

TWELFTH MEETING

Friday, 22 January 2010, at 18:15

Chairman: Dr S. ZARAMBA (Uganda)

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

Guidance on the WHO review of psychoactive substances for international control: proposed revision: Item 4.18 of the Agenda (Document EB126/21)

The CHAIRMAN said that, in May 2009, the Board had postponed discussion on the matter in order to implement a consultation process with Member States on the proposed revisions to the Guidelines.¹ The proposed amendments to the Guidelines were included as an annex to the report and he invited further comments.

Mr OULD ABDI SALEM (adviser to Dr Ould Horma, Mauritania), speaking on behalf of the Member States of the African Region, thanked the Secretariat for the report. The purpose of the review was to consolidate international recommendations on pharmacodependence and clarify the WHO review process, ensuring that it was based on scientific and public health-related principles.

The proposed amendments to the Guidelines, prepared by a group comprising six Member States from four regions and three experts, suggested the use of current good practices for assessing the abuse liability of substances, the use of the Internet to improve the transparency of the process, and the reporting and publishing of the Expert Committee's procedures. He supported the proposed amendments.

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union, expressed appreciation for the work carried out by Member States, the Expert Committee on Drug Dependence, the Expert Advisory Panel on Drug Dependence, and other experts and proposed the following amendments to the wording of paragraph 23: subparagraph 23(5) should be separated into two points so that subparagraph 23(5) read "toxicology", and a new subparagraph 23(6) would read "adverse reactions in humans"; in subparagraph 23(8) "and epidemiology of medical use" should be added to the end of the sentence; and in subparagraph 23(12) the words "of medical and" should be deleted so that the phrase read "epidemiology of non-medical use, abuse and dependence".

Ms ROCHE (New Zealand) proposed the following amendment: in paragraph 45 the phrase "Any proposal for a change in the existing status of the substance should be made only if specific new control measures are necessary ..." should be changed to "Any proposal to move a substance from one convention to another should be made only if specific new control measures are necessary ..." with the paragraph then continuing unchanged.

Ms BLACKWOOD (United States of America)² reported that her country had submitted comments to the online discussion and emphasized that the modifications had improved the review guidelines, allowing for a more precise and scientific assessment in the review of substances.

¹ See document EB125/2009/REC/1, summary record of the first meeting, section 5.

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

The steps in the control process for substances with narcotic abuse potential was the responsibility of multiple organizations and bodies, including the International Narcotics Control Board, the Commission on Narcotic Drugs and WHO. Decisions relating to drug scheduling should be made based on several factors, including the abuse potential and the drug's availability for medical and scientific use.

She proposed the following amendments: the sixth line of paragraph 4 should be changed to read "including the risk of abuse and the need to ensure medical availability, as well as the relevant resolutions ..."; and in paragraph 45, "universal access to essential medicines for" should be deleted, so the last line would read "and will not unduly limit availability for medical and scientific purposes."

In addition, she commented that the phrase "essential medicines" should not be used in guidelines for narcotic drugs scheduling as the term had a specific meaning to WHO and the list of essential medicines was not reviewed by the Expert Committee. The term "universal access" could also cause confusion, as it did not appear in either the Single Convention on Narcotic Drugs, 1961 or the 1971 Convention on Psychotropic Substances.

Dr DAHL-REGIS (Bahamas), in response to the CHAIRMAN's request for support for the amendments proposed by the representative of the United States of America, offered her support, and emphasized the importance of the removal of the term "essential medicines".

Dr ETIENNE (Assistant Director-General) expressed her appreciation for the contributions of the Member States on the issue. It was essential that the medical needs of patients who use psychoactive drugs were addressed without limiting access, while addressing the dependency and abuse potentials of those drugs. She had noted the proposed amendments; the changes would be implemented accordingly.

The Board approved the revised guidelines on the WHO review of psychoactive substances for international control, as amended.¹

Availability, safety and quality of blood products: Item 4.16 of the Agenda (Documents EB126/19, EB126/19 Add.1 and EB126/19 Add. 2) (continued from the eleventh meeting)

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union, thanked Board members and the Secretariat for their work and patience on the issue and announced that he was ready to adopt the draft resolution.

Dr TAKEI (adviser to Dr Omi, Japan) thanked the member for the United Kingdom of Great Britain and Northern Ireland for his proposals, and announced that he too wished to adopt the draft resolution.

The Board adopted the resolution, as amended.²

Treatment and prevention of pneumonia: Item 4.20 of the Agenda (Document EB126/40)

The CHAIRMAN, introducing the item, noted that the end of the first sentence of paragraph 6 of the report should read "under-five mortality is estimated at US\$ 38 billion." He also drew attention to a draft resolution proposed by the United Kingdom of Great Britain and Northern Ireland, which read:

¹ See EB126/2010/REC/1, Annex 6.

² Resolution EB126.R14.

