prospects remained good: his Government had recently made available significant further funding for eradication of poliomyelitis, as had key partners. Other Member States must also make contributions, and endemic countries must seize the opportunity to rid themselves of poliomyelitis. He suggested that those countries should be invited to report to the forthcoming Health Assembly on the review findings and on actions being taken.

Dr OULD JIDDOU (Mauritania), speaking on behalf of the Member States of the African Region, said that eradication in Africa could be compromised by the re-emergence of wild poliovirus type I in Nigeria. Vaccination coverage had been raised but 20% of the children targeted remained unvaccinated, in particular in the high-risk northern part of the country. Low herd immunity owing to suboptimal immunization coverage had allowed the virus to spread to several countries that had been poliomyelitis-free. Nigeria remained the only country where poliomyelitis was endemic in the Region, but confirmed cases of wild poliovirus had been recorded in eight other African countries as of August 2008. There were increasing concerns in Africa regarding the long-term risks of reintroduction of the poliovirus and re-emergence of poliomyelitis, as a result of the continued use of oral poliovirus vaccine once the disease had been eradicated. The views of the countries of the African Region must be taken into account in planning for post-eradication risk management.

Dr JAYANTHA (alternate to Mr de Silva, Sri Lanka) thanked the Director-General for making eradication of poliomyelitis the Organization's top operational priority, as should the regional offices so that all of the remaining countries where poliomyelitis was endemic and poliovirus had been reintroduced could benefit fully from WHO's support. In view of the ongoing risk of the importation of the poliovirus into areas free of the disease, he suggested that the Secretariat should prepare a report for the Health Assembly on additional measures that Member States could take to protect themselves from reinfection.

Dr SADRIZADEH (Islamic Republic of Iran)¹ regretted that, despite the remarkable achievements of the Global Polio Eradication Initiative, the disease remained endemic in four countries, with outbreaks continuing in 10 others. The international community would continue to provide support to the affected countries, but those countries, particularly the four in which

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

poliomyelitis was endemic, must mobilize resources to eliminate wild poliovirus from their territories. Should they fail to do so, three decades of achievements would be lost and the global consequences would be disastrous.

Dr BARNARD-JONES (Rotary International), speaking at the invitation of the CHAIRMAN, recalled that two independent bodies, the Advisory Committee on Polio Eradication and the Strategic Advisory Group of Experts for immunization, had recently reaffirmed the technical feasibility of eradicating poliomyelitis. Rotary International was increasing its own financial support for the eradication of the disease and was seeking to raise further funding. However, money alone was not the answer. The remaining countries affected by poliomyelitis must be genuinely committed to reaching and vaccinating more children. Political commitment must address urgently the remaining operational challenges, and to bring under control outbreaks in countries previously free of poliomyelitis before greater spread of the disease.

He was grateful to the Director-General for having made eradication of poliomyelitis a personal priority. The reviews of country campaigns concerning poliomyelitis should lead to refinements in eradication operations. The international community must not let slip the opportunity to improve the world through eradication of poliomyelitis. Rotary International would support all eradication efforts and looked forward to the day of victory.

Dr GEZAIRY (Regional Director for the Eastern Mediterranean Region) said that he had recently returned from Afghanistan and Pakistan. Despite the strong political commitment to eradicating poliomyelitis that existed, the security situation could seriously hinder the work. Since international staff were not allowed into security-compromised areas, nationals and local tribes people worked without proper supervision. The commitment of those engaged in conflicts was also required in order to end hostilities and enable effective work. Agreements had been brokered to cease hostilities and to permit the immunization of children.

No case of poliomyelitis had been reported in Afghanistan during the previous month. The disease could be eradicated from Afghanistan during 2009. Attempts had been made to extend vaccination coverage to those living close to the security-compromised areas as a prevention strategy in the event of importation of the virus from high-risk areas. That strategy had been successful in Somalia. National immunization days in Sudan were being increased following the importation of the virus into the south of the country from Chad and Ethiopia.

Recalling the support from Member States, Rotary International and the Bill & Melinda Gates Foundation, he said that the prospects for eradicating the disease were good.

