SECOND MEETING

Monday, 16 January 2012, at 14:35

Chairman: Mr R. EL MAKKAOUI (Morocco)

1. REPORT OF THE PROGRAMME, BUDGET AND ADMINISTRATION COMMITTEE OF THE EXECUTIVE BOARD: Item 4 of the Agenda (Document EB130/4) (continued)

Dr BIRINTANYA (Burundi), speaking on behalf of the Member States of the African Region, expressed concern at the budgetary imbalances in the Programme budget 2010–2011 and the funding shortfalls already identified for the period 2012–2013. Further efforts were needed to identify flexible financing options and ensure better mobilization of resources to cover those gaps.

The Organization's efforts to reduce currency risks and resolve the systemic problem of outstanding salary advances were laudable but, for the former, more effective and sustainable long-term solutions were a priority, and in the case of the latter the Secretariat should strengthen the Global Management System so as to avoid recurrence of similar situations.

Internal control framework reports should concentrate on work done in the year covered by the report before outlining actions to be taken in the subsequent year. An independent external evaluation of WHO should be conducted to find radical and sustainable solutions to the Organization's problems. In the light of current circumstances, particularly with respect to human resources, the Office of Internal Oversight Services could not be expected to conduct the first phase of the evaluation, as the Independent Expert Oversight Advisory Committee had recommended.

In the context of the reform process, maintaining an open dialogue with representatives of the staff was particularly important. The steps already made towards decentralization were welcome and should be pursued by transferring posts currently held at headquarters to regional and country offices. Priority programmes should be protected from excessive cuts in staff. Currently-empty key posts should be filled as soon as the financial outlook improved.

Balanced geographical and gender representation should be ensured within the Independent Expert Oversight Advisory Committee.

Dr DANKOKO (Senegal) deplored the fact that, in finalizing its report to the Board, the Programme, Budget and Administration Committee had seen only a version in English, creating difficulties for participants speaking other languages, who had taken the risk of adopting a text that had been modified during a debate in which they could not participate. Multilingualism should be the byword at all the Organization's meetings, in order to guarantee transparency, equity and democracy.

2. TECHNICAL AND HEALTH MATTERS: Item 6 of the Agenda

Global burden of mental disorders and the need for a comprehensive, coordinated response from the health and social sectors at the country level: Item 6.2 of the Agenda (Document EB130/9)

The CHAIRMAN drew attention to the following draft resolution, which had been proposed by India, Switzerland and the United States of America and which read as follows:

The Executive Board,

Having considered the report on global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level,[1]

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

The Sixty-fifth World Health Assembly,

PP1 Having considered the report on global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level;

PP2 Recalling resolution WHA55.10, which urged Member States to increase investments in mental health both within countries and in bilateral and multilateral cooperation, as an integral component of the well-being of populations;

PP3 Recalling further United Nations General Assembly resolution A/RES/65/95, which recognized that "mental health problems are of major importance to all societies and are significant contributors to the burden of disease and the loss of quality of life, and have huge economic and social costs" and which also welcomed the WHO Report on *Mental Health and Development*,[2] which highlighted the lack of attention to mental health in development, and made the case for governments and development actors to reach out to people with mental disorders in poverty reduction and development strategies as well as education, employment, health, social protection and other policies;

PP4 Noting the High Level Meeting of the United Nations General Assembly on the Prevention and Control of Noncommunicable Diseases, held 19–20 September, 2011, which recognized that mental and neurological disorders, including Alzheimer's disease, are an important cause of morbidity and contribute to the global noncommunicable disease burden, for which there is a need to provide equitable access to effective programmes and health-care interventions;

PP5 Recognizing that mental disorders can be disabilities, as reflected in the United Nations Convention on the Rights of Persons with Disabilities, which also notes that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others and that the *World Report on Disability*[3] charts the steps that are required to improve the participation and inclusion of people with disabilities, including persons with mental disabilities;

[1] Document EB130/9.

[2] Funk M et al (Eds). Mental health and development: targeting people with mental health conditions as a vulnerable group. Geneva, World Health Organization, 2010.

[3] World Health Organization, The World Bank, World Report on Disability. Geneva, World Health Organization, 2011.

PP6 Concerned that millions of people worldwide are affected by mental disorders, that in 2004, mental disorders accounted for 13% of the global burden of disease, defined as premature death combined with years lived with disability, and that, when taking into consideration only the disability component of the burden of disease calculation, mental disorders account for 25.3% and 33.5% of all years lived with a disability in low- and middle-income countries, respectively;

PP7 Concerned also that exposure to humanitarian emergencies is a potent risk factor for mental health problems and psychological trauma and that social structures and ongoing formal and informal care of persons with severe, pre-existing, mental disorders are disrupted;

PP8 Recognizing that the treatment gap for mental disorders is high all over the world, and that between 76% and 85% of people with severe mental disorders receive no treatment for their mental health conditions in low- and middle-income countries, and that the corresponding figures for high-income countries are also high – between 35% and 50%;[1]

PP9 Noting that mental disorders are often co-morbid with noncommunicable diseases and a range of other priority health conditions, including HIV/AIDS, maternal-child health, and violence and injuries, and that in women and children, mental disorders often coexist with other medical and social factors, such as poverty, harmful use of alcohol and exposure to domestic violence and abuse, which have a negative impact on the quality of life;

PP10 Recognizing that the social and economic impact of mental disorders, including mental disabilities, is diverse and far-reaching;

1. URGES Member States:
   (1) to develop comprehensive policies and strategies that address care, support and treatment of persons with mental disorders by promoting human rights, tackling stigma, addressing poverty and, as appropriate, creating opportunities for generating income, providing housing and education as well as providing health-care services in the community;
   (2) to give appropriate priority to mental health in health and development programmes and to allocate appropriate resources in this regard;
   (3) to collaborate with WHO in the development of an Action Plan to enable persons with mental disorders to live a full and productive life in the community;

2. REQUESTS the Director General:
   (1) to develop a comprehensive Action Plan for consideration by Member States, covering services, policies, plans, strategies, programmes and legislation, to enable persons with mental disorders to live a full and productive life in the community;
   (2) to include in the Action Plan provisions to address:
      (a) protection, promotion and respect for the rights of persons with mental disorders;
      (b) access to quality comprehensive health services that include mental health at all levels of the health care system;

[1] Demyttenaere K et al (2004). JAMA, 291:2581–90.