Accelerating progress towards achievement of Millennium Development Goal 4
(Reduce child mortality): prevention and treatment of pneumonia

The Executive Board,

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

The Sixty-third World Health Assembly,

Aware of the joint WHO/UNICEF report on a global action plan for the prevention and control of pneumonia, presented in November 2009;¹

Noting the first advance market commitment on the pneumococcal vaccine and the progress made so far in integrating the *Haemophilus influenzae* type b vaccine into routine immunization programmes;

Noting also the introduction of the pneumococcal Accelerated Development and Introduction Plans;

Concerned at the lack of substantial progress towards reducing morbidity and mortality from pneumonia, despite it being globally the leading cause of mortality of children under the age of five years, and recognizing that prevention of pneumonia in children would significantly help progress towards reaching Target 4.A (Reduce by two thirds, between 1990 and 2015, the under-five mortality rate) of Millennium Development Goal 4 (Reduce child mortality);

Noting that safe and highly effective tools are available for pneumonia control in the form of the WHO's Integrated Management of Childhood Illness approach for case management at all levels, universal childhood immunization against *Haemophilus influenzae* type b and *Streptococcus pneumoniae* infections, improvement of nutrition and low birth weight, control of indoor air pollution, and prevention and management of HIV infection;

Concerned that pneumonia continues to cause more than 1.8 million preventable deaths in children less than five years of age globally each year;

Noting that the GAVI Alliance and other donors have made substantial resources available, and that the International Finance Facility for Immunisation provides a powerful mechanism for directing resources to immunization programmes;

Welcoming the contribution to the mobilization of resources for development of voluntary innovative financing initiatives taken by groups of Member States;

Mindful that decreasing the global burden of pneumonia will be essential for reaching Target 4.A (Reduce by two thirds, between 1990 and 2015, the under-five mortality rate) of Millennium Development Goal 4 (Reduce child mortality);

Noting in addition that efforts to strengthen the capacity of health systems to detect and manage pneumonia effectively are likely also to contribute positively to efforts to achieve Millennium Development Goal 5 (Improve maternal health);

Aware that pandemic (H1N1) 2009 has raised awareness of the need for system-wide strengthening of management of serious acute respiratory infections, and noting that the time is therefore opportune to build upon investments made related to the pandemic and to continue efforts to ensure that patients with acute respiratory infections receive prompt and effective treatment,

¹ Document WHO/FCH/CAH/NCH/09.04.

1. URGES Member States:
 - (1) to apply according to their specific contexts, the policies, strategies and tools recommended by WHO;
 - (2) to establish evidence-based national policies and operational plans for strengthening health systems in order to expand coverage of populations at risk with major preventive and curative interventions;
 - (3) to assess programme performance and the coverage and impact of interventions in an effective and timely manner, particularly with use of WHO's country-profile database;
 - (4) to identify national and international resources, both human and financial, for strengthening health systems and for the provision of technical support in order to ensure that the most locally and epidemiologically appropriate strategies are implemented and target populations reached;
 - (5) to seek to implement, where appropriate, the recommendations in the joint WHO/UNICEF global action plan for the prevention and control of pneumonia, noting the importance of:
 - (a) immunization
 - (b) case management at community, health centre and hospital levels
 - (c) exclusive breast-feeding for six months
 - (d) improvement of nutrition and prevention of low birth weight
 - (e) control of indoor air pollution, and
 - (f) prevention and management of HIV infection;
 - (6) to encourage integrated approaches to pneumonia prevention and treatment through multisectoral collaboration and community responsibility and participation;

2. REQUESTS the Director-General:
 - (1) to strengthen human resources for prevention and control of pneumonia at all levels, especially the country level, thereby improving the capacity of WHO's country offices to provide support to national health programmes for coordinating the work of partners on preventing and controlling pneumonia;
 - (2) to bring together interested Member States, organizations in the United Nations system, the GAVI Alliance, medical research councils, and other interested stakeholders in a forum in order to improve coordination between different stakeholders in the fight against pneumonia;
 - (3) to report to the Sixty-fourth World Health Assembly, through the Executive Board, on progress made in implementation of this resolution as part of the progress report on the achievement of the health-related Millennium Development Goals.

The financial and administrative implications of the resolution would be:

1. Resolution Accelerating progress towards achievement of Millennium Development Goal 4 (Reduce child mortality): prevention and treatment of pneumonia	
2. Linkage to programme budget	
Strategic objective:	Organization-wide expected result:
1. To reduce the health, social and economic burden of communicable diseases.	1.1 Policy and technical support provided to Member States in order to maximize equitable access of all people to vaccines of assured quality, including new immunization products and technologies, and to integrate other essential child-health interventions with immunization.

4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals.

4.5 Guidelines, approaches and tools for improving child health and development applied at the country level, with technical support provided to Member States for intensified action towards universal coverage of the population with effective interventions and for monitoring progress, taking into consideration international and human-rights norms and standards, notably those stipulated in the Convention on the Rights of the Child.

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

The resolution is consistent with the listed expected results and supports the following indicators: for strategic objective 1 – (i) Number of Member States with at least 90% immunization coverage (DPT 3); and (ii) Number of Member States that have introduced *Haemophilus influenzae* type b vaccine into their national immunization schedule; and for strategic objective 4 – (i) Number of targeted Member States that have an integrated policy on universal access to effective interventions for improving maternal, newborn and child health and (ii) Number of Member States implementing strategies for increasing coverage with child health and development interventions.

3. Budgetary implications

(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities)

US\$ 110 million are required for the period 2010–2015 in respect of costs at headquarters and at regional and country office levels.

(b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant)

In respect of strategic objective 1: headquarters – total US\$ 5.9 million (US\$ 900 000 for staff, US\$ 5 million for activities); regional and country offices – total US\$ 27.4 million (US\$ 5 million for staff, US\$ 22.4 million for activities).

In respect of strategic objective 4: headquarters – total US\$ 600 000 (US\$ 450 000 for staff, US\$ 150 000 for activities); regional and country offices – total US\$ 8 million (US\$ 2.4 million for staff, US\$ 5.6 million for activities).

(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?

Yes.

4. Financial implications

How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?