Dr HEYMANN (Assistant Director-General) thanked the Board for its guidance and support, and Rotary International, the Bill & Melinda Gates Foundation, and the Governments of the United Kingdom and Germany for their announcement of additional support for poliomyelitis eradication. He also recalled Dr Omi's inspiring comments made earlier in the session. The Secretariat innovated in order to ensure that the best possible tools and evidence-based strategies were available to Member States. A full research agenda guided the best use of inactivated poliovirus vaccine.

The Director-General had, at the outset, called together the stakeholders in poliomyelitis eradication and laid down milestones. An external review of those two years was being finalized for publication in February 2009 in order to recommend solutions for removing any remaining obstacles to the eradication of poliomyelitis. It would represent a fresh, forward-looking appraisal of the poliomyelitis eradication efforts, and necessary steps would be included in the next strategic plan.

The DIRECTOR-GENERAL observed that the high political commitment to poliomyelitis eradication within the leadership of the four endemic countries needed to reach local levels. Mobilizing local leaders, particularly women, was essential to ensuring that every child was vaccinated. WHO was extremely grateful for the support from Rotary International and the other

donors mentioned earlier. Since the high-level consultation in early 2007, poliomyelitis eradication was a topic regularly reviewed by herself and the Regional Directors. Streamlined administration now enabled human and financial resources to be deployed where needed within 24 to 48 hours. She welcomed the request that she report to the Sixty-second World Health Assembly on progress and, in particular, on the evidence that would be gathered from the external review. WHO was committed to reporting honestly on what did and did not work, for the sake of collective and expeditious solutions.

B. Smallpox eradication: destruction of variola stocks (resolution WHA60.1)

Dr KAMOTO (Malawi), speaking on behalf of the Member States of the African Region, recalled that resolution WHA60.1 had requested the Director-General to review the membership of the WHO Advisory Committee on Variola Virus Research and the representation of advisers and observers at meetings of the Committee. The aim was to ensure balanced geographical representation and the independence of the members of the Committee from any conflict of interest. She requested an update on that representation.

She also recalled that the Secretariat had given an update at the Sixty-first World Health Assembly¹ on the legal status of the variola virus stocks held at the two repositories, as mandated by resolution WHA60.1. That report had noted that information was insufficiently clear. The Secretariat had concluded that there appeared to be uncertainties regarding ownership of the stocks in question. She therefore asked the Secretariat for further recommendations on how to address that challenge.

She supported the Advisory Committee's proposal to review all current research proposals. That would enable Member States to reach conclusions on the use of live variola virus and make decisions on the timing of destruction of the virus stocks. The Region had already incorporated the smallpox case definition and basic information into the revised guidelines for integrated disease surveillance and response. That accorded with the provisions of the International Health Regulations (2005) which required Member States to notify smallpox cases to WHO immediately. The African Region remained firmly committed to deciding on a date for destruction of the remaining stocks of variola virus as mandated by the Health Assembly.

Dr HEYMANN (Assistant Director-General) replied that the Secretariat had approached new experts with a view to their joining the Advisory Committee, whose membership would change in 2010.

C. Malaria, including proposal for establishment of World Malaria Day (resolution WHA60.18)

Dr BIN SHAKAR (United Arab Emirates), speaking on behalf of the Member States of the Eastern Mediterranean Region, reported that at its fifty-fifth session the Regional Committee had approved a resolution urging a step-by-step procedure for combating malaria. That included investment in training experts to combat malaria and greater support for subregional networks, notably in combating drug-resistant vectors. The funding difficulties referred to in the progress report were a matter of concern. Improved artemisinin-based treatment was needed, as were treatment organized at community level and rapid detection of cases in countries endemic for malaria. The United Arab Emirates had been declared malaria-free but his Government continued to work hard in order to maintain that status, particularly since malaria was a disease that migrated easily.

Dr DOS RAMOS (Sao Tome and Principe), speaking on behalf of the Member States of the African Region, emphasized the strengthening of health systems and intensification of community-based interventions. Review of programmes, timely implementation of appropriate measures, and

¹ Document A61/6.

rigorous tracking and evaluation of performance all required further efforts. Transborder initiatives involving several countries of the Region had helped to reduce malaria transmission in the target regions, thereby showing that coordinated support, increased funding and multi-country initiatives were crucial to success. Those outcomes should be documented and disseminated.