(bbis) development of adequate human resources to provide mental health services equitably;

(c) access to educational and social services, including health care, schooling, housing, secure employment and participation in income generation programmes;

(d) involvement of civil society organizations of persons with mental disorders in voicing their opinions and contributing to decision-making processes;

(e) participation of people with mental disorders in family and community life and civic affairs; and

(f) mechanisms to involve all relevant sectors in Member States in the implementation of the Action Plan

(3) to collaborate with Member States, international, regional and national nongovernmental organizations, donors and technical agency partners in the development of the Action Plan.

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

1. Resolution: Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level

2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)

Strategic objective(s): 3

Organization-wide expected result(s): 3.1, 3.2, 3.5 and 3.6

How would this resolution contribute to the achievement of the Organization-wide expected result(s)?

The implementation of the resolution would increase political, financial and technical commitment in Member States to tackle mental disorders. It would also provide support for the development of services, policies, plans, strategies, programmes and legislation to enable people with mental disorders to live full and productive lives in the community through the adoption of a coordinated and integrated approach across all sectors including health, social services and housing, education and employment.

Does the programme budget already include the products or services requested in this resolution? (Yes/no)

No

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

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

(i) One year to develop the action plan (covering the period 2012)

(ii) Total US$ 970 000 (staff US$ 270 000; activities: US$ 700 000)

(b) Cost for the biennium 2012–2013

Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US$ 10 000).

Total US$ 970 000 (staff US$ 270 000; activities: US$ 700 000)

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

The costs would be incurred at all levels of the Organization.

Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

No

If "no", indicate how much is not included.

US$ 900 000

(c) Staffing implications

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

No

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

One P.4 staff member (50% full-time equivalent) would be required for 12 months at headquarters in order to coordinate both the development of the action plan and the relevant consultations.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

No

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

US$ 900 000; source(s) of funds not yet known.

The CHAIRMAN suggested that members comment first on the report before proposing amendments to the draft resolution.

Mr DESIRAJU (India) noted that, although the burden of mental disorders in low- and middle-income countries in particular was high, the subject had not received the attention merited in national health and development plans. Countries needed to confront the realities of mental disorders, which resulted in, and were in some cases caused by, poverty, lack of opportunity, and stigmatization, and, as the report mentioned, the social and economic impacts, such as homelessness, violation of rights, drug abuse and domestic violence. Recognition of the importance of dealing with mental disorders was increasing, both in WHO with its recent reports and with the recognition by the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (New York, 19 and 20 September 2011) that mental disorders deserved attention. Countries needed to recognize that national responses could be put in place. The WHO Mental Health Gap Action Programme, which had not been developed in consultation with Member States, did not adequately cover prevention of mental disorders, raising public awareness and health promotion. The Secretariat could contribute significantly to better coordination by developing a comprehensive action plan, helping to strengthen

health services for the mentally ill and tackling the social determinants of mental disorders. He appealed to all Member States to support the draft resolution.

Dr LARSEN (Norway) observed that mental health was influenced mainly by factors outside the health-care sphere, including family, school, work and community. Greater awareness of the impact of such social determinants was needed, and that should be reflected in the draft resolution. The number of new cases of mental disorders should be reduced through universal measures for health promotion and disease prevention. He endorsed the Secretariat's proposed strategy of providing packages of care on the basis of their cost-effectiveness, affordability and feasibility. Pharmacological treatment was not sufficient; sustainable psychosocial strategies to help people to cope with their condition and the challenges of daily life should also be promoted. Efforts to prevent the stigmatization and violation of human rights often faced by the mentally ill should continue. Besides improving health care, public health work had to be broadened to deal with factors outside the health system.

A distinction should be made between neurological disorders, such as epilepsy and dementia, and other mental disorders, such as depression, as the latter often represented an even greater challenge than the former, in both low- and high-income countries. The two types of disorders also had different causes, risk factors, prevention measures and treatments.

Ms REINAP (Estonia), speaking on behalf of the European Union and its Member States, welcomed the connection between mental health and other noncommunicable diseases that had been recognized at the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (New York, September 2011). Health inequalities were particularly apparent between people with mental disorders and the rest of the population, but the Member States of the European Union, many of which had instituted comprehensive mental health strategies, had significantly narrowed that gap in recent years. The European Pact for Mental Health and Well-being reflected the European Union's commitment to good practice in priority areas of mental health. The Secretariat should accord high priority to work on the effective management of mental disorders, including the promotion of mental health and well-being. Such work must be based on four main principles: promotion of human dignity and social justice; combating stigmatization and discrimination; commitment to the recovery model; and use of holistic approaches combining practical and emotional support.

Mental health systems should focus on promoting early intervention, which was vital to balancing risk to both the patient and the public; providing care in the least restrictive environment possible; encouraging independence; improving the education and training of mental health professionals; and taking a holistic view of health.

The European Union supported the proposed draft resolution, but noted the need to avoid duplication of efforts, for instance through not repeating the work already done by the Secretariat.

Mr DÍAZ ANAIZ (Chile) said that mental disorders, a growing concern in most countries, could only be addressed effectively through the coordination of all social sectors, given the influence of social factors on mental health. In that connection, Chile had formulated a national health strategy for 2011–2020, one objective of which was to improve the functioning of people with mental disorders. The actions set out in the proposed draft resolution were in line with the measures his country had already been taking for several years, and were worthy of support.

Dr ABDI (Somalia) said that people with mental disorders were vulnerable and neglected; more than half of them were homeless and many were deprived of their basic human rights. There was a wide gap between the need for and provision of treatment for mental disorders, which were a public health concern worldwide, especially in countries in emergency situations. Somalia fully supported

WHO's recommendations for improving mental patients' quality of life, which included the provision of better mental health care, greater human rights protection and increased access to welfare services and housing. In low- and middle-income countries, funding for the prevention and treatment of mental disorders remained inadequate. He supported the draft resolution.

Dr GULLY (Canada) said that his country was committed to promoting mental health and well-being as an important means of reducing illness, disability and injury. That and the prevention of mental disorders called for multipartner collaboration, and his Government was working closely with provincial and territorial governments and other stakeholders on various population-specific initiatives. In 2007 Canada had set up a mental health commission to develop a national strategy and raise awareness of mental illness.

He endorsed the proposed draft resolution. If it were adopted, countries would probably need to review their population demographics in order to tailor approaches to specific groups, such as aboriginal youth or the elderly. Already-existing strategies and tools would be useful in that regard.