In respect of strategic objective 1: funds for 2010 are available through the GAVI Alliance and the Gates Foundation. Some of the funding required for 2011 may be available through the same sources, but a funding gap is likely to appear in 2011.

In respect of strategic objective 4: voluntary contributions will be sought to fund these activities.

5. Administrative implications

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

All levels of WHO, with a specific focus on the 68 priority countries that are the focus of the “Countdown to 2015” initiative, on which the disease places a high burden. Most of the countries concerned are also eligible for funding from the GAVI Alliance.

(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below

No. Additional staff will be needed to implement the resolution, especially in countries with a high burden of the disease.

(c) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile)

Three staff members (full-time equivalent) at the P4 grade: 1 at headquarters, 1 at the Regional Office for South-East Asia and 1 at country level.

(d) Time frames (indicate broad time frames for implementation of activities)

The period 2010–2015.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) recalled that pneumonia was the leading cause of death of children under five years of age. When discussing the approach to the disease, it was important to consider also the economic impact of the disease, on both communities or governments and individual families, such as lost hours at work, hospital and treatment costs and sometimes funeral costs. In order to achieve Millennium Development Goal 4 (Reduce child mortality), it was vital that control of pneumonia be given priority.

Besides his own, the following countries had agreed to cosponsor the draft resolution: Austria, Belgium, Burundi, the Czech Republic, Denmark, France, Ghana, Hungary, Ireland, Italy, Israel, Malawi, Malta, Monaco, New Zealand, Niger, Nigeria, Oman, Paraguay, Peru, Poland, Portugal, Serbia, Slovenia, Spain, Sao Tome and Principe, and Uganda. Following further discussion with other Member States, he proposed the following, minor amendments to the original text: in the fourth preambular paragraph “and recognizing that prevention of pneumonia in children would significantly help progress towards reaching Target 4.A (Reduce by two thirds, between 1990 and 2015, the under-five mortality rate) of Millennium Development Goal 4 (Reduce child mortality)” be deleted; a new paragraph should be inserted between the fourth and fifth preambular paragraphs to read “Mindful that decreasing the global burden of pneumonia will be essential for reaching Target 4.A of Millennium Development Goal 4;”; the last line of the fifth preambular paragraph should read “control of indoor air pollution arising from household use of solid fuels ...”; the first line of the seventh preambular paragraph should read “Noting that the GAVI Alliance and the PAHO Revolving Fund for Immunization ...”; the ninth preambular paragraph, beginning “Mindful that decreasing ...”, should be deleted; in operative paragraph 1(1), the words “to prevent and treat pneumonia” should be inserted at the end; in subparagraph 1(2), “major” should be replaced by “effective”; and subparagraph 1(3) be changed to read “to assess programme performance including the coverage and impact of interventions in an effective and timely manner, and use this assessment to inform WHO’s country profile database;”.

Dr DAHL-REGIS (Bahamas) asked with regard to the reported 67% reduction in deaths due to pneumonia (paragraph 7 of the report) what proportion was expected to be from prevention of disease due to *Streptococcus pneumoniae*? She also asked for clarification of the financial and administrative implications of the Board’s adoption of the resolution, in particular how Member States that were not among the 68 priority countries that were the focus of the “Countdown to 2015” initiative would benefit from the existing procurement mechanisms. Furthermore, how would the PAHO procurement fund apply to the 68 priority countries or remaining Member States? What infrastructure was available to deliver vaccines, in relation to for instance vaccine costs and formulations and human resources? The administrative implications document indicated that work would be done at all levels of the Organization; what preparatory work had been done? Finally, what commitment was there to financial sustainability beyond the period during which the GAVI Alliance supplied the vaccine? Previous experience showed that political commitment rather than donor commitment was the problem.

Ms TOELUPE (Samoa) agreed with the points raised by the member for the Bahamas relating to procurement of vaccines, human resources and financial issues, but expressed further concern about the aspects of equity and universal access inherent in the philosophy of primary health care and instruments such as the United Nations Convention on the Rights of the Child. Other countries, including small island countries such as her own, would also benefit from the investment in pneumococcal conjugate vaccine programmes.

Dr MUÑOZ (Chile) said that, every winter, his country set up so-called “acute respiratory infection rooms” in primary health care centres, with medical staff, including kinesiologists, and supplies of bronchodilator medicines. An extensive immunization campaign and wide-ranging awareness-raising activities were also conducted. Since 1990, mortality from pneumonia among children under the age of one year had fallen from 242 to 33 per 100 000 live births, or from 600 deaths per year to about 15. He welcomed the measures for primary health care, hospital care and pneumococcal vaccination campaigns advocated in the draft resolution. His country wished to be included as a sponsor.

Dr KABULUZI (Malawi), speaking on behalf of the Member States of the African Region, welcomed the inclusion on the agenda of the item on pneumonia, which was a significant cause of death in children under five years of age, particularly in Africa, and placed a heavy burden on families and health systems. Its control was essential if the Millennium Development Goal 4 (Reduce child mortality) was to be achieved.

In Malawi, with a population of some 30 million people, more than 800 000 cases of acute respiratory tract infection had been reported in children under five years of age in 2008 alone, leading to about 1500 deaths. Malawi needed more national and international resources to tackle the problem. He called upon international agencies to intensify their support for the implementation of the Global Action Plan for the Prevention and Control of Pneumonia in developing countries and upon WHO and partners to help to fill gaps in knowledge about pneumonia control in Member States, coordinate their efforts and develop appropriate tools.