Nevertheless, most countries of the Region were still far from achieving universal coverage. In Sao Tome and Principe, malaria had been, until 2003, the leading cause of medical treatment, admission to hospital, and child deaths. Determination by the Government, technical support from WHO, and the efforts of multiple partners had led to a substantial drop in the number of cases with no more than three deaths in 2007. Areas to pursue included integration, multisectoral action and community participation, strategic and technical support for tracking, evaluation and consolidation of programmes.

Professor ALI (alternate to Professor Haque, Bangladesh) said that the Member States of the South-East Asia Region supported the observance of World Malaria Day. They had been working in collaboration with the Global Malaria Programme and the Roll Back Malaria Partnership in developing the *World malaria report 2008* and the Global Malaria Action Plan, successfully launched in September 2008. The Regional Office was working on supporting Member States in scaling up key interventions for malaria control in line with the Revised Malaria Control Strategy for the South-East Asia Region for 2006–2010.

Dr SERPAS MONTOYA (alternate to Dr Larios López, El Salvador) said that his country's malaria control programme had successfully reduced cases of malaria from more than 80 000 a year in the 1980s to fewer than 50 in 2007 and 2008. The present morbidity rate of 1 per 100 000 was one of the lowest in the world. Regarding the monitoring of progress, the fight against malaria must continue in those countries where it was a health priority. Likewise, achievements to date must also be preserved.

Dr NAKATANI (Assistant Director-General) confirmed that he had taken note of the concerns expressed and would follow up appropriately. Malaria was no longer the "poor relation" among major diseases as more resources were being received to combat it.

D. Implementation by WHO of the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors (resolution WHA59.12)

The Board noted the report.

E. Prevention and control of sexually transmitted infections (resolution WHA59.19)

Dr DOS RAMOS (Sao Tome and Principe), speaking on behalf of the Member States of the African Region, noted that sexually transmitted infections were a major cause of sickness and death in Africa. Their prevalence could be reduced through prevention, care, and access to health services. The Regional Committee for Africa had, at its fifty-sixth session, requested the Regional Office to draw up a framework for implementing WHO's Global strategy for the prevention and control of sexually transmitted infections, which should take account of the Region's specific characteristics and strategy for acceleration of HIV prevention. That framework had been drawn up and would be submitted for adoption in 2009. It emphasized promotion of healthy sexual behaviour to prevent sexually transmitted infections; improved management of such infections; strengthening of surveillance; and greater commitment of political leaders to preventing and combating sexually transmitted infections.

Areas in which to pursue efforts included: education and information for adolescents on responsible behaviour in the area of sexual health; creation of an environment conducive to lowered

vulnerability and better access to care; relevant programmes and clinical services, without stigmatization; improvement of service and care delivery in treatment of sexually transmitted infections; and provision of timely and reliable information on the scale and distribution of sexually transmitted infections in the general population, in vulnerable groups and in high-risk populations.

Ms MAFUBELU (Assistant Director-General) said that the Secretariat had taken note of action being taken in the African Region and would continue to provide the necessary support for implementation of the resolution.

F. Strengthening of health information systems (resolution WHA60.27)

Professor ALI (alternate to Professor Haque, Bangladesh) said that countries assisted by the Health Metrics Network had significantly improved their health information systems. Financial support from the Health Metrics Network had enabled his country to assess its own system. The Global Fund to Fight AIDS, Tuberculosis and Malaria had also provided support to countries for improving health information in cooperation with the Network. Nevertheless, the opportunity for cooperation had not been fully taken in some countries, including Bangladesh.

Countries such as his own required support to develop their health information plans, to build the information and communications networks that would be required in every hospital ward and community health office. The need to collect and build evidence and reliable data; to measure progress towards the Millennium Development Goals; and to analyse the health workforce. Yet no matter how keen they were to build information systems and analyse the data they provided, many developing countries confronted their scarce resources, often devoted to providing food and emergency medicines for their populations. WHO and the Health Metrics Network must continue to provide support to countries in implementing health information systems, with both financial and technical assistance to enable them to meet their goals.