Dr VALENTIN (Seychelles), speaking on behalf of the Member States of the African Region, said that the long-standing exclusion of mental disorders from the global health agenda had led to huge disparities in national approaches to mental health. Outpatient mental health facilities were 58 times more prevalent in high-income countries than low-income countries, and, in the former, mental health legislation covered 92% of the population as opposed to 36% in the latter. He welcomed the increasing attention that was being paid to mental health internationally, in particular by WHO, given the revelation of how little was spent on mental health worldwide and the inequitable distribution of resources for mental health.

He recommended the following: mental health services should be linked more effectively with other health sector services; greater attention should be paid to mental disorders as a subset of noncommunicable disease; the human rights of persons with mental disorders should be fully respected and the public should be made aware of mental health issues; and WHO should increase its efforts to reverse negative mental health trends through stronger advocacy and financial and technical support, especially in the least developed parts of the world. It should also provide support to countries for developing or updating, monitoring and evaluating national policies, improving access to mental health facilities in communities, dealing with risk factors associated with mental disorder, conducting research, and setting up systems to collect data on mental and behavioural disorders.

Mr LEI Zhenglong (China) welcomed WHO's recent efforts and initiatives to improve global mental health, which had guided Member States in developing national policies, including those on service-assessment, and establishing psychosocial support systems in disaster areas. Knowledge sharing, coordination and legal frameworks needed to be improved both globally and nationally. He urged the Secretariat to continue providing support to governments for advocacy work and improving access to treatment. Such measures would help to ensure more effective implementation of WHO's recommendations.

Dr DAULAIRE (United States of America) said that his Government was committed to raising awareness of mental, neurological and substance use disorders, particularly given the predicted disease burden due to depression, and recommended that the three disorders be thus grouped together consistently in order to reflect the scope of the problem more accurately. He commended the Secretariat's efforts to support the training of health-care workers in non-specialized settings and urged further provision of training for mental health professionals. His Government had been focusing its efforts on taking people out of mental hospitals and integrating them into their communities, while providing a range of support services.

In its next report on mental disorders, the Secretariat should draw attention to the close correlation between mental, neurological and substance use disorders and physical health problems, including hypertension and heart disease. The Secretariat should provide guidance to countries on adapting the strategies outlined in the report to national circumstances.

As a cosponsor of the draft resolution, the United States urged Member States to allocate adequate resources to mental, neurological and substance use disorders within health and development programmes and to work with the Secretariat on the development of an action plan to aid people with mental disorders.

Ms VIEITEZ MARTÍNEZ (Mexico) said that the growing public health problem of mental disorders had a high social cost and affected people regardless of age, sex or socioeconomic status. Close cooperation between the health sector and the social, education and labour sectors was needed in order to implement community-based strategies to increase health service coverage and to integrate mental health programmes into broader categories such as noncommunicable diseases.

Greater financial and human resources would help to improve access to medicines and treatment, especially in low- and middle- income countries, and to reduce the stigmatization attached to mental disorders. She commended the Secretariat's efforts to assist Member States in drawing up evidence-based programmes based on systematic data collection, which would ensure a more efficient and equitable distribution of resources. WHO's support for countries that had conducted assessments of their mental health services from a human rights perspective was also laudable and had led to public policy protecting the interests of persons with mental disorders. She supported the draft resolution.

Mr ESPINOSA SALAS (Ecuador) said that greater attention needed to be paid to conditions such as depression, epilepsy, bipolar disorder, dementia and drug abuse in view of their social and economic impacts on subjects and their families. Special attention must be paid to human resources for mental health, which were particularly scarce in developing countries. Many countries earmarked only a paltry portion of their budget for mental health; in some cases, the figure was less than 1%. He supported the strategies recommended in the report and underlined the application of global policies aimed at improving inpatient psychiatric care and developing community services; helping countries to draw up legislation to protect the human rights of mental health patients; developing medicines for the principal existing mental disorders; promoting training for specialized mental health workers; and encouraging the development of affordable programmes for the promotion of mental health and the prevention of mental illness.

Dr ST. JOHN (Barbados) welcomed the attention paid in the report to the impact of mental health on general health and well-being. In recent years, her country had taken various measures to promote mental health, including the adoption of a national mental health policy and the establishment of a mental health commission. The Government also planned to draw up minimum standards of care in substance abuse cases and to develop a programme aimed at reducing discrimination against people with mental disorders.

The time had come to include mental health in a broader health policy context, as recommended in the draft resolution. Mental disorders were present in all societies, even if the resources available to combat the problem varied widely.

Mr ALMEIDA CARDOSO (Brazil)[1] urged bold steps to improve the lives of people with mental disorders, including better treatment, greater access to social welfare services and to education and employment opportunities, and protection of human rights.

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

Brazil was endeavouring, at national, regional and international levels, to improve mental health. Recent measures included shifting the focus from psychiatric hospital care to community service networks and redirecting resources accordingly; increasing the number of psychosocial care centres; establishing a national programme for the social reintegration of long-term psychiatric hospital patients; and addressing substance abuse issues.

Much remained to be done in order to provide adequate health treatment of mental disorders in the developing countries, which lacked financial and human resources and affordable treatment and care. Mental illness must be brought to the fore in order to combat stigmatization and discrimination and guarantee the social integration and human rights of affected persons. He welcomed the proposed development of a comprehensive action plan and supported the draft resolution.

Dr NICKNAM (Islamic Republic of Iran)[1] said that the report would have been stronger if it had included benchmarks for adequate levels of spending on mental health; calculations or estimates of the economic cost of various disorders, including out-of-pocket expenses for patients; further information on the paucity of human resources for mental health and an explanation of how the Mental Health Gap Action Programme planned to scale up its services; guidance on how to protect the mental health of those who were currently free of mental disorders but who sometimes experienced mental distress; and strategies to deal with children's mental health and development issues. In view of the link between mental disorders and chronic disease, programmes to prevent noncommunicable diseases and promote a healthy lifestyle should be expanded to include mental health issues, with particular emphasis on the world's increasingly large elderly population and the rising incidence of age-related diseases.

Ms ADAMS (International Council of Nurses), speaking at the invitation of the CHAIRMAN, observed that there had been little progress in improving access to prevention and treatment of mental illness. Failure to integrate mental health care into primary health care systems and shortages of human resources, including psychiatric nurses, were among the main barriers to access, as shown in a global survey of mental health nursing conducted by WHO and her Council. The nursing workforce could play a leading role in mental health services if adequate training was available. The opportunity for nurses to take on other responsibilities, for example, prescriptive authority, was currently restricted by outdated nursing practice legislation and overly protective medical legislation that was unresponsive to population and community needs. The Council had launched an initiative on noncommunicable diseases that aimed to develop nursing capacity and which included a project on the concurrent management of diabetes and depression. It was being piloted in five African countries and would be expanded to other regions and countries.