Mr KAZI (adviser to Professor Haque, Bangladesh) proposed the following amendments to the draft resolution, which had been drawn up after consultation with the delegation of Thailand. In the title, the brackets around the words “Reduce child mortality” should be removed. A new preambular paragraph should be added after the current third paragraph, along the following lines: “Recalling that World Health Assembly resolution WHA58.15 on the Global Immunization Vision and Strategy requested the Director-General to mobilize resources to promote the availability and affordability in countries of future new vaccines based on evidence of epidemiological profiles”. Another new preambular paragraph should be added after the fifth preambular paragraph along the following lines: “Further noting that affordable price of vaccines in preventing pneumonia and significant scaling-up of cold-chain capacities determine the adoption and implementation of vaccination programmes, particularly in developing countries”.

Paragraph 1(5) should be amended to read: “to implement the recommendations ...”. Subparagraph 1(5)(a) should be amended to read: “immunization by accelerating the adoption of affordable and cost-effective vaccines based on evidence of national epidemiological profiles”. Paragraph 2(2) should be amended to read: “the fight against pneumonia, and mobilize resources to promote the availability of *Haemophilus influenzae* type b and pneumococcal vaccines”.

Dr MOHAMED (Oman) said that reducing mortality from pneumonia, especially among children under five years of age, was a major priority for primary health care in general and the achievement of Millennium Development Goal 4 in particular. If reductions in mortality were to be achieved, a programme of universal immunization would be required. That had been achieved in most Member States of the Eastern Mediterranean Region, including his own. The price of vaccines had fallen by 50% owing to increased competition among vaccine manufacturers and cooperation between countries through the GAVI Alliance. However, prices needed to fall even further. A funding

mechanism similar to the PAHO Revolving Fund had been established in the Region five years before, although it had yielded few quantifiable results as yet. He called upon the Secretariat to continue its work to help countries to increase their vaccination coverage and reduce the associated costs.

Mr PRASAD (alternate to Ms Sujatha Rao, India) supported the draft resolution as amended by the member for Bangladesh and agreed with the concerns raised by the member for the Bahamas. He remained concerned about the financial, logistical and human-resource implications for a large country such as his own. In addition, more research was needed into the pneumococcal strains circulating in India. He called for more consultation on the subject before it was brought up at the Health Assembly.

Dr BUSS (Brazil) expressed full support for the draft resolution, as amended by the member for Bangladesh. Brazil had added pneumococcal vaccines to its immunization programme and had begun to manufacture those vaccines itself through the Oswaldo Cruz Foundation.

Ms BULLINGER (Switzerland)¹ said that her country had been omitted from the list of sponsors of the draft resolution, and asked for it to be restored.

Dr NAKORN PREMSI (Thailand)¹ welcomed the draft resolution as amended by the member for Bangladesh. His country valued the joint WHO/UNICEF global action plan for the prevention and control of pneumonia. The report gave the impression that immunization against bacterial causes of pneumonia was a major contributor to mortality reduction. Evidence cited in the *Bulletin of the World Health Organization*, however, had identified respiratory syncytial virus as the major cause of childhood pneumonia;² bacterial vaccines were not a “magic bullet”. Good case management at the community, health-centre and hospital levels was the most significant factor, and the report should reflect that fact. All pneumonia-control measures should be integrated into general health care interventions.

Dr REN Minghui (China)¹ sought clarification of paragraph 2(3) of the draft resolution. He recalled resolution WHA61.18, in which the Director-General was requested to report annually to the Health Assembly on progress towards achievement of the health-related Millennium Development Goals. He understood the draft resolution to mean that reports on pneumonia-control activities should form a major component of those annual reports.

Dr MAFUBELU (Assistant Director-General) said that WHO’s policy on pneumonia control took an integrated approach, which certainly did not treat vaccination as a “magic bullet”. Replying to the points raised by the member for the Bahamas, she said that almost 97% of child deaths from pneumonia occurred in the 68 priority countries mentioned in the report. Demand for vaccines was expected to rise, which should cause prices to fall for all countries. Moreover, new manufacturers were expected to enter the market, including some from developing countries, a move that should also bring prices down.

In respect of delivery systems, WHO and UNICEF were working together to help countries to meet the requirements relating to cold chains and appropriate human resources necessary to obtain funding from the GAVI Alliance. As for financial sustainability, there were various issues related to reliance on the GAVI Alliance as a source of funding, but consideration needed to be given to cofinancing or use of a country’s own domestic resources; political commitment was important.

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

² Rudan I et al. Epidemiology and etiology of childhood pneumonia. *Bulletin of the World Health Organization*, 2008;**86**:408–416.

Some US\$ 110 million would be required to implement the measures proposed in the draft resolution. It would be necessary to mobilize additional resources, and the Secretariat would provide assistance with that process, at Member States' request.

WHO worked with UNICEF, UNFPA and the World Bank to intensify support to countries, including conducting research to fill the gaps in knowledge that still existed and disseminating the resulting information.

Dr OKWO-BELE (Immunization, Vaccines and Biologicals) said that the figure for the potential reduction in mortality of 67% was based on estimates that indicated that 30% to 40% of pneumonia deaths were attributable to streptococcal infection and a further 20% to *Haemophilus influenzae* type b. In some cases, bacterial and viral coinfection could occur.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) apologized for the omission of Switzerland as a sponsor and announced that Chile wished also to be a sponsor.