Dr MAIGA (alternate to Mr Touré, Mali), speaking on behalf of the Member States of the African Region, emphasized reliable health information systems and accurate statistics at country level as the basis of recommendations and decision making. Progress had been made through the Health Metrics Network, and 13 countries in the African Region had undertaken evaluation of their resources and services at district level, focusing on areas such as fighting HIV/AIDS and tuberculosis.

Nevertheless, countries still faced significant challenges in strengthening health systems, to meet the objectives of eradication, elimination and epidemiological surveillance: building professional capacity; developing information and data gathering; implementation of coding systems in national and regional hospitals; and establishing links between strengthening information systems, policies and vertical programmes.

Decision-making and planning were facilitated by the availability of reliable data which in turn required greater resources and capacity at national level. The International Health Partnership Compact and WHO and other partners should launch an appeal to strengthen health systems, which were an essential prerequisite for developing countries in achieving the Millennium Development Goals.

Dr DAHL-REGIS (Bahamas) expressed strong support for the previous speaker's comments. "One-country" health information systems were desirable. She asked how the Secretariat planned to provide support to countries in establishing them and what the role of e-health should be in building health information systems.

Dr EVANS (Assistant Director-General) said that the importance of country health information systems had been identified mainly thanks to the work of the Health Metrics Network. Advocacy by the Network had succeeded in mobilizing more than US\$ 40 million in direct funding from Round 8 of

the Global Fund to Fight AIDS, Tuberculosis and Malaria to support proposals by countries to strengthen their health information systems. The global community was moving support towards the building of “one-country” health information systems. WHO was working with the Health Metrics Network and other partners in Member States in order to address both the supply side and the demand side in respect to strengthening health information systems.

With regard to e-health and information systems, WHO had been working on a health informatics strategy during the previous year, examining how information communications technology could benefit health information systems in two key areas: clinical and facility-based information systems and population-based surveillance. Work was ongoing in both areas, with particular attention being given to interoperability of systems.

G. Working towards universal coverage of maternal, newborn and child health interventions (resolution WHA58.31)

Dr MOHAMED (Oman), speaking on behalf of the Member States of the Eastern Mediterranean Region, highlighted the difficulties facing the Region, in particular political instability, shortages of financial and human resources and inadequate legislation. Each year, 55 000 mothers died in childbirth, and the annual figure for deaths of newborns was even higher. WHO had urged the global community to focus on Millennium Development Goals 4 and 5 with a view to improving maternal and child health worldwide. The Goals must be accorded sufficient attention and priority or they would not be met by 2015. More funding was needed for maternal, newborn and child health programmes. He urged WHO and other specialized agencies to improve understanding of countries' needs and to coordinate their programmes in order to provide more effective assistance.

Dr GOPEE (Mauritius), speaking on behalf of the Member States of the African Region, pointed out that maternal mortality in sub-Saharan Africa had fallen by only 0.1% between 1990 and 2005, much less than the minimum annual reduction of 5.5% required to meet Millennium Development Goal 5. Increasing the coverage of essential interventions had progressed very slowly and the proportion of births assisted by skilled attendants remained low in many countries. Africa accounted for over half of the world's under-five mortality: 4.6 million children under five died every year. Only five countries in the Region were on track to achieve Millennium Development Goal 4 by 2015.

In many countries, vital clinical care for children still lagged behind. He contrasted the gains made in vaccination coverage, vitamin A supplementation and malaria prevention with the lack of progress in treating children with pneumonia, malaria or diarrhoea. Additional investment for maternal, newborn and child health interventions would be needed if Millennium Development Goals 4 and 5 were to be achieved in the Region. Nevertheless, efforts had produced positive results. He outlined a range of measures taken by African countries, including the implementation of national action plans, training of staff, support for local capacity-building and expanding newborn care.

Mauritius provided health care free of user cost and allocated around 2% of its gross domestic product to health. It had established comprehensive antenatal and postnatal services for pregnant women, and provided universal immunization coverage against tetanus. All deliveries took place in public hospitals or private clinics and were attended by skilled staff; specialist care was always available. His Government was committed to reducing the infant mortality rate to less than 10 per 1000. The maternal mortality ratio had stood at 0.37 per 1000 live births in 2007.