She urged the Secretariat and Member States to provide more mental health training for nurses and to increase the number of mental health nurse specialists. She also recommended that nurses should be authorized to identify, assess and treat common mental health disorders in primary health care settings.

Professor OMIGBODUN (International Association for Child and Adolescent Psychiatry and Allied Professions), speaking at the invitation of the CHAIRMAN, said that early investment in the mental and physical health of children offered the best results in future years for families, communities and countries, with improved levels of health, reductions in inappropriate use of health care, a decline in delinquency and violence, and economic gains, including a more productive workforce. Research indicated that interventions should start at conception and continue through gestation, delivery and thereafter. One in five children had a treatable mental disorder and half all cases of adult psychiatric illness began before the age of 14 years. There were almost no resources for the promotion of child and adolescent mental health in developing countries.

His Organization served as a resource, with an easily accessible web site, for countries considering policy development and programme implementation in the field of child and adolescent mental health. He endorsed the 2010 *WHO mhGAP Intervention guide for mental, neurological and substance use disorders in non-specialized health settings*, and joined calls for the inclusion of a child mental health plan in every national health agenda. Child mental health was relevant to every aspect of noncommunicable disease and it improved treatment compliance for communicable diseases.

Mrs LACHENAL (World Federation for Mental Health), speaking at the invitation of the CHAIRMAN, endorsed the draft resolution. The proposed comprehensive action plan should include an assessment of progress by independent civil society, in parallel to assessments by Member States; guidelines for the development of outcome protocols reflecting recovery and community orientation of mental health treatment and services, for use in monitoring progress; a focus on making psychiatric hospitals more humane and community-oriented; and an emphasis on children, adolescents, older adults and rural populations. Special attention should be paid to the physical health needs of people with severe mental disorders and the detection and treatment of mental illness in people with diabetes, cancer, and cardiovascular and respiratory diseases.

Dr THAKSAPHON THAMARANGSI (Thailand)[1] said that, although mental health problems were largely preventable, their global incidence remained high. Lack of access to care, insufficient prevention measures and violations of human rights were examples of the social injustice facing people with mental disorders. Financial, technical and political commitment to mental health was insufficient. Tackling mental health issues required a dual approach: focusing on mental health risk factors and attitudes towards mental disorders, and integrating mental health care into primary health-care systems – a step which would, among other things, lessen the stigmatization attached to mental health screening. Greater efforts and cooperation were needed in order to develop and strengthen both policy and practice and ensure that mental health was made a priority. That was the only way to reduce the burden of mental disorders on society.

He endorsed the draft resolution but proposed that the action plan include promotion of mental health and prevention of mental disorders.

Ms KUN NARYATIE (Indonesia)[1] strongly endorsed the draft resolution. Mental health problems were of great concern in many societies and the international community needed to come to grips with the social and economic burdens of mental disorders. Indonesia had developed national policies to incorporate mental health into the primary health-care system. It had also increased mental health funding and placed the medicines needed to treat mental disorders on a national list of essential medicines.

Dr WORNING (Assistant Director-General, ad interim), drawing attention to the estimated financial and administrative implications of the draft resolution, said that the calculations were based on past experience in developing similar action plans, but that the cost could be reduced if fewer consultative meetings were held, consultations were web-based, and no extra staff members were recruited to help implement the plan. If Member States agreed to such changes, the estimated costs could be decreased from about US$ 1 million to US$ 200 000 and could be incorporated into the regular budget. As a result, however, some lesser elements of the plan might need to be deferred or abandoned.

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

Dr SILBERSCHMIDT (Switzerland) said that his country had chosen to cosponsor the draft resolution for two reasons: first, the decision at the United Nations High-level Meeting on the Prevention and Control of Non-communicable Diseases that mental disorders should not be included explicitly in discussions on noncommunicable diseases as the risk factors were too varied and, secondly, the recognition that the global burden of mental disorders had not been sufficiently addressed to date. He encouraged the proposal of amendments that would further strengthen the draft resolution.

Dr LARSEN (Norway) suggested that the preamble to the draft resolution should be amended to include two additional paragraphs; the first should read "Recognizing that mental disorders can be prevented and that mental health can also be promoted in sectors outside health" and the second "Concerned that persons with mental disorders are stigmatized, and underlining the need for health authorities, working together with relevant groups, to change attitudes to mental disorders".

In paragraph 1, the words "mental health promotion and disease promotion as well as" should be inserted after "strategies that address". In subparagraph 1(3), the words "to promote mental health and" should be inserted after "Action Plan".

The words "including the need to avoid stigmatization of persons with mental disorders" should be added to the end of subparagraph 2(2)(a), and a new paragraph inserted after subparagraph 2(2)(b), to read "The need for prevention to be included in policies in mental health".

Ms REINAP (Estonia), speaking on behalf of the European Union, suggested that in the ninth preambular paragraph the words "in women and children" should be deleted and a new paragraph be inserted after the tenth preambular paragraph, to read "Noting that there is increasing evidence on effectiveness and cost-effectiveness of interventions to promote mental health and prevent mental disorders, particularly in children and adolescents;".

In paragraph 1, a footnote should be inserted after the words "URGES Member States", to read "And, where applicable, regional economic integration organizations" and in subparagraph 1(1), the words "mental health promotion, prevention of disorders, in particular among children and adolescents, as well as" should be inserted after "strategies that address". In the same subparagraph, "empowering service users" should be inserted after "tackling stigma".

In subparagraph 2(1), the word "comprehensive" should be deleted and the words "to promote mental health, prevent mental disorders and provide care and services and" should be inserted.

At the end of subparagraph 2(2)(b), the words "with particular focus on deinstitutionalized care and empowerment of service users" should be inserted after "programmes and legislation". Following subparagraph 2(2)(bbis), a new subparagraph should be inserted, to read "enhance initiatives to promote mental health and prevent mental disorders, including, where appropriate, support for parental skills".

In subparagraph 2(3), the words "and as appropriate, with" should be inserted after "Member States".

Dr PE THET KHIN (Myanmar) said that in subparagraph 1(1) the words "promotion and prevention of mental health problems and screening" should be inserted after "strategies that address", and in the same subparagraph the words "tackling major modifiable risks of mental health problems" should be inserted after "addressing poverty".