Dr YOUNES (Office of Governing Bodies), affirming that the title of the draft resolution would be adjusted in line with the request from the member for Bangladesh, read out the proposed amendments to the draft resolution, beginning with the preambular paragraphs. A new paragraph should be inserted after the third, reading: "Recalling that resolution WHA58.15 on the global immunization strategy requested the Director-General to mobilize resources to promote the availability and affordability in countries of future new vaccines based on evidence of epidemiological profiles". The latter part of the fourth paragraph, from "and recognizing that prevention" to "Millennium Development Goal 4 (Reduce child mortality)", should be deleted. A new paragraph should be added after the fourth, reading: "Mindful that decreasing the global burden of pneumonia will be essential for reaching Target 4.A of Millennium Development Goal 4". The end of the fifth paragraph should be amended to read: "... indoor air pollution arising from household use of solid fuels, and prevention and management of HIV infection". A new paragraph should be added after the fifth, reading: "Further noting that affordable price of vaccines in preventing pneumonia and significant scaling up of cold-chain capacities determine the adoption and implementation of vaccination programmes particularly in developing countries;". The first line of the seventh paragraph should be amended to read: "Noting that the GAVI Alliance and the PAHO Revolving Fund for Immunization have made substantial resources available ...". The ninth paragraph should be deleted.

In paragraph 1, the end of subparagraph 1(1) should be amended to read: "... recommended by WHO, to prevent and treat pneumonia;". The word "major" towards the end of subparagraph 1(2) should be replaced by "effective". Subparagraph 1(3) should be amended to read: "to assess programme performance including the coverage and impact of interventions in an effective and timely manner, and use this assessment to inform WHO's country-profile database;". The words "where appropriate" in the first line of subparagraph 1(5) should be deleted. Subparagraph 1(5)(a) should be amended to read: "immunization by accelerating the adoption of affordable and cost-effective vaccines based on evidence of national epidemiological profiles;". Finally, the end of subparagraph 2(2) should be amended to read: "... stakeholders in the fight against pneumonia and mobilize resources to promote the availability of Hib and pneumococcal vaccines;".

Dr DAHL-REGIS (Bahamas), with regard to the seventh preambular paragraph, requested clarification as to the connection between the GAVI Alliance and the PAHO Revolving Fund for Immunization, which was a procurement fund.

The DIRECTOR-GENERAL said that the GAVI Alliance was both a funding mechanism and a co-investment partnership, working with governments, whereas the PAHO fund was strictly a procurement mechanism – Member States in the Region of the Americas had to pay for the vaccines.

Dr GIMÉNEZ (Paraguay) stressed the importance of the PAHO fund for Latin American Member States in affording them equitable access to vaccines through group purchases, as well as in offering technical support.

The DIRECTOR-GENERAL concurred, but clarified that the PAHO fund was not a mechanism to provide funds but to facilitate collective purchasing. The paragraph in question aimed to recognize the role of the GAVI Alliance and the International Finance Facility for Immunisation in mobilizing resources to assist countries.

The CHAIRMAN added that the PAHO fund made vaccines available at slightly reduced prices, thereby enabling Member States to pay less or procure more.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) proposed that, in order to remove any confusion, the paragraph could read: “Noting that the GAVI Alliance and other donors have made substantial resources available, and that the International Finance Facility for Immunisation and the PAHO Revolving Fund for Immunization provide powerful mechanisms for directing resources to immunization programmes”.

Dr GIMÉNEZ (Paraguay) said that the mention of the PAHO Revolving Fund should appear immediately after that of the GAVI Alliance.

Dr REN Minghui (China)¹ asked whether paragraph 2(3) meant to say that the Director-General would only report on progress in implementing the resolution to the Sixty-fourth World Health Assembly, and that the pneumonia component would not figure in any subsequent progress reports on the achievement of Millennium Development Goal 4.

The DIRECTOR-GENERAL said that paragraph 2(3) had been intended to mean that the contribution of the pneumonia component to overall achievement of Millennium Development Goal 4 would not be reported to the Health Assembly before 2011, and that it would then form part of every subsequent annual report. The Secretariat would rewrite the paragraph appropriately.

Dr VIROJ TANGCHAROENSATHIEN (Thailand),¹ drawing attention to the evidence published in 2008 that second-hand smoking was another major risk factor contributing to childhood pneumonia,² suggested that the words “and second-hand smoking in households” should be inserted after “household use of solid fuels” at the end of the fourth preambular paragraph.

Mr PRASAD (adviser to Ms Sujatha Rao, India) and Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) supported the amendment proposed by the representative of Thailand.

In the absence of any further comments, the CHAIRMAN took it that the Board wished to adopt the draft resolution, as amended.

The resolution, as amended, was adopted.³

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

² Anthony J, Scott G. The global epidemiology of childhood pneumonia 20 years on. *Bulletin of the World Health Organization*, 2008; **86**:494-495.

³ Resolution EB126.R15.

Leprosy (Hansen disease): Item 4.21 of the Agenda (Document EB126/41)

The CHAIRMAN drew attention to a draft resolution on leprosy proposed by Brazil, which reads:

The Executive Board,
Having considered the report on leprosy;¹

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

The Sixty-third World Health Assembly,
Having considered the report on leprosy;
Considering the history of certain other diseases that demonstrates the impossibility of their eradication, as in the case of leprosy;

Considering that leprosy is a contagious disease, caused by slow-growing mycobacteria and, consequently, with a prolonged incubation period;

Recognizing that the diagnosis of leprosy is based on clinical examination of patients and epidemiologic data, as no test yet exists that enables an early diagnosis, in either the subclinical phase or the incubation period;

Considering that only diseases for which there are vaccines have been eradicated or eliminated and that there is no vaccine for leprosy;