Increasing coverage remained the biggest challenge facing many countries in the African Region, given the weak health systems, insufficient funding and poor community participation in maternal, newborn and child health care.

Ms MAFUBELU (Assistant Director-General) said that she had noted the concerns about the lack of progress towards Millennium Development Goal 5, particularly as reflected in unacceptably high levels of maternal mortality. The Secretariat would continue to increase its support to Member

States to enable them to expand the numbers and distribution of skilled birth attendants; widen access to emergency obstetric care; increase medical supplies; and expand services, including referral services. Those measures would help Member States to deal effectively with the four main lethal threats to women in pregnancy and childbirth. To achieve that aim, additional investment in maternal, newborn and child health would be needed. She expressed appreciation for the experience shared by the member for Mauritius, particularly with regard to reducing user costs for health care. The Secretariat would continue to work with Member States and with other international organizations, in particular UNICEF, UNFPA and the World Bank.

H. Strategy for integrating gender analysis and actions into the work of WHO (resolution WHA60.25)

Dr ZARAMBA (Uganda), speaking on behalf of the Member States of the African Region, said that there was still significant misunderstanding of gender issues at community level, with persistent sociocultural barriers in many countries in the Region. The focus on women and girls was important, but men and boys must not be overlooked. A multisectoral approach was needed in order to mobilize partners. WHO's collaboration at global and regional levels must be translated into greater action at country level.

Ms MAFUBELU (Assistant Director-General) said that the Secretariat was working to ensure the involvement of men and boys in efforts to improve gender balance.

I. Rational use of medicines (resolution WHA60.16)

Dr ZARAMBA (Uganda), speaking on behalf of the Member States of the African Region, emphasized the need for a multisectoral approach in order to mobilize partners. The countries in the Region were at different stages in their implementation of rational use strategies, but clearly many needed support. Dissemination of information and raised public awareness about the rational use of medicines was also needed.

Mr LANDOETA (Bolivarian Republic of Venezuela)¹ said that the progress report should have contained more details on community participation and its relationship to primary health care, and on the link between rational use of medicines and the advertising and promotion of medicines. The existence and activities of specialized therapeutic committees should also have been mentioned. His country's programmes included training of multipliers to relay information to the community at large, producing training manuals supplementary materials in accessible languages, and multi-media campaigns. Health authorities, professionals and the community were all involved in efforts to promote rational use of medicines.

Dr ETIENNE (Assistant Director-General) said that the Secretariat was taking a multistakeholder approach in the area of essential medicines, notably in reorienting programmes to reflect the renewed emphasis on primary health care. The community education programmes introduced in the Bolivarian Republic of Venezuela were noteworthy in that regard. When resolution WHA60.16 had been adopted, it had been estimated that about US\$ 50 million would be required over a period of five years in order to implement the resolution in full. Implementation had been constrained up to then by the inability to mobilize sufficient resources.

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

J. Better medicines for children (resolution WHA60.20)

Dr DJIBO (Niger), speaking on behalf of the Member States of the African Region, said that each year 10 million children died of illnesses for which effective treatments already existed. Often they died because of inadequate clinical services, lack of medicines or of paediatric formulations, and the cost of medicines. The treatment of neglected tropical diseases was affected by an absence of paediatric formulations. A survey undertaken in 14 African countries in 2007 had indicated a lack of training at all levels in regard to: the inclusion of medicines for children in the list of essential medicines; availability of those medicines; and insufficient guidance on standard treatments.

Many countries in the Region continued to experience shortages of paediatric medicines and lacked the resources to put into effect strategies to promote their rational use.

Dr ETIENNE (Assistant Director-General) said that the Secretariat's activities to implement resolution WHA60.20 were well funded and were achieving significant results. She expressed appreciation to Member States for their support and urged them to continue their collaboration.