In subparagraph 1(2), the words "give appropriate priority" should be replaced with "prioritize and streamline" and the word "appropriate" should be replaced with "adequate". Subparagraph 1(3) should be amended with the insertion of "to promote mental health and prevent mental health problems and" after the words "Action Plan".

In subparagraph 2(1), the words "in consultation with" should be inserted after "Action Plan" and the words "to promote mental health and prevent mental health problems and" should be inserted

after "programmes and legislation". In subparagraph 2(2)(b) the word "equitable" should be inserted before "access" and the word "affordable" before "quality". In subparagraph 2(2)(bbis), the word "competent" should be inserted after "development of"; the words "and equitable distributions" should be inserted after "adequate" and the words "promotion, prevention and" should be inserted after "mental health". The word "equitably" should be deleted from the end of subparagraph 2(2)(bbis).

In subparagraph 2(3), the word "donors" should be replaced with "international development partners". A new subparagraph 2(4) should be inserted to read "to submit the Action Plan for consideration by the Sixty-seventh World Health Assembly through the 134th Executive Board."

Dr GULLY (Canada) endorsed the amendments proposed by the member for Norway, and the suggestion by the member for Estonia to delete the words "in women and children" from the ninth preambular paragraph. He suggested that the words "according to national priorities and within their specific contexts" should be inserted at the beginning of subparagraph 1(1). In the same subparagraph, the words "mental health promotion, mental illness prevention, as well as" should be inserted after "strategies that address", the word "including" after "mental disorders", the words "and homelessness" after "addressing poverty" and the words "promoting public awareness" after "as appropriate".

In subparagraph 1(2), the words "including mental health promotion, mental illness prevention, care, support and treatment" should be inserted after "mental health". In subparagraph 1(3), the words "promote mental health, prevent mental illness and" should be inserted after "Action Plan to".

In subparagraph 2(1), the words "mental health promotion and mental illness prevention, as well as public awareness" should be inserted after "covering", and following subparagraph 2(2)(a), a new paragraph should be added, to read "mental health promotion and mental illness prevention".

Ms VIEITEZ MARTÍNEZ (Mexico) suggested that two new subparagraphs should be added under subparagraph 1(1), the first of which should read "to develop comprehensive programmes that include an integral approach to prevent and attend mental disorders with community-based interventions" and the second "to develop appropriate surveillance frameworks that include risk factors as well as social determinants of health to evaluate and analyse trends regarding mental disorders".

A new subparagraph should be added under subparagraph 2(2)(d), to read "to design and provide special mental health support systems that will enable community resilience and will help people cope during humanitarian emergencies". A new subparagraph should be added under subparagraph 2(2)(e), to read "to create special programmes for health-care providers that include mental health in community and primary care settings".

Three new subparagraphs should be added under paragraph 2. The first should read "to ensure equitable access to quality health-care attention and medications", the second "to ensure mental health support in schools and labour settings" and the third "to build up social frameworks in order to support people with mental disorders as well as their families". In addition, subparagraph 1(2) should be shifted to paragraph 2 and in that subparagraph, the words "to prevent mental disorders, as well as to provide appropriate treatment" should be inserted after the word "resources".

Dr EL OAKLEY (Libya),[1] expressing support for the proposal made by the member for the United States of America to replace the term "mental disorders" in the Secretariat's report with the words "mental, neurological and substance use disorders", proposed that the draft resolution be amended along the same lines, ensuring in particular that it contained adequate reference to under-diagnosed conditions such as cognitive dysfunction, dementia and Alzheimer's disease.

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

Dr SAXENA (Mental Health and Substance Abuse) said that the amendment proposed by the representative of Libya would require a major reworking of most of the resolution's text and would dramatically change its scope. Furthermore, from a technical perspective, the issues related to neurological and substance abuse disorders varied greatly and would affect specific strategies that had already been suggested for inclusion in the draft resolution. Could Board members clarify their position with respect to the proposal?

The DIRECTOR-GENERAL also sought clarification from members on the proposal to replace the term "mental disorders" with "mental, neurological and substance abuse disorders", which would dramatically change the scope of the draft resolution and require it to be rewritten.

Dr DAULAIRE (United States of America) said that the measures endorsed by the Board needed to be practical, targeted and amenable to implementation. The term "mental disorders" in the draft resolution should therefore remain as it stood to ensure a more targeted scope. In his earlier statement, he had suggested that, in general, the words "mental, neurological and substance use disorders" should be used to refer to that particular cluster. He had not intended to modify the wording of the draft resolution in that respect.

Dr GULLY (Canada), endorsing the statement made by the member for the United States of America, asked whether the proposed expansion of the draft resolution to include mental health promotion was necessarily linked to the proposed use of the wording "mental, neurological and substance use disorders" or whether the two issues were separate. If the Board chose to include mental health promotion in the draft resolution, it should be treated as a substantive issue. The alternative was to draft two separate resolutions, one on mental health promotion and the other on treatment of mental health disorders.

Dr SILBERSCHMIDT (Switzerland) said that the scope of the draft resolution should not be broadened. A new preambular paragraph, drafted by the Secretariat and making reference to neurological and substance use disorders, might however usefully be added to the draft resolution.

Mrs REITENBACH (Germany) endorsed the views of the previous speakers.

The DIRECTOR-GENERAL said that keeping the title of the draft resolution as it stood did not rule out making reference to prevention of mental disorders and promotion of mental health in the body of the resolution.

The CHAIRMAN requested the Secretariat to prepare a new draft resolution, taking into account Member States' comments and proposed amendments.

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

Nutrition: infant and young child nutrition; nutrition of women in the preconception period, during pregnancy and the breastfeeding period: Item 6.3 of the Agenda (Documents EB130/10 and EB130/11)

Mr MAXTONE-GRAHAM (Papua New Guinea) welcomed the multisectoral nature of, and the inclusion of global targets in, the draft comprehensive implementation plan on maternal, infant and young child nutrition. In order for them to be effective and win the endorsement of Member States, the targets must be ambitious, meaningful and linked to tried and tested activities. The implementation plan should also include safeguards to prevent potential conflicts of interest and should avoid

promoting public-private partnerships. With regard to specific targets, he proposed that global target 5 should read "To increase each national exclusive breastfeeding rate by 50%, and work towards setting up targets of exclusive breastfeeding at six months" and expressed concern that the global target 4 on obesity was not sufficiently ambitious and did not seek to reverse the growing trend of childhood obesity. Was the assumption that the challenge of nutrition deficiencies would be met by untested market solutions involving lipid-based prepared food rather than by community-based approaches encouraging the use of local ingredients? Would the promotion of foods and beverages high in sugar and fat continue unabated?