Considering that the control of leprosy is based on early diagnosis of cases, with the aim of eliminating the sources of infection and avoiding the sequelae resulting from late diagnosis and the absence of adequate monitoring;

Recognizing that the target for elimination of leprosy as a public health problem is reduction of the prevalence to less than one case per 10 000 population was adopted, with the objective of breaking the transmission chain and reducing the number of cases among the population, by the Health Assembly in resolution WHA44.9 in 1991;

Recognizing that, for the reasons stated in the previous paragraphs and despite having added political strength to the control programmes, this objective was not achieved, as has been demonstrated by several studies and confirmed in WHO's epidemiological reports;

Considering that since the year 2000 the Health Assembly has not adopted a specific resolution on the theme;

Aware that, recognizing the need to review WHO's targets, the managers of leprosy programmes of 44 Member States, with the participation of WHO regional offices as well as nongovernmental organizations, representing the people affected by leprosy (New Delhi, 20–22 April 2009), agreed an enhanced global strategy for further reducing the disease burden due to leprosy: 2011–2015 which focused on the reduction of new cases, and operational guidelines;²

Further considering that, according to WHO, eliminating a disease is achieving a condition in which there are no occurrences of new cases, or achieving incidence zero with the need to maintaining control measures,

¹ Document EB126/41.

² Documents SEA-GLP-2009.3 and SEA-GLP-2009.4, respectively.

1. URGES Member States:
 - (1) to adapt appropriately their national policies to the “enhanced global strategy for further reducing the disease burden due to leprosy: 2011–2015”,¹ with a reduction target up to 35% until 2015;
 - (2) to consider the following as the main technically sustainable indicators for monitoring progress of the endemic: the number and the coefficient of detected new cases per 100 000 population, the coefficient of detected new cases with grade 2 incapacity in the general population, and the proportion of cured patients;
 - (3) to adopt as indicators for evaluating the detection of leprosy the proportion of new cases with grade 2 incapacity, and the proportion of cases of in women and children and the proportion of multibacillary cases among new cases;
 - (4) to incorporate into their specific contexts policies, strategies and WHO’s recommended instruments to define and implement actions to promote health, prevention, diagnosis and assistance to those affected with leprosy;
 - (5) to strengthen leprosy control programmes at the national level;

2. REQUESTS the Director-General:
 - (1) to provide the necessary support to Member States for introducing into their public policies the targets and indicators referred to in paragraphs 1(1)–1(3) of this resolution;
 - (2) to provide the necessary support for the development of scientific research related to prevention, diagnosis and treatment of leprosy;
 - (3) to consider the possibility of allocating additional resources in order to ensure that the knowledge arising from research be translated into efficient public health policies for the control and prevention of leprosy, including in accordance with the global strategy on public health, innovation and intellectual property;²
 - (4) to report to the Sixty-fifth World Health Assembly, through the Executive Board, on progress in implementing this resolution.

The financial and administrative implications of the draft resolution, if adopted, would be:

1. Resolution Leprosy (Hansen disease)	
2. Linkage to programme budget	
Strategic objective: 1. To reduce the health, social and economic burden of communicable diseases.	Organization-wide expected result: 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 is consistent with the indicator on leprosy for the expected result.	
3. Budgetary implications	
(a) Total estimated cost for implementation over the life-cycle of the Secretariat’s activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).	
The estimated cost for the period 2010 to 2015 is about US\$ 16 580 000.	

¹ Document EB126/41.

² Adopted in resolution WHA61.21.

- (b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).**

The estimated cost for the biennium is US\$ 5 320 000 (African Region, US\$ 1 980 000; Region of the Americas, US\$ 510 000; South-East Asia Region, US\$ 1 350 000; Eastern Mediterranean Region, US\$ 140 000; Western Pacific Region, US\$ 150 000 and headquarters, US\$ 1 190 000).

- (c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?**

Yes.

4. Financial implications

- How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?**

From voluntary contributions from donors such as the Nippon Foundation and some individual members of the International Federation of Anti-Leprosy Associations.

5. Administrative implications

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

The Global Leprosy Programme is based in the Regional Office for South-East Asia under the leadership of the Regional Director. The technical and administrative management of the leprosy-control activities in WHO will be carried out by the Programme. The donation for the supply of drugs for multidrug therapy and logistics pertaining to distribution are to be handled by headquarters.

- (b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.**

Yes.

- (c) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile).**

No additional staff required.

- (d) Time frames (indicate broad time frames for implementation of activities).**

2010–2011. The following activities will be implemented: improving quality of currently reported data on grade 2 incapacity among new cases; improving monitoring and evaluation including surveillance of drug resistance; capacity building of health workers; promoting early detection of new cases and treatment with multidrug therapy; strengthening integration of leprosy-control activities into general health-care services; promoting activities aimed at reducing stigma and discrimination against persons affected by leprosy and their families.

2012–2015. The following activities will be implemented: promoting early detection of new cases and treatment with multidrug therapy; improving monitoring and evaluation including surveillance of drug resistance; capacity building of health workers; promoting activities aimed at reducing stigma and discrimination against persons affected by leprosy and their families; improving referral services for management of acute and chronic complications including rehabilitation services.