K. Health technologies (resolution WHA60.29)

Dr KAMOTO (Malawi), speaking on behalf of the Member States of the African Region, commended WHO's leadership on the issue. Health technology was a pillar of health service delivery, but it remained a weak point of national health systems in Africa. The high cost of equipment and devices, and the lack of policies and guidelines on procurement and donation of health technology, left most countries in the Region with poor-quality and outdated technologies. Frequently, abandoned equipment occupied needed space in health facilities. Guidelines and training on preventive and corrective maintenance were also in short supply.

Six countries in the Region were currently implementing policies for health technology management. The guidance on health technologies currently being elaborated by WHO and other partners was eagerly awaited. She called on the Director-General to continue encouraging Member States to draw up national plans for the assessment, procurement and management of such technologies. The Region would appreciate both technical and financial assistance.

Dr DAHL-REGIS (Bahamas) said that countries in the Caribbean had a system in place that had proved useful in the selection of health technologies and that might be adopted in other regions.

Dr ETIENNE (Assistant Director-General) said that WHO's health technologies programme was being strengthened significantly. Guidance on donation was already available and guidelines for procurement were being prepared. Updated policies and tools should become available during the second half of 2009 and would include a glossary of health technologies and medical devices. The Secretariat was working with other organizations in the United Nations system to harmonize the use of medical devices related to activities to achieve the Millennium Development Goals and primary health care, and was also working with regional partners and Member States.

The Board took note of the reports.

5. CLOSURE OF THE SESSION

Dr ZARAMBA (Uganda) observed that, as the Board's session had progressed, time constraints on speakers had increased, and a full sharing of experiences in respect of the later agenda items had not always been possible. He recalled his earlier statements opposing expansion of the Health Assembly's provisional agenda.

Mr VIEGAS (alternate to Dr Buss, Brazil) announced that his Government proposed to host a global conference in July 2010 on social determinants of health, in pursuance of the request to the Director-General in paragraph 4(10) of resolution EB124.R6. By that date, two thirds of the time frame for achievement of the Millennium Development Goals would have elapsed. For that reason, he proposed that both matters should be discussed at the conference.

The DIRECTOR-GENERAL said that discussions at the present session had been exceptionally frank and informative, giving her a better understanding of what the Board expected of the Secretariat and how, by working together, the Organization's goals might be accomplished. The session had seen the appointment of a new Regional Director for the Western Pacific, Dr Shin Young-soo, and the reappointment of Dr Samlee Plianbangchang as Regional Director for South-East Asia. It had also expressed appreciation to Dr Shigeru Omi on his retirement as Regional Director for the Western Pacific. Dr Omi had urged WHO to finish the task of eradicating poliomyelitis, reminding all parties concerned that there were no excuses for not doing so. The disease had been eradicated in the Western Pacific Region despite serious security problems, fragile political commitment and uncertain funding. Freedom from such a crippling and disabling disease would be a lasting gift to the world. The remaining obstacles were operational rather than technical and could be managed together.

Members of the Board had clearly articulated their full commitment to the attainment of the Millennium Development Goals and their deep concern at the lack of progress on some specific goals and in certain geographical areas, notably Africa. They had also displayed a strong commitment to primary health care, showing how it could further the objectives of equity, social justice and universal access while also increasing efficiency. The report of the Commission on Social Determinants of Health had been welcomed as a policy tool for tackling the root causes of inequities in health. Member States had announced plans to give effect to the Commission's recommendations; one example was the Brazilian Government's offer to host a global conference in 2010. Concerns about the health impact of the financial crisis had influenced the Board's discussions. As requested, WHO would continue the work begun in the previous week at the high-level consultation on the financial economic crisis and global health. The Government of Norway would host a regional consultation on the subject and she thought it likely that other regions would follow suit.

The lack of progress in reducing maternal mortality was a major concern and one that she shared. The answers lay in strengthening health systems in order to increase the numbers of skilled birth attendants and improve emergency obstetric care, but that was a slow process. She had heeded members' requests for prompt information on what needed to be done and how to do it.

The high level of the Board's technical discussions had signalled its confidence that the work of WHO mattered and that the agreements reached would have an impact at a practical as well as a policy level. She pledged to tackle the hard work that would be required with a renewed sense of duty and satisfaction.

After the customary exchange of courtesies, the CHAIRMAN declared the 124th session closed.

The meeting rose at 18:50.