Mr DÍAZ ANAIZ (Chile) said that the promotion of maternal and infant health, in relation to which his country had achieved excellent results, called for ongoing review of strategies to meet the needs of populations at all levels. His country had implemented, solely and in cooperation with other countries in the Region, multisectoral policies to combat malnutrition among the most vulnerable sectors of the population, which had resulted in one of the lowest regional rates. He expressed his full support for the draft resolution.

Ms REINAP (Estonia), speaking on behalf of the European Union and its Member States, said that the acceding State Croatia, the candidate countries the former Yugoslav Republic of Macedonia, Montenegro and Iceland, the countries of the Stabilisation and Association Process and potential candidates Albania and Bosnia and Herzegovina, and Georgia aligned themselves with her statement. Proper nutrition was particularly important during the first two years of life, as it could determine a child's future disease and mortality profile. Governments, civil society, the international community and the private sector must therefore take joint action to combat undernutrition, malnutrition and obesity, which were key risk factors for noncommunicable diseases and posed a significant threat to the development of cognitive functions in infants and young children. Owing to the multisectoral nature of the issue, she welcomed the dialogue between WHO, FAO, UNICEF and WFP, partners in the Scaling Up Nutrition framework launched by the United Nations General Assembly in September 2010.

Despite vigorous campaigning, less than 40% of babies worldwide were breastfed exclusively for the first six months. That figure could only be augmented through a more comprehensive approach which should strive to improve access to nutritious foods for the first two years of life and to promote exclusive breastfeeding. Most Member States had nutrition policies, but they often failed to meet the complex challenges of maternal, infant and young child nutrition. The global targets and time frames set out in the draft implementation plan might well be the key to solving that problem. Member States should be provided with the opportunity to consult further on the draft plan, preferably through web-based systems, before it was submitted to the Sixty-fifth World Health Assembly.

Dr BAYE LUKONG (Cameroon), speaking on behalf of the Member States of the African Region, said that malnutrition was particularly prevalent among African children under the age of five years as a result of poor breastfeeding practices, improper weaning and a lack of information on the use of locally available foods. Ongoing efforts to reduce the malnutrition rate included promotion of exclusive breastfeeding, community-based approaches and the organization of child health days. However, the main challenge was to expand such interventions, and countries in the Region had been urged to draw up comprehensive plans for doing so.

Welcoming the incorporation of suggestions made by the Region into the draft implementation plan, she also proposed some amendments. A new subparagraph (3) should be inserted under paragraph 46, to read "Promote transformation of locally-produced, high-quality weaning foods and ensure their financial accessibility." In the section on food manufacturing in Table 2, an additional intervention should be inserted, to read "Transformation and subsidizing of rich locally-produced weaning foods". Implementation of the draft plan would give rise to various challenges, which included identifying ways to strengthen socioeconomic development, ensuring financial investment

and technical capacity in food safety and nutrition, and formulating comprehensive communication strategies on food security and nutrition. The plan should be implemented using a multisectoral approach, with particular emphasis on community participation.

Mr YUSOF (Brunei Darussalam) said that his country had taken various measures to meet the multifaceted challenges of nutrition. Children under the age of five years were screened to detect, treat and monitor cases of undernutrition as early as possible; pregnant women were tested for anaemia in maternal health clinics and standard guidelines on such procedures had been issued. In an effort to increase the rate of exclusive breastfeeding during the first six months of life, breastfeeding education was dispensed and mandatory maternity leave had almost doubled to 105 days. He endorsed the five global targets of the draft plan and urged Member States to commit themselves wholeheartedly to achieving them.

Ms XU Xiachao (China) endorsed the targets and time frames set out in the draft plan. In China, there had been a sharpened focus on maternal, infant and young child nutrition in recent years, with the implementation of projects such as the distribution of free folic acid supplements in rural areas. There were also plans to develop projects for preschool children in poor areas and she encouraged the Secretariat to increase its assistance in that area and to monitor the effectiveness of such projects. It should also provide a platform to strengthen communication and allow Member States to share their experience.

Mr PRADHAN (India) said that improvement of maternal and child nutrition required an intersectoral approach based on the life cycle. In India, the Prime Minister chaired a National Council on Food Challenges to set priorities and facilitate multisectoral interventions, including food security. The global targets proposed in the draft implementation plan seemed reasonable, but the percentages aimed for should be country-specific rather than universal. Under the section on Actions, actions 1 and 3 should be merged.

The draft plan referred to two new initiatives - Scaling-Up Nutrition and Renewed Efforts Against Child Hunger and Undernutrition - but failed to provide an institutional mechanism for identifying, preventing and managing conflicts of interest or to emphasize the obligation of the private sector to comply with the International Code of Marketing of Breast-milk Substitutes or the global strategy for infant and young-child feeding. The areas of food security, infant and young child feeding practices, and water and sanitation required fuller treatment in the draft plan.

Mr ÁLVAREZ LUCAS (Mexico) supported the draft implementation plan. His country had reduced undernutrition among children under the age of five years, but had witnessed an alarming increase in obesity rates in recent years owing to poor eating habits, combined with a lack of nutritious food, during the early years of development. Mexico had been tackling the problem of undernutrition, overweight and obesity by offering nutrition programmes in primary health care units and providing training to parents and child-care workers. He proposed three additional measures: training of multi-country working teams under the leadership of WHO to develop progress indicators on breastfeeding, on the basis of which effective methods to promote breastfeeding could be developed; vigorous campaigns to promote breastfeeding at the local level; and establishment of closer ties with WHO for the planning of capacity-building workshops. Table 3 of the draft plan should be revised, as it appeared to contain some inconsistencies.

Dr SHEIKH YUSUF (Somalia) said that, although effective nutrition interventions existed, they had not been implemented on a large scale. Indeed, countries with the greatest burden of undernutrition were often not able to carry out measures on the scale necessary to prevent undernutrition and foster child development. He fully endorsed the draft plan, into which the views expressed at the regional consultations had been incorporated.