Mr HAGE (adviser to Dr Buss, Brazil), introducing the draft resolution, recalled that the Health Assembly had adopted resolution WHA44.9 on leprosy, in 1991 amid the great optimism generated by the early successes of multidrug therapy, and had given a major political boost to national leprosy control programmes. However, evidence of increasing resistance to that therapy over 25 years had been confirmed in review published in 2005. In 2009 the Regional Office for South-East Asia had issued an enhanced global strategy for further reducing the disease burden due to leprosy for the period 2011–2015,¹ based on the recommendations of 44 programme managers attending a meeting on leprosy control strategy (New Delhi, 20–22 April 2009). The outcome included a new deadline and fresh guidelines for (and indicators to monitor progress towards) eliminating leprosy as a public health problem. Resolution WHA44.9 had set the target of a reduction in prevalence to a level below one case per 10 000 population; that figure did not amount to zero incidence and might be interpreted as effective elimination, possibly leading to a relaxation of leprosy-control measures and a dismantling of surveillance and health-care services, which might in turn lead to a greater risk of tardy diagnosis and more serious new cases. Furthermore, if governments ceased regarding leprosy as a priority, financial and technical resources for existing programmes might become harder to come by, thereby undermining the political impetus initially provided by resolution WHA44.9. The three main indicators contained in the enhanced global strategy were far more comprehensive and clear than their predecessors; they made it possible to identify which strategies to prioritize in order to have a better impact on the disease; and they had been developed, and the guidelines had been updated, on the basis of proposals from the managers in countries endemic for leprosy, of which Brazil itself was a major example, as well as on more recent and sounder scientific evidence. He therefore recommended that the Board adopt the draft resolution.

Mr CHAUDHRY (adviser to Ms Sujatha Rao, India) outlined the progress his country had made in combating leprosy from 1955 through to its elimination as a public health problem at the national level, according to the indicator of fewer than one case per 10 000 population, in December 2005. The three remaining states yet to reach that goal were expected to do so by 2012. Although the national prevalence had fallen to less than 100 000 cases, some 134 000 new cases were still being detected each year, a situation that would only improve gradually owing to the lengthy incubation period of the infection. In the meantime, the Indian national health system, aware of the risk of an accumulation of hidden and untreated cases, remained vigilant and committed to early detection and treatment.

Dr DAHL-REGIS (Bahamas) supported the draft resolution, especially the target in paragraph 1.

Dr DJIBO (Niger), speaking on behalf of the Member States of the African Region, said that they had managed to reach the target of reducing the prevalence of leprosy to a level below one case per 10 000 population – thereby eliminating it as a public health problem – at the national level, and had set themselves the target of doing likewise at the health-district level. Understandably, they therefore remained attached to resolution WHA44.9 and resolution AFR/RC44/R5 Rev.1 on elimination of leprosy in the African Region adopted by the Regional Committee for Africa in 2004, and would regard it as a step in the wrong direction for the Region to call their validity into question.

Dr KÖKÉNY (Hungary), speaking on behalf of the European Union, said that the commitment set out in resolution WHA44.9, to attain the global elimination of leprosy as a public health problem, remained as valid today as it had been in 1991. Anything less would constitute a serious step backwards. The Secretariat should continue to work towards the elimination of leprosy in the small number of countries that had not yet achieved the target of reaching prevalence below one case per

¹ Document SEA-GLP-2009.3.

10 000, while providing support to countries with a low prevalence of leprosy in order to sustain their leprosy activities through a combination of integrated services supported by specialized referral facilities.

Dr TAKEI (adviser to Dr Omi, Japan) thanked all stakeholders for their efforts to achieve the target of attaining the global elimination of leprosy. When that objective had been set in 1991, there had been about 4.5 million cases of the disease, whereas in 2008 slightly more than 213 000 cases had been notified; 120 of the 122 countries in which leprosy had previously been endemic had achieved the elimination target. WHO and the international community should help the countries that continued to encounter difficulties in attaining that goal.

Japan was concerned that the draft resolution was much weaker than resolution WHA44.9. There was no evidence indicating that it was impossible to eradicate leprosy; vaccination was not the only medical tool for achieving eradication of a particular disease, as had shown for dracunculiasis. Multidrug therapy was a powerful weapon in reducing prevalence, and BCG vaccine had been scientifically proven to offer some protection against leprosy. Insufficient evidence had been provided to ascertain whether the indicators and targets referred to in subparagraphs 1(1)–(3) were scientifically appropriate. WHO should convene the Expert Committee on Leprosy in order to examine the scientific evidence and distribute the findings to Member States. The past gains achieved in eliminating leprosy should be built on in order to eradicate the disease.

Dr SADRIZADEH (Islamic Republic of Iran)¹ thanked WHO for its significant efforts to eliminate leprosy since 1991. The number of cases had been drastically reduced, and the disease had been eliminated in 120 of the countries considered to be endemic for leprosy, including Iran. The argument that leprosy could not be eradicated because of the long incubation period and the absence of a vaccine was therefore questionable. WHO should continue to work towards the elimination of leprosy in countries where the disease remained a public health problem, and assist the countries in which the prevalence was low in sustaining their activities against leprosy, through a combination of integrated services supported by specialized referral facilities. He too encouraged WHO to convene the Expert Committee on Leprosy to review the current situation, establish new leadership of the WHO Global Leprosy Programme, and strengthen the efforts to eliminate leprosy by building on past gains.

Mr HAGE (adviser to Dr Buss, Brazil) said that representatives of countries where leprosy remained endemic had held discussions within the framework of the WHO Global Leprosy Programme. They had identified the need to develop indicators, considering that the more scientific evidence available, the easier it would be to control the disease. Brazil, for its part, had made sustained efforts to reduce the prevalence of leprosy, which had fallen by more than 30% over the previous five years. However, for a number of countries the target of reaching prevalence below one case per 10 000 was not sufficient in view of the need to avoid a resurgence of the disease. He welcomed the suggestion by the member for Japan of a review of the scientific evidence available.

Dr DAHL-REGIS (Bahamas) supported the proposed convening of the Expert Committee on Leprosy.

The CHAIRMAN suggested that, as the Board had not reached consensus on the draft resolution, the Director-General should convene the Expert Committee before the 128th session of the Executive Board in order to consider the scientific information. She should circulate the Committee's findings to Member States.

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

The DIRECTOR-GENERAL thanked Brazil for its flexibility. There was no conflict with Brazil's intention to raise awareness of the important work on leprosy. The concern was the length of time that had passed since a resolution had been adopted in order to raise political commitment and technical awareness of the leprosy issue. It was her understanding that Brazil would wish to participate in work of the Expert Committee, which she would convene as soon as possible, to consider the latest evidence and review existing indicators of progress in order to ascertain whether better indicators could be introduced. Countries would be able to propose a draft resolution at a future date depending on the outcome of the Expert Committee's work.

Mr HAGE (adviser to Dr Buss, Brazil) said that his country sought to ensure continued progress in the control of leprosy given the fact that political commitment could dwindle as more countries achieved the target of reaching prevalence below one case per 10 000. Brazil's concern was based not only on its own assessment but also on discussions with other countries where leprosy was endemic. The aim was to ascertain whether more recent scientific evidence and the use of other indicators would provide for more effective control. He agreed with the recommendation for the Director-General to convene the Expert Committee during 2010.

The CHAIRMAN said that he took it that the Board agreed to the convening of the Expert Committee on Leprosy, and to take up the subject again at its 128th session in January 2011.

It was so agreed.

2. MANAGEMENT MATTERS: Item 7 of the Agenda (continued)

Provisional agenda of the Sixty-third World Health Assembly and date and place of the 127th session of the Executive Board: Item 7.4 of the Agenda (Document EB126/27)

Dr YOUNES (Office of Governing Bodies) said that the Secretariat had noted one amendment to the draft provisional agenda for the Sixty-third World Health Assembly contained in the report. A new subitem had been proposed for Committee A, under item 11, Technical and health matters, namely item 11.23 on Treatment and prevention of pneumonia. The subitem entitled "Progress reports" would thus become subitem 11.24.

The DIRECTOR-GENERAL, responding to a request for clarification from Dr DAHL-REGIS (Bahamas) as to the duration of the Health Assembly, said that, in accordance with the conclusion of the Programme, Budget and Administration Committee, an optimal duration of the Health Assembly would be five days for non-budget years; accordingly, the Health Assembly in May 2010 would span five days. Appropriate agenda management, good time management and discipline on the part of Member States would be required if the full agenda was to be completed. The Secretariat would circulate information in that regard to the broader membership of WHO.

The CHAIRMAN said that he took it that the Board wished to adopt the draft decision contained in paragraph 3 of document EB126/27, as amended.

The decision was adopted.¹

The CHAIRMAN said that, since the Board had elected a new officer at its current session, namely Dr E.R. Sedyaningsih (Indonesia), it would be appropriate to update the decision taken in 2009 on

¹ Decision EB126(3).

representation of the Board at the Sixty-third World Health Assembly. He therefore invited the Board to consider the following draft decision:

Further to decision EB125(4) of 23 May 2009, and in accordance with paragraph 1 of resolution EB59.R7, the Executive Board decided to appoint its Chairman, Dr S. Zaramba (Uganda), and its first three Vice-Chairmen, Dr E.R. Sedyaningsih (Indonesia), Dr E. Giménez (Paraguay) and Professor Sohn Myongsei (Republic of Korea) to represent the Executive Board at the Sixty-third World Health Assembly. It was understood that if any of those members were not available for the Health Assembly, the other Vice-Chairman, Dr A.J. Mohamed (Oman) and the Rapporteur, Professor T. Milosavljević (Serbia), could be asked to represent the Board.

The decision was adopted.¹

The CHAIRMAN suggested that the 127th session of the Executive Board should be held in Geneva from 24 May 2010, closing no later than 26 May 2010, although in fact it was envisaged that it would last only one day.

Dr KÖKÉNY (Hungary), noting that it had just been agreed that the Health Assembly would finish on Friday, 21 May, asked whether it would be possible to schedule the Board's session for Saturday, 22 May 2010.

The DIRECTOR-GENERAL pointed out that the election of new Board members was scheduled to take place on Friday, 21 May and that it might be difficult for the newly elected members to make the necessary visa and travel arrangements in order to be present on Saturday, 22 May.

After an exchange of views in which Dr JESSE (Estonia), Dr DJIBO (Niger), Dr SADRIZADEH (Islamic Republic of Iran),² Dr MOHAMED (Oman), Dr DAHL-REGIS (Bahamas), the DIRECTOR-GENERAL and the CHAIRMAN participated, the CHAIRMAN invited the Board to agree that the 127th session of the Board should be held on Saturday, 22 May 2010, it being understood that the Secretariat would determine whether the timetable of the Health Assembly could be adjusted to permit the election of new Board members early in the week and in accordance with the Rules of Procedure.

It was so agreed.

The DIRECTOR-GENERAL appealed to Member States to ensure, with the support of the Regional Directors, that the mechanisms for proposing Members entitled to designate members to serve on the Board and for making the visa and travel arrangements for those so designated were implemented as expeditiously as possible so that all the newly elected Board members could attend the 127th session.

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

The meeting rose at 20:40.

¹ Decision EB126(2).

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