Dr LARSEN (Norway) said that the draft plan, which he fully endorsed, should be accorded high priority and the necessary human and financial resources to implement it. The plan should focus on measures to promote breastfeeding, which had the single largest impact on child survival of all preventive measures, and should give more coverage to the Baby-Friendly Hospital Initiative, which should be expanded to cover neonatal wards and primary health-care services. The plan should also mention WHO's Child Growth Standards, and Table 1a should include vitamin D supplementation for women and children from northern countries at high latitudes.

Professor BABLOYAN (Armenia) said that inadequate nutrition represented a significant barrier to achieving the Millennium Development Goals. He therefore welcomed the draft plan, which proposed important measures for tackling that problem. Drawing attention to the progress made in his country with regard to nutrition, he explained that the Armenian Government had drafted a bill, which had the support of governmental and nongovernmental organizations, on appropriate breast-milk substitutes.

Dr AL-THANI (Qatar), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that they were committed to implementing health interventions that would improve nutrition in a wide range of settings, including health facilities, local communities and such sectors as agriculture, education and employment. Those interventions were to be followed by integrated action plans as part of the regional strategy on nutrition 2010–2019.

Malnutrition was a serious health problem in most countries in the Region, where millions of children were insufficiently active owing to lack of food and poor early feeding practices. Recent statistics showed that more than half of the deaths among the under-five-year-olds in the Region were linked to malnutrition and that almost one third of under-fives were stunted for their age. The roots of malnutrition lay in political instability, high food prices and natural disasters.

WHO's ongoing technical support for the implementation of its Child Growth Standards in the Region was much appreciated, as were its efforts to strengthen nutritional monitoring, including through capacity building. Several countries had introduced a strategy for infant and young child feeding, based on WHO's global strategy, which formed an integral part of child health programmes. The continuing lack of information available on the effectiveness and scope of such feeding initiatives was a hindrance to their improvement, however. The regional strategy for nutrition had nonetheless promoted the elaboration of nutritional policies and plans aimed at reducing the double burden of malnutrition, which would in turn promote the global efforts to promote nutritional activities and the United Nations Millennium Campaign. The Road Map for Scaling-Up Nutrition also envisaged multi-stakeholder processes at local and national levels that aimed to help programme staff, organizations and society effectively to expand activities on nutrition.

Dr GULLY (Canada) said that his country was playing a leading role in the Scaling-Up Nutrition movement and was a major donor in support of nutrition efforts at the country level. The International Code of Marketing of Breast-milk Substitutes should be adapted by countries to suit their specific conditions. The global targets set out in the draft implementation plan were a useful tool for measuring success and ensuring accountability, but also had to be meaningful, measurable and adaptable to country-specific situations. Achieving the targets would require strong and functional health services and fully trained health personnel, particularly in the least developed countries. It was not clear how the global targets had been developed and he asked the Secretariat to prepare for the Sixty-fifth World Health Assembly a background document explaining the process. The actions recommended in the draft plan tended to be prescriptive; it would be preferable to view them as options that could be implemented on the basis of each country's needs. He wondered whether the Board would be able to note the report as requested, given that the member for Cameroon had called for it to be modified.

Dr DAULAIRE (United States of America) recognized that a significant amount of work had gone into drafting the implementation plan, but substantial further collaboration with multilateral and bilateral partners was needed, as the targets set out in the plan depended on concerted action. For example, it was not clear whether the other partners in the Scaling-Up Nutrition movement even supported all the targets, a matter that needed to be clarified. The International Code of Marketing of Breast-milk Substitutes should be vigorously and universally supported, applied and enforced. The draft plan should provide standardized guidance on legislation, labelling of food and Codex standards to assist Member States in implementing their own laws. Despite his comments at the 128th session of the Executive Board, the plan still contained no reference to the WHO recommendations on the marketing of foods and non-alcoholic beverages to children, which weakened the plan's ability to reduce obesity. He urged the Secretariat to identify and harmonize common targets in the areas of nutrition and noncommunicable diseases to avoid duplication of effort.

Mr ESPINOSA SALAS (Ecuador), endorsing the draft resolution, said that the nutritional strategy being implemented in his country focused on all stages of the life cycle, with particular emphasis on the target of "zero undernutrition", and recommended specific activities to combat micronutrient deficiencies and obesity, and to promote healthy lifestyles. He encouraged the Secretariat to continue expanding its scientific database, to publish guidelines on health and nutrition during pregnancy, and to make them available in the WHO electronic library.

Dr SAKAMOTO (Japan) welcomed the comprehensive plan's focus on mother and child nutrition, as good nutrition throughout a woman's life-cycle was closely related to the health of her children. Moreover, improving the nutritional status of mothers would contribute to the attainment of Millennium Development Goal 5 (Improve maternal health). Implementation of the draft plan should take into account local conditions, as nutrition problems varied greatly by region. Greater collaboration was needed among departments in the Secretariat dealing with nutrition, as was closer cooperation between the Organization and the relevant bodies in the United Nations system, such as FAO and UNICEF.

Dr AL-HALKI (Syrian Arab Republic) said that in the low-income countries of the Eastern Mediterranean Region poor maternal health and malnutrition were responsible for the incidence of low birth-weight children, who were vulnerable to infection and, in extreme cases, neonatal death.

Regardless of economic status or income level, women and children throughout the Region commonly suffered from iron-deficiency anaemia, primarily because of the low bioavailability of iron in the diet, the presence of intestinal parasites and close birth spacing. A substantial proportion of women had osteoporosis and were underweight and short in stature. Programmes aimed at ensuring iron-rich nourishment and iron supplementation were therefore ongoing in several countries of the Region with a view to addressing the problem.

The Secretariat continued to provide all countries of the Region with technical assistance for implementing its Child Growth Standards, thus far adopted by 17 of those countries, with the remainder due to complete the necessary changes to their own national standards by the end of 2012. The regional strategy on nutrition had also stimulated the development of nutritional policies, notably in order to tackle the double burden of undernutrition and overweight through a variety of means, including guidelines, technological resources and various forms of cooperation. Field studies would undoubtedly be needed for the purpose of designing further programmes and effective interventions for the Region.

Mr DA FONSECA (Timor-Leste), stressing the importance of proper nutrition for pregnant women and for children, proposed that paragraph 43 of the draft plan should include a reference to the creation of an environment in the workplace for breastfeeding mothers that would enable them to breastfeed long enough to have a positive impact on their child's health. Moreover, the

recommendation in paragraph 46(b) on dialogue between the health sector and other government sectors should also contain a reference to dialogue with those responsible for developing labour policies.

Dr ST. JOHN (Barbados) expressed appreciation of the strategic and operational support her country had been receiving from the PAHO/WHO Caribbean Food and Nutrition Institute, notably its assistance in improving the national child health record, which played a key role in monitoring the effects of nutrition on development. Barbados was pursuing its efforts to promote infant and young child nutrition, with a special focus on exclusive breastfeeding. Other activities included training in complementary feeding for health-care workers and the development of practical guidelines for nutritious school lunches. The implementation plan was particularly welcome as it should be one of the foundations for efforts to study the effects of noncommunicable diseases on health and development. More information was needed, however, on the plan's global targets and time frames.

Dr NICKNAM (Islamic Republic of Iran)[1] said that the complex subject of nutrition demanded resolute and concerted efforts. The draft plan contained effective nutritional strategies, and mentioned new global and regional joint initiatives that would presumably carry them out. Improved mechanisms for delivery of those strategies were nonetheless needed. Gaps in current programmes and ways to improve coordination across sectors should be identified. In addition, greater understanding was needed of the relationship between nutrition and other factors, such as micronutrient deficiencies and blood disorders, which were widespread in the Eastern Mediterranean Region. The plan should include ways to strengthen operational research on the obstacles to achieving good nutrition. The Secretariat should strengthen its advocacy and consider organizing a global campaign on maternal and child health.

Ms CABALLERO (Peru)[1] thanked the members for Chile and Ecuador for cosponsoring the draft resolution on the implementation plan. Adequate nutrition was an investment in the future. Her Government was making sustained efforts to promote social inclusion in all areas, including by ensuring optimal nutrition to newborn infants and promoting exclusive breastfeeding during the first six months of life and complementary feeding until the age of two years. Implementation of the plan would contribute to the achievement of the Millennium Development Goals.

Dr NAPAPHAN VIRIYAUTSAHAKUL (Thailand)[1], drawing attention to the draft plan, said that global target 5 was not sufficiently ambitious, given that an annual increase of only 1.5% was required to reach the target and some countries had already gone beyond that threshold. Moreover, the language of the target was not clear enough and might be misinterpreted. She suggested that the word "in" should be replaced by "for" in the target title, to read: "Increase exclusive breastfeeding rates for the first six months up to at least 50% by 2022". A more ambitious target, which would include countries that had already reached the 50% threshold, might be worded: "to halve the rate of non-exclusive breastfeeding for the first six months by 2022". Another concern was that the plan did not adequately address the issue of maternity protection and unsupportive environments. The maternity leave period defined in the ILO Maternity Protection Convention merited review.

Ms SMITH (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN, said that breastfeeding was the underlying principle of optimal nutrition and, as such, was the key to the successful execution of the draft implementation plan. She therefore called on WHO to ensure that breastfeeding did not get lost among other plans and to acknowledge that breastfeeding also affected mother-child bonding and the health of the community. She endorsed

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

global target 5 in particular and considered that the target level might even be raised. She encouraged the Secretariat to reinvigorate and strengthen the promotion of the International Code of Marketing of Breast-milk Substitutes which was, unfortunately, flouted in many countries.

Dr COSTEA (International Special Dietary Foods Industries), speaking at the invitation of the CHAIRMAN, endorsed the implementation plan, and, in particular, its emphasis on dialogue and partnerships with relevant stakeholders, support for complementary feeding, improving sanitation and water supply and respect for the International Code of Marketing of Breast-milk Substitutes. In addition to breastfeeding, appropriate complementary feeding was crucial to good nutrition. Inadequacies in the composition of complementary foods and absence of appropriate preparation, use and storage of such foods put young children at risk. For that reason, the plan's focus on social determinants of health and nutrition counselling for women was welcome.

Dr LHOTSKA (Consumers International), speaking at the invitation of the CHAIRMAN, said that the draft plan placed excessive emphasis on nutrients and micronutrient deficiencies, failed to highlight adequately the impact of poor infant and young child feeding practices and made no reference to the inappropriate promotion of baby foods. More emphasis was required, furthermore, on the need for maternity protection to facilitate a full six months of breastfeeding. The Scaling-Up Nutrition "movement", not yet fully operational, did not have adequate safeguards in place to avoid conflicts of interest, defined links with the United Nations coordinating mechanism for nutrition or a proven record of effectiveness. The specific reference to that movement could be removed from the plan and replaced with paragraph 44 of the Global strategy on infant and young child feeding to ensure that the plan did not undermine the very policy document it was meant to implement. The report by the Secretariat failed to emphasize the right to adequate food and nutrition or the right to health; it also did not provide an analysis of the root causes of poor nutrition in women, which included structural violence and discrimination.

Ms HOLLY (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, said that progress on reducing malnutrition had been far too slow. The draft implementation plan was therefore welcome and, in that context, the Secretariat should work closely with the Scaling-Up Nutrition movement to ensure harmonization between the plan and other country-level nutrition progammes. The plan itself would benefit from a stronger focus on reducing inequalities in the nutritional status of women and children within countries, providing disaggregated data on gender, income level and other equity-related matters. The actions set out in the section on human resources should include methods to close the global health worker gap and improve the distribution of fully trained health workers. To make real progress on nutrition, other critical sectors, such as agriculture and education, should help to ensure that the plan was implemented in a cross-sectoral manner, with duly assigned accountability.

Dr BRANCA (Nutrition for Health and Development) said that the draft plan contained a set of actions that Member States could confidently implement according to their needs. The plan had been formulated following a lengthy consultation process that had included web-based and face-to-face consultations with Member States, organizations in the United Nations system, civil society and the Scaling-Up Nutrition community. As requested, further information would be provided on the global targets, in particular on the process by which they were developed, the actions required to achieve them, and the links to noncommunicable disease targets. Cooperation with organizations in the United Nations system had been vital to the development of the plan and would be needed to ensure harmonization of activities at country level. The Renewed Efforts Against Child Hunger and Undernutrition Initiative had been implemented in 10 countries in 2011, and WHO was committed to its support. The plan was still in draft form and amendments from Member States were welcome.

The DIRECTOR-GENERAL, responding to the question by the member for Canada about changes to the draft plan, said that Secretariat reports might omit information or contain points needing clarification like any other document and could always be modified by the Member States. The plan would be adjusted to take into account the comments made during the session. The Secretariat would also comply with the request by the member for Canada for a background document on the rationale for the global targets. Further web-based consultations on the draft plan could be held as needed, in order to finalize it for consideration by the Sixty-fifth World Health Assembly in May 2012.

The Board noted the report.

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

The meeting rose at 12:45.

